UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

CONEY ISLAND PREP; LESLIE-BERNARD JOSEPH; HOUSING WORKS, INC.; CHARLES KING; MARK LEVINE; and ALEXANDRA GREENBERG,	:	
Plaintiffs,	:	No. 1:20-cv-_____
-against-	:	
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, *in his official capacity as Secretary of Health and Human Services*; DR. ROBERT KADLEC, *in his official capacity as Assistant Secretary of Health and Human Services*; CENTERS FOR DISEASE CONTROL AND PREVENTION; DR. ROBERT R. REDFIELD, *in his official capacity as Director for the Centers for Disease Control and Prevention*,	:	
Defendants.	:	

DECLARATION OF KAHLIL C. WILLIAMS
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION AND AN ORDER SHOW CAUSE

I, Kahlil C. Williams, an attorney duly admitted to practice before the Southern District of New York, affirm the following under penalties of perjury:

1. I am an attorney at Ballard Spahr LLP, attorneys for plaintiffs Coney Island Prep ("CIP"), Leslie-Bernard Joseph, Housing Works, Inc., Charles King, Mark Levine, and Alexandra Greenberg (collectively, "Plaintiffs"). Plaintiffs seek injunctive relief and an Order to Show Cause because of the immediate, continuing, and irreparable harm caused by Defendants during this pandemic, which is described further in the Complaint and Memorandum of Law in

Support of Plaintiffs' Motion for a Preliminary Injunction filed in the above-captioned action. Plaintiffs have not made an application for this form of relief previously.

2. I make this declaration based on personal knowledge and in support of the Plaintiffs' Motion for a Preliminary Injunction and the Order to Show Cause.

3. A true and correct copy of an article entitled "US racial and ethnic data for COVID-19 cases: still missing in action," published at www.thelancet.com on October 22, 2020, is attached as Exhibit A.

4. A true and correct copy of a letter from Sen. Elizabeth Warren and Rep. Ayanna Pressley to Defendant Alex M. Azar, dated July 14, 2020, is attached as Exhibit B.

5. A true and correct copy of HHS guidance and frequently asked questions for Covid-19 hospital reporting, updated on July 10, 2020, is attached as Exhibit C.

6. A true and correct copy of remarks regarding HHS Protect by Defendant Robert R. Redfield and HHS Chief Information Officer Jose Arrieta, dated July 15, 2020, is attached as Exhibit D.

7. A true and correct copy of a letter to Defendant Alex M. Azar from Maura Healey, Attorney General for the Commonwealth of Massachusetts, and other state attorneys general, dated July 28, 2020, is attached as Exhibit E.

8. A true and correct copy of the written testimony of Dr. Lisa M. Maragakis before the United States House of Representatives Subcommittee on Oversight and Investigations, dated September 23, 2020, is attached as Exhibit F.

9. A true and correct copy of a letter entitled "Diverting COVID-19 Information from the CDC to DHHS: Another Strike Against Science," dated July 31, 2020, is attached as Exhibit G.

10. A true and correct copy of a letter to Vice President Mike Pence from the Infectious Diseases Society of America, dated August 5, 2020, is attached as Exhibit H.

11. A true and correct copy of a blog entry entitled "Hospitalization Data Reported by the HHS vs. the States: Jumps, Drops, and Other Unexplained Phenomena," posted at covidtracking.com on August 11, 2020, is attached as Exhibit I.

12. A true and correct copy of a *Wall Street Journal* article entitled "Covid-19 Data Reporting System Gets Off to Rocky Start," dated August 11, 2020, is attached as Exhibit J.

13. A true and correct copy of a letter to Defendant Alex M. Azar, Dr. Deborah Birx, and Vice President Mike Pence from the Infectious Diseases Society of America, dated July 17, 2020, is attached as Exhibit K.

14. A true and correct copy of a screenshot of the HHS Protect dashboard, taken October 13, 2020, is attached as Exhibit L.

