Supporting Statement

HHS Teletracking COVID-19 Portal (U.S. Healthcare COVID-19 Portal) Information Collection

Requests for OMB Review and Approval
Under the Paperwork Reduction Act and 5 CFR 1320

Department of Health and Human Services

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Office of Resources Management
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A. Justification

1. Circumstances Making the Collection of Information Necessary

Section 319 of the Public Health Service Act (42 U.S.C. § 247d) - Under section 319 of the PHS Act, when the Secretary of the Department of Health and Human Services declared a PHE on January 31, 2020 (https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx), consistent with his other statutory authorities, he can take such action as may be appropriate to respond to the PHE including making grants; entering into contracts; and conducting and supporting investigations into the cause, treatment, or prevention of the disease or disorder.

Hospitals are key partners in the U.S. response to COVID-19. The response is locally executed, state managed, and federally supported. At the Federal level, the U.S. Department of Health & Human Services COVID-19 Response Function, the White House Coronavirus Task Force, and the Centers for Disease Control & Prevention COVID-19 Response Function work together to support the effective operations of the American healthcare system.

This collection initially began at the end of March through a letter from the Vice President Pence to the nation's 4,700 hospitals, asking them to submit data daily on the number of patients tested for COVID-19, as well as information on bed capacity and requirements for other supplies. (https://www.cms.gov/files/document/32920-hospital-letter-vice-president-pence.pdf)**.**

The Teletracking portal includes some data that were initially submitted by hospitals to HHS through CDC's National Healthcare Safety Network (NHSN) COVID-19 Module (OMB Control No. 0920-1290) that was approved 3/26/2020. Over the last several months time, the guidance for which data elements should be sent to HHS and through which method was updated at the request of the White House Coronavirus Task Force and other leaders to improve upon this collection in order to inform the response. Timeline below:

- **4/10/2020:** Addition of two modules, for staffing and supply information
- **4/24/2020:** Information collection for long term care facilities added
- **5/4/2020:** Inclusion of instructions for LTCF to upload information to NHSN, and to include the burden required for enrollment of facilities.
- **5/13/2020:** Provide revised versions of instructions for LTCFs to upload information to NHSN
- **5/18/2020:** Modification of the Patient Impact and Hospital Capacity form in response to a request form the White House Coronavirus Task Force.
- **6/1/2020:** Addition of data elements to the Patient Impact and Hospital Capacity form in order to strengthen the COVID-19 response efforts.
- **7/3/2020:** Addition of nine data elements to the Patient Impact and Hospital Capacity form and will add TeleTracking to the NHSN collection at the request the White House Coronavirus Task Force in order to strengthen COVID-19 response efforts.

- **7/15/2020:** Transition of NHSN reporting for COVID-19 response efforts to Teletracking.

Because this collection is mandatory to receive certain types of Federal support, clearance under the Paperwork Reduction Act of 1995 (PRA) was required. As such, the NHSN clearance under the PRA only included a portion of the hospitals that are reporting though Teletracking, this ICR is being submitted as "in use without an OMB approval."

2. Purpose and Use of Information Collection

The data collected through this ICR is intended to inform the Federal government's understand disease patterns and develop policies for prevention and control of health problems related to COVID-19. One of the important uses of the data collected through this ICR is to inform critical allocations of limited supplies (e.g., protective equipment and medication). For instance, the Teletracking portal been used to distribute Remdesivir via distinct data calls on regular intervals. As of July 10, HHS reduces the number requests for data from hospitals to support allocations of the drug Remdesivir, a vital therapeutic that HHS distributes to the American healthcare system. HHS stopped sending out one-time requests for data to aid in the distribution of Remdesivir or any other treatments or supplies. This daily reporting is the only mechanism used for the distribution calculations, and daily reports are needed daily to ensure accurate calculations.