15. A true and correct copy of a *Wall Street Journal* entitled "Trump, in Bob Woodward Interview, Said He Played Down Coronavirus's Severity," dated September 9, 2020, is attached as Exhibit M.

16. A true and correct copy of HHS guidance and frequently asked questions for Covid-19 hospital reporting, updated on October 6, 2020, is attached as Exhibit N.

17. A true and correct copy of an article entitled "Internal Documents Reveal COVID-19 Hospitalization Data the Government Keeps Hidden," dated October 30, 2020, is attached as Exhibit O.

18. A true and correct copy of a statement by Defendant Robert Kadlec, dated June 25, 2019, is attached as Exhibit P.

I swear under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct.

Dated: October 30, 2020

KAHLIL C. WILLIAMS

EXHIBIT A

US racial and ethnic data for COVID-19 cases: still missing in action

On June 4, 2020, the Trump Administration, responding to criticisms regarding the incompleteness of racial and ethnic data for COVID-19 test results (and other demographic data), including as reported by the US Centers for Disease Control and Prevention (CDC), released new reporting requirements.[1] The guidance stated: "this information should be made available in all reporting (including through methods using existing technical infrastructure such as an HIE [Health Information Exchange] to state and local public health departments and subsequently the CDC as soon as possible, but no later than August 1, 2020".[2]

To our knowledge, no reports have evaluated whether reporting of racial and ethnic data for US COVID-19 cases has improved since Aug 1, 2020. On Sept 15, 2020 (ie, 6 weeks after the data for cases was required by law), we checked the publicly available websites and made the following key findings.

The current CDC demographic tracker for COVID-19 cases first reported data on Aug 28, 2020, at which time 2 263 017 (51%) of its 4 458 258 cases were missing data on race and ethnicity. As of Sept 16, 2020, 2 445 731 (50%) of its 4 880 315 reported cases were missing these data. Mathematically, this means that 43% of the 422 057 cases added between these two dates were missing racial and ethnic data.

The COVID-19 Racial Data Tracker, which uses publicly available data from state and local health departments, as well as the CDC, reported on Sept 13, 2020, that among the 6 448 573 cases recorded (notably larger than the tally reported by the CDC), 37·5% were missing data on race (appendix); for individual states, the range spanned from none (Minnesota, South Dakota, West Virginia) to 100% (New York), with a median of 21%. For ethnicity, the range of percent missing extended from none (Minnesota, South Dakota) to 100% (Louisiana, North Dakota), with a median of 24%. However, several states do not appear to report any ethnicity data at all (West Virginia, Hawaii, New York). As also shown in the supplementary table (appendix), in states that are the home base for leaders of the US Government (President, Vice President, Senate Majority Leader, and Speaker of the US House of Representatives), data on race and ethnicity are missing for upwards of a quarter to over a third of COVID-19 cases.

These findings suggest that compliance with regulations to report data on race and ethnicity for US COVID-19 cases is inadequate and continues to hamper understanding of and efforts to mitigate racial and ethnic inequities in COVID-19.[3]

We declare no competing interests.

*Nancy Krieger, Christian Testa, William P Hanage, Jarvis T Chen
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1 Weiland N, Mandavalli A. Trump Administration sets demographic requirements for coronavirus reports. June 4, 2020. https://www.nytimes.com/2020/06/04/us/politics/coronavirus-infection-demographics.html?searchResultPosition=2 (accessed Sept 14, 2020).
2 US Dept of Health and Human Services. COVID-19 pandemic response, laboratory data reporting: CARES Act Section 18115. June 4, 2020. https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf (accessed Sept 14, 2020).
3 Krieger N, Gonsalves G, Bassett MT, Hanage W, Krumholz HM. The fierce urgency of now: closing glaring gaps in US surveillance data on COVID-19. April 14, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200414.238084/full/ (accessed Sept 14, 2020).

Published **Online** October 22, 2020 https://doi.org/10.1016/S0140-6736(20)32220-0

For the **CDC COVID-19 tracker** see https://covid.cdc.gov/covid-data-tracker/#demographics

For the **COVID Racial Data Tracker** see https://covidtracking.com/race/dashboard

See **Online** for appendix

Submissions should be made via our electronic submission system at http://ees.elsevier.com/thelancet/

EXHIBIT B

Congress of the United States
Washington, DC 20510

July 14, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Azar:

We write to you today because the coronavirus disease 2019 (COVID-19) pandemic has laid bare the deepest and most entrenched chronic public health crisis plaguing our country: systemic racism. The unjust reality that Black, Brown, and Indigenous communities have been disproportionately infected and killed by COVID-19 underscores that racism, discrimination, and bias are public health problems that the federal government must prioritize. The Department of Health and Human Services (HHS) is required by law to report biannually to Congress on its progress to address health disparities, but these reports appear to have stopped under the Trump Administration. Without successfully addressing these racial disparities in health outcomes and health care access, we will not be able to mitigate and fully control the COVID-19 pandemic. You have, to date, failed to do so, with tragic consequences.

Today, as coronavirus outbreaks are surging to record levels across the United States,[1] we are just beginning to understand the extent to which racial disparities are driving this increase. People of color are disproportionately likely to contract COVID-19—with one expert noting that "these communities share common social and economic factors, already in place before the pandemic, that increase their risk for COVID-19," such as working in essential jobs, living in crowded housing conditions, or lacking access to health care[2]—and when they contract the disease, they are more likely to be severely affected by it. Centers for Disease Control and Prevention (CDC) data show that fatality rates due to COVID-19 are significantly higher for Black and Hispanic/Latinx people than for white people—leading the agency to conclude that "long-standing systemic health and social inequities have put some members of racial and ethnic minority groups at increased risk of getting COVID-19 or experiencing severe illness, regardless of age."[3] Recently released data from the Centers for Medicare and Medicaid Services (CMS)

[1] NPR, "Tracking the Pandemic: Are Coronavirus Cases Rising or Falling In Your State," Stephanie Adeline et. al., July 9, 2020, https://www.npr.org/sections/health-shots/2020/03/16/816707182/map-tracking-the-spread-of-the-coronavirus-in-the-u-s.
[2] Johns Hopkins Medicine, "Coronavirus in African Americans and Other People of Color," Sherita Hill Golden, April 20, 2020, https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/covid19-racial-disparities.
[3] Centers for Disease Control and Prevention, "Coronavirus Disease 2019: Racial & Ethnic Minority Groups," Updated June 25, 2020, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

reveals that Black Medicare enrollees were four times as likely to be hospitalized from COVID-19 as white enrollees, and Hispanic enrollees were more than twice as likely to be hospitalized.[4]

The coronavirus pandemic is just the latest and clearest manifestation of racial disparities affecting health outcomes—but it should come as no surprise. In 2003, the Institute of Medicine synthesized a large body of research and found that "evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services."[5] In the nearly-twenty years since the report was published, these health care disparities persisted, including in health outcomes for diabetes, heart disease, asthma, AIDS/HIV, and, now, COVID-19.[6] Black people, in particular, are disproportionately impacted. Black babies are more than twice as likely to die than non-Hispanic white babies.[7] Black women are three to four times more likely to die of pregnancy-related complications than non-Hispanic white women.[8] Black men are up to 3.5 times as likely to be killed by police as white men, and 1 in every 1,000 black men will die as a result of police violence.[9] This police violence has adverse effects on mental health in Black communities.[10] And the average life expectancy of Black Americans is almost four years lower than it is for white Americans.[11]

In addition, people of color are also less likely to be insured,[12] and many communities of color have shortages of health care providers, making it difficult to access appropriate care.[13]

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[4] NPR, "Black Medicare Patients With COVID-19 Nearly 4 Times As Likely to End Up In Hospital," Maria Godoy, June 22, 2020," https://www.npr.org/sections/health-shots/2020/06/22/881886733/black-medicare-patients-with-covid-19-nearly-4-times-as-likely-to-end-up-in-hosp.