Building upon this framework, HHS CIO has improved upon this initiative to collect key data from hospitals to inform the Federal response and other key policymaking decisions. Furthermore, HHS CIO and CDC are working with the Office of Management and Budget's United States' Digital Services (OMB, USDS) and in close coordination with state and local stakeholders, including health departments, associations, hospitals, and community leaders to assess the need for each of the data elements collected as well as to ensure the data are harmonized among respondents and that the burden on hospitals, state and local health departments, and others are considered as the COVID-19 PHE continues. HHS CIO will continually assess the mechanism of submission, burden of compliance and reporting, and utility of the information collected and update this package accordingly based on those assessments.

This data is critical for numerous purposes including:

- Federal Government's effective allocation of resources. **(**For example, the data collected is used to determine and allocate limited Federal supplies of Remdesivir. Remdesivir is a key therapeutic for mitigation of the effects of COVID-19.)
- Production of reports to inform state and local officials of changing local conditions (e.g., Governor's Reports)
- Production of internal reports to inform and guide key decision-makers, including the White House Coronavirus Task Force and Operation Warp Speed
- Incorporation into models and other projections, estimations, or data analyses in numerous endeavors, both public and private, via the HHS Protect platform
- Distribution via HHS Protect Public to inform a range of public stakeholder and leaders

- Coordination with other Federal health providers (Defense Health Agency, Indian Health Service, Department of Veterans Affairs) for federally-provided healthcare.

3. Use of Improved Information Technology and Burden Reduction

NHSN was collecting data from approximately 3,200 hospitals on the week of July 6, 2020. At that time, estimated 1200 hospitals were already reporting only through the Teletracking portal, and approximately 2,000 hospitals were reporting through both the Teletracking portal and NHSN. During the July 2020 to August 2020 period, OMB's USDS provided technical assistance to hospitals requesting assistance from HHS in changing their reporting from NHSN to the Teletracking portal. Many of these hospitals were also reporting some of the same data elements to their state health departments separately. OMB's USDS is working with state health departments who wish to take responsibility for reporting data from all of the hospitals in their state, thereby reducing burden on the hospitals and increasing the quality of the data. To date, 23 states have been certified by USDS, and several more are in the process of becoming certified.

4. Efforts to Identify Duplication and Use of Similar Information

Previous to July 10, 2020, HHS permitted the use of submission of data via the NHSN COVID-19 module, Teletracking, or other mechanisms, including the use of EHRs for direct submission. The data fields requested were agnostic of submission vehicle. The purpose of this inherently duplicative approach was to ensure hospitals began collecting this critical data expeditiously, consciously leveraging hospitals' long standing familiarity and use of NHSN. However, as our experience grew throughout the pandemic, it became clear that this duplication was not effective for the aforementioned purposes and was an additional burden on the respondents and on the Department to maintain and update as the response and the associated data needs changed. Thus, on July 10, 2020 HHS discontinued collection using National Healthcare Safety Network, which was collecting similar information. This single collection (along with collections intermediated through state health departments) represent the source for hospitalization information related to COVID-19 feeding the HHS Protect platform.

5. Impact on Small Businesses or Other Small Entities

HHS is conscious of the numerous requests for data placed upon small and rural hospitals, as well as other small businesses in the healthcare industry. HHS has sought to be judicious in the number of required fields, and commit to continue to doing so, in coordination and in communication with our numerous partners. Teletracking is built with this burden in mind and is capable of receiving incomplete submissions, providing the flexibility for the timely delivery of critical information. HHS is mindful of the data infrastructure and limitations of many small entities, many of whom are rural, and has sought, wherever possible to allow states and hospitals to leverage existing reporting capabilities, or where those capabilities are insufficient, to utilize HHS reporting capabilities. We are allowing choice in reporting to lower burden.