[5] Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003, https://www.ncbi.nlm.nih.gov/books/NBK220355/.

[6] Kaiser Family Foundation, "Disparities in Health and Health Care: Five Key Questions and Answers," Samantha Artiga, Kendal Orgera, and Olivia Pham, March 4, 2020, https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.

[7] U.S. Department of Health and Human Services Office of Minority Health, "Infant Mortality and African Americans," https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23.

[8] Centers for Disease Control and Prevention, "Reproductive Health: Pregnancy-Related Deaths," https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.

[9] Washington Post, "Police killing black people is a pandemic, too," Osagie K. Obasogie, June 5, 2020, https://www.washingtonpost.com/outlook/police-violence-pandemic/2020/06/05/e1a2a1b0-a669-11ea-b619-3f9133bbb482_story.html.

[10] The Lancet, "Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study," Jacob Bor et. al, June 21, 2018, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31130-9/fulltext.

[11] New York Times, "Black Americans Are Living Longer, C.D.C. Reports," Gina Kolata, May 2, 2017, https://www.nytimes.com/2017/05/02/health/black-americans-death-rate-cdc-study.html.

[12] Kaiser Family Foundation, "Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018," Samantha Artiga, Kendal Orgera, and Anthony Damico, March 5, 2020, https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/.

[13] Academic Medicine: Journal of the Association of American Medical Colleges, "Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review," Amelia Goodfellow et al., 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5007145/.

8 Mother Jones, "Big Outbreaks like the Coronavirus Actually Do Discriminate: Against the Poor and Most Needy," Kiera Butler, February 7, 2020, https://www.motherjones.com/environment/2020/02/these-groups-could-suffer-themost-in-a-us-coronavirus-outbreak/.

Furthermore, a history of discrimination and marginalization has left some people of color distrustful of the medical system,[14] making them less likely to seek out timely care.

In 2010, Congress recognized racial disparities as an urgent health crisis and as part of the *Patient Protection and Affordable Care Act* (ACA), elevated the Office of Minority Health at the Department of Health and Human Services (HHS) to "lead and coordinate activities that improve the health of racial and ethnic minority populations and reduce health disparities."[15] As part of that effort, six offices of minority health were established within agencies at HHS: CDC, CMS, the Agency for Healthcare Research and Quality (AHRQ), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA).[16]

The ACA also required the Office of Minority Health to report to Congress on its activities every two years, and required the heads of the sub-agencies at HHS to "submit to the Deputy Assistant Secretary for Minority Health a report summarizing the minority health activities of each of the respective agencies."[17] In 2011, HHS published its "Action Plan to Reduce Racial and Ethnic Health Disparities," which defined goals and priorities for the agency.[18] HHS proceeded to publicly post reports to Congress on its website for the subsequent two years.[19] However, the Trump Administration has failed to publicly produce reports as mandated by Congress for 2017 and 2019.

The latest HHS report to Congress on Minority Health Activities available from 2015 highlights a number of initiatives the Obama Administration undertook across all offices and sub-agencies within HHS specifically aimed at addressing racial disparities. The contribution from the Office of the Assistant Secretary for Preparedness and Response (ASPR) could have been particularly informative in preparing for the COVID-19 pandemic. It highlights a number of goals that the agency identified as important for the federal government to address in its response to natural disasters and infectious disease outbreaks, including increasing the diversity of health care and public health workforce involved in the National Disaster Medical System; reducing disparities in population health by strengthening the Hospital Preparedness Program; promoting outreach campaigns through the ASPR Office of Communications; implementing the National Health Security Strategic Implementation Plan; expanding medical countermeasure (MCM) label indicators to at-risk populations; considering at-risk individuals' needs in Strategic National Stockpile formulary analyses; improving the availability and quality of data on racial and ethnic minority populations through ASPR; and conducting research to inform disparities and reduction

[14] New York Times, "Bad Medicine: The Harm That Comes From Racism," Austin Frakt, January 13, 2020, https://www.nytimes.com/2020/01/13/upshot/bad-medicine-the-harm-that-comes-from-racism.html.
[15] 42 USC §300u–6; U.S. Department of Health and Human Services, "Offices of Minority Health at HHS," https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=7.
[16] U.S. Department of Health and Human Services, "Offices of Minority Health at HHS," https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=7.
[17] Pub. L. 111–148, title X, §10334(a)(3), Mar. 23, 2010, 124 Stat. 972.
[18] U.S. Department of Health and Human Services, "HHS Action Plan to Reduce Racial and Ethnic Health Disparities," 2011, https://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf.
[19] U.S. Department of Health and Human Services, "Report to Congress on Minority Health," Accessed July 9, 2020, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=57.

initiatives.[20] Fulfilling and building upon these goals would have improved pandemic response efforts aimed at mitigating racial disparities prior to the start of the COVID-19 outbreak in the United States. The Trump Administration's inability or unwillingness to take these actions represent part of a long list of failures in preparing for and responding to the COVID-19 outbreak.

To help us understand why HHS under the Trump Administration has failed to take appropriate action to address racial disparities in health care and health outcomes, we ask that you, please provide the requested documents and answers to the following questions by no later than July 28, 2020:

1. The ACA requires that HHS report biannually to Congress on Minority Health Activities. HHS has publicly posted reports for the years 2011, 2013, and 2015.[21] Please provide the reports for 2017 and 2019. If these reports are not available, please explain why not and the agency's plans to provide the next report.

2. Please provide the latest reports produced by HHS's six sub-agencies for the Deputy Assistant Secretary for Minority Health as required by the ACA.[22] If these reports do not exist, please explain why not.

3. Please provide an update on all of the ASPR's efforts to complete the goals laid out in the 2015 "Report to Congress on Minority Health Activities as Required by the Patient Protection and Affordable Care Act (P.L. 111-148)."[23] For each of the specific goals outlined for the ASPR in the report, please provide an update on the agency's efforts to achieving those goals in the past five years and an update on the agency's related-efforts specific to COVID-19.

4. Please provide any additional updates on the actions sub-agencies or offices within HHS have undertaken to address racial disparities in health outcomes in the past five years, including by answering these specific questions:

    a. The CDC has produced two CDC Health Disparities and Inequalities Reports in 2011 and 2013, and two Strategies for Reducing Health Disparities Reports in

[20] U.S. Department of Health and Human Services, "Report to Congress on Minority Health Activities as Required by the Patient Protection and Affordable Care Act (P.L. 111-148)," Office of the Secretary & Office of Minority Health, 2015, https://www.minorityhealth.hhs.gov/Assets/pdf/2015_0916_Report_to_Congress_on_Minority_Health_Activities_FINAL.pdf.
[21] U.S. Department of Health and Human Services, "Report to Congress on Minority Health," Accessed July 9, 2020, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=57.
[22] Pub. L. 111–148, title X, §10334(a)(3), Mar. 23, 2010, 124 Stat. 972.
[23] .S. Department of Health and Human Services, "Report to Congress on Minority Health Activities as Required by the Patient Protection and Affordable Care Act (P.L. 111-148)," Office of the Secretary & Office of Minority Health, 2015, https://www.minorityhealth.hhs.gov/Assets/pdf/2015_0916_Report_to_Congress_on_Minority_Health_Activities_FINAL.pdf.

2014 and 2016.[24] When does CDC plan to produce its next report on health equity?

b. In 2015, CMS produced the "CMS Equity Plan for Improving Quality in Medicare," and also produced an update on the agency's progress to completing the plan one year later.[25] Please provide an update on the agency's efforts to carry out the plan in the past five years. Are there additional efforts CMS has undertaken to address health disparities in the past five years?

c. In 2017, HRSA produced and publicly posted a Health Equity Report.[26] The report concluded that "future editions of the Report might explore in-depth a specific health equity theme or an emerging public health issue." Please provide an update on future editions of the report, and what progress HRSA has made in addressing its health equity goals in the years since it published its 2017 report.

Thank you for your attention to this matter.

Sincerely,

Elizabeth Warren
United States Senator

Ayanna Pressley
United States Representative

[24] Centers for Disease Control and Prevention, "Health Equity," https://www.cdc.gov/minorityhealth/strategies2016/index.html.
[25] Centers for Medicare and Medicaid Services, "CMS Equity Plan for Medicare," https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/equity-plan.
[26] Health Resources and Services Administration Office of Health Equity, "Health Equity Report 2017," https://www.hrsa.gov/sites/default/files/hrsa/health-equity/2017-HRSA-health-equity-report.pdf.

EXHIBIT C

COVID-19 Guidance for Hospital Reporting and FAQs
For Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting
Updated July 10, 2020

On March 29, 2020, Vice President Pence sent a letter to hospital administrators across the country requesting daily data reports on testing, capacity and utilization, and patient flows to facilitate the public health response to the 2019 Novel Coronavirus (COVID-19). Many separate governmental entities are requesting similar information, resulting in stakeholder requests to reduce duplication and minimize reporting burden. This document details the Federal Government's data needs, explains the division of reporting responsibility between hospitals and states, and provides clear, flexible options for the timely delivery of this critical information. The objective is to allow states and hospitals either to leverage existing data reporting capabilities or, where those capabilities are insufficient, to provide guidance in how to build upon existing capabilities. These FAQs will be posted to the various HHS and HHS division websites, and will be as necessary.

It is critical to the COVID-19 response that all of the information listed below is provided on a daily basis to the Federal Government to facilitate planning, monitoring, and resource allocation during the COVID-19 Public Health Emergency (PHE). This data will be used to inform decisions at the federal level, such as allocation of supplies, treatments, and other resources. We will no longer be 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 the daily is needed daily to ensure accurate calculations.

As information is received on a complete, and daily basis, HHS and the Administration can turn to moving away from a manual entry process and toward an automated one to ultimately reduce the burden on data collection.

Who is responsible for reporting?

By default, hospitals should report the detailed information listed below *on a daily basis* through one of the prescribed methods. However, we recognize that many states currently collect this information from the hospitals. Therefore, hospitals may be relieved from reporting directly to the Federal Government if they receive a written release from the State stating that the State will collect the data from the hospitals and take over Federal reporting responsibilities.

For the purposes of this request, hospitals to report include critical access hospital, children's hospital, general hospital (including acute, trauma, and teaching hospital), long term acute care hospital, military hospital, oncology hospital, orthopedic hospital, pediatric long term acute care hospital, psychiatric hospital, rehabilitation hospital, surgical hospital, Veterans Administration hospital, women's hospital, and women's and children's hospital.

When are states permitted to provide such a written release to hospitals?

States must first receive written certification from their ASPR Regional Administrator affirming that the State has an established, functioning data reporting stream to the Federal Government that is delivering all of the information below at the appropriate daily frequency. States that take over reporting must provide this data, regardless of whether they are seeking immediate Federal assistance.

Capacity and Utilization Data

1. Capacity and utilization data: what to submit?

The following data will greatly assist the White House Coronavirus Task Force in tracking the movement of the virus, identifying potential strains in the healthcare delivery system, and infoming distribution of supplies. If reporting multiple facilities at once, it is critical that this data be reported at the facility and county level of detail rather than just a total summary. Data must be submitted in accordance with the definitions and formats specified. Data that is submitted directly as a file instead of through an online portal should be sent in Excel or CSV format using the same column headings as in the template provided by HHS Protect. A scanned image or any other format that is not directly importable is not acceptable. Submit data once per calendar day.

Note: For all references of "adult" and "pediatric" below, "adult" references adult-designated equipment and locations and "pediatric" references pediatric-designated equipment and locations. Unless specified for a specific time (e.g. previous day), you can select a time of day that is convenient for you to report each day (e.g. can be midnight to midnight or a time that is convenient for you that is relatively consistent).

ID	Information Needed	Definition
1.	Hospital information (in separate fields) a) Hospital name b) CCN c) OrgID d) State e) County f) ZIP	Provide the information about the hospital (in separate fields) • Name of hospital • Hospital CMS Certification Number (CCN) • NHSN OrgID • State where the hospital is located • County where the hospital is located • ZIP where the hospital is located
2.	a) All hospital beds Subset: b) All Adult hospital beds	Total number of all staffed inpatient and outpatient beds in your hospital, including all overflow and surge/expansion beds used for inpatients and for outpatients (includes all ICU, ED, and observation).

		Total number of all staffed inpatient and outpatient adult beds in your hospital, including all overflow and surge/expansion beds used for inpatients and for outpatients (includes all ICU, ED, and observation).
3.	a) All hospital inpatient beds Subset: b) Adult hospital inpatient beds	Total number of staffed inpatient beds in your hospital including all overflow and surge/expansion beds used for inpatients (includes all ICU beds). This is a subset of #2. Total number of staffed inpatient adult beds in your hospital including all overflow and surge/expansion beds used for inpatients (includes all ICU beds). This is also a subset of #2.
4.	a) All hospital inpatient bed occupancy Subset: b) Adult hospital inpatient bed occupancy	Total number of staffed inpatient beds that are occupied. Total number of staffed inpatient adult beds that are occupied.
5.	a) ICU beds Subset: b) Adult ICU beds	Total number of staffed inpatient ICU beds. This is a subset of #2 and #3. Total number of staffed inpatient adult ICU beds. This is also a subset of #2 and 3.
6.	a) ICU bed occupancy Subset: b) Adult ICU bed occupancy	Total number of staffed inpatient ICU beds that are occupied. This is a subset of #4. Total number of staffed inpatient adult ICU beds that are occupied. This is also a subset of #4.
7.	Total Mechanical ventilators	Enter the total number (in use and not in use) of all mechanical ventilators, including adult, pediatric, neonatal ventilators, anesthesia machines and portable/transport ventilators available in the facility. Include BiPAP machines if the hospital uses BiPAP to deliver positive pressure ventilation via artificial airways.
8.	Mechanical ventilators in use	Enter the total number of mechanical ventilators in use at the time the data is collected, including adult,

		pediatric, neonatal ventilators, anesthesia machines and portable/transport ventilators. Include BiPAP machines if the hospital uses BiPAP to deliver positive pressure ventilation via artificial airways.
9.	a) Total hospitalized adult suspected or confirmed positive COVID patients Subset: b) Hospitalized adult confirmed-positive COVID patients	Patients currently hospitalized in an adult inpatient bed who have laboratory-confirmed or suspected COVID-19. Patients currently hospitalized in an adult inpatient bed who have laboratory-confirmed COVID-19.
10.	a) Total hospitalized pediatric suspected or confirmed positive COVID patients Subset: b) Hospitalized pediatric confirmed-positive COVID patients	Patients currently hospitalized in a pediatric inpatient bed, including NICU, who are suspected or laboratory-confirmed-positive for COVID-19. Patients currently hospitalized in a pediatric inpatient bed, including NICU, who have laboratory-confirmed COVID-19.
11.	Hospitalized and ventilated COVID patients	Patients currently hospitalized in an adult, pediatric or neonatal inpatient bed who have suspected or laboratory-confirmed COVID-19 and are on a mechanical ventilator (as defined in 7 above).
12.	a) Total ICU adult suspected or confirmed positive COVID patients Subset: b) Hospitalized ICU adult confirmed-positive COVID patients	Patients currently hospitalized in an adult ICU bed who have suspected or laboratory-confirmed COVID-19. Patients currently hospitalized in an adult ICU bed who have laboratory-confirmed COVID-19.
13.	Hospital onset	Total current inpatients with onset of suspected or laboratory-confirmed COVID-19 fourteen or more days after admission for a condition other than COVID-19.
14.	ED/overflow	Patients with suspected or laboratory-confirmed COVID-19 who currently are in the Emergency Department (ED) or any overflow location awaiting an inpatient bed.

15.	ED/overflow and ventilated	Patients with suspected or laboratory-confirmed COVID-19 who currently are in the ED or any overflow location awaiting an inpatient bed and on a mechanical ventilator. This is a subset of #14.
16.	Previous Day's Deaths	Number of patients with suspected or laboratory-confirmed COVID-19 who died on the previous calendar day in the hospital, ED, or any overflow location.
17.	Previous day's adult admissions: a) Previous day's adult admissions with confirmed COVID-19 and breakdown by age bracket: b) Previous day's adult admissions with suspected COVID-19 and breakdown by age bracket:	 Enter the number of patients who were admitted to an adult inpatient bed on the previous calendar day who had confirmed COVID-19 at the time of admission. This is a subset of #9. Provide the breakdown by age bracket: 20-29 30-39 40-49 50-59 60-69 70-79 80+ Unknown Enter the number of patients who were admitted to an adult inpatient bed on the previous calendar day who had suspected COVID-19 at the time of admission. This is a subset of #9. Provide the breakdown by age bracket: 20-29 30-39 40-49 50-59 60-69 70-79 80+ Unknown
18.	Previous day's pediatric COVID-19 admissions:	

	a) Previous day's pediatric admissions with confirmed COVID-19: b) Previous day's pediatrics admissions with suspected COVID-19	Enter the number of pediatric patients who were admitted to an inpatient bed on the previous calendar day who had confirmed COVID-19 at the time of admission. This is a subset of #10. Enter the number of pediatrics patients who were admitted to an inpatient bed on the previous calendar day who had suspected COVID-19 at the time of admission. This is a subset of #10.
19.	Previous day's total ED Visits	Enter the total number of patient visits to the ED who were seen on the previous calendar day regardless of reason for visit.
20.	Previous day's total COVID-19-related ED Visits	Enter the total number of ED visits who were seen on the previous calendar day who had a visit related to COVID-19 (meets suspected or confirmed definition or presents for COVID diagnostic testing).
21.	Previous day's Remdesivir Used	Number of remdesivir vials used on the previous calendar day in an inpatient, ED, and/or overflow location
22.	Current Inventory of Remdesivir	Enter the number of remdesivir vials in inventory at 11:59pm on the previous calendar day in the hospital pharmacy
23.	Critical Staffing shortage today (Y/N)	Enter Y if you have a critical staffing shortage today. Enter N if you do not have a staffing shortage today. (Environmental services, nurses, respiratory therapists, pharmacists and pharmacy techs, physicians, other licensed independent practitioners, temporary physicians, nurses, respiratory therapists, and pharmacists, other critical healthcare personnel).
24.	Critical Staffing shortage anticipated within a week (Y/N)	Enter Y if you anticipate a critical staffing shortage within a week. Enter N if you do not anticipate a staffing shortage within a week.
25.	Staffing shortage details	If Y to 23 or 24, specify type of shortage (Environmental services, nurses, respiratory therapists, pharmacists and pharmacy techs, physicians, other licensed independent practitioners, temporary physicians, nurses, respiratory therapists, and pharmacists, other critical healthcare personnel).

26.	Are your PPE supply items managed (purchased, allocated, and/or stored) at the facility level or, if you are part of a health system, at the health system level (or other multiple facility group)?	Check the response below which reflects the management of PPE for your facility (including purchasing, allocation, and/or storage). • Health system level or multiple-hospital group (e.g., PPE purchased at the health system level, par levels managed centrally, in stock supply available at another system location such as a central warehouse). • Facility level (e.g., PPE purchased by your individual facility, par levels managed