6. Consequences of Collecting the Information Less Frequent Collection

To accurately and expeditiously inform the COVID-19 response, hospitals (or states on behalf of hospitals) are encouraged provide to information on a daily basis. However, we acknowledge the burden placed on many hospitals, including resource constraints, and have allowed for flexibilities, such as back-submissions or submitting every business days, with the understanding that respondents may not have sufficient staff working over the weekend. It is our belief that collection of this information daily is the most effective way to detect outbreaks and needs for Federal assistance over time and by hospital and geographical area and alert the appropriate officials for action. Given the rapidly evolving nature of the pandemic, delays in identifying outbreaks or shortages in PPE/other critical materials could lead to delays in action, impacting our ability to address the prevalence, incidence, and mortality rates of COVID-19 within the US, as well as expeditiously respond to the needs of frontline and health care workers and essential workers (e.g., meatpackers).

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This information is collected in response to a public health emergency.

8. Comments in Response to the Federal Register Notice/Outside Consultation

***Emergency Clearance* –** As of 9/10 over 190,000 Americans have lost their lives as a result of the COVID-19 pandemic. HHS has mobilized emergency operations and systems to support and respond to this national emergency. For more than 4,800 individual acute care facilities, this is the only means to report hospital capacity and utilization. Without this feed being immediately available the federal response apparatus was flying blind to the needs of our healthcare system. As a result, this capability was immediately stood up and we are processing the relevant paperwork to support this collection. Federal Register Notice was published on September 23, 2020, pg. 59809, vol.85.

9. Explanation of any Payment/Gift to Respondents

Respondents are not offered gifts or payment directly for response to this information collection. However, response to this collection directly impacts federal and state decisions regarding allocation of scarce supplies and resources. While there is no payment or gift to respondents in the direct sense of the question, lack of response could lead to suboptimal allocation of resources and frustrate the national response to COVID-19.

10. Assurance of Confidentiality Provided to Respondents

No personally identifiable information (for COVID-19 patients) is collected as part of this information collection. Business identifiable information is collected, including the name of the relevant hospitals or businesses, its operating address, and unique keys or identifiers that the

Federal Government uses for identification of the hospitals. Hospitals are told that data may be released to certain entities that would allow identification.

Data at the Need to know includes, but is not limited to, public health surveillance, ensuring stable operations of the American healthcare system, allocation of supplies, and other internal US government uses.

11. Justification for Sensitive Questions

Providing certain metrics about a hospital's operating status may allow inference of business, utilization, or other financial status. To the extent practicable, HHS manages this by limiting access to line level data, aggregating data to blend information about different hospitals, and other statistical techniques. As having information identifiable at a facility level is crucial to understand local conditions and taking appropriate action, this collection is reasonable for response to a public health emergency.

12 A. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Hospitals	HHS Teletracking COVID-19 Portal	5500	365	1.5	3,011,250
Total					3,011,250

12 B. Estimated Annualized Respondent Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Hospital Staff – Registered Nurses	3,011,250	$70.48	$212,232,900
Total			$212,232,900

Hourly Wage Rate Determination Source:
https://www.bls.gov/ooh/healthcare/registered-nurses.htm

13. Estimates of other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

There are no start-up costs, beyond customary and usual business practices that a hospital incurs to maintain inventories of beds, maintain inventories of supplies, and manage basic metrics associated with hospital utilization. Hospitals may choose, at their discretion, to provide this information collection through automated means (direct FTPS, etc.). In this case, there are various configuration costs that may be incurred to automate the response to this collection. For example, a hospital could create reports in their business intelligence systems to support ease of information collection. Due to the variability of complex, multi-hospital systems vs. small acute care facilities (who may be manually counting), the scenarios for collection are complex and variable.

14. Annualized Cost to Federal Government

Estimated Annualized Cost: $40.3 million

- HHS Protect – 25% of Total System Cost
- HHS Teletracking – 100% of Total System Cost
- Government Personnel Costs (50 state liaisons, 5 HHS Protect/CDC personnel) - $253k fully burdened pay

15. Explanation for Program Changes or Adjustments

This is a data collection in response to a public health emergency, and its associated impact over the past several months. This ICR is being submitted as "in use without an OMB approval."

16. Plans for Tabulation and Publication and Project Time Schedule

In use without an existing OMB control number.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

Display of the OMB control number and expiration date are appropriate.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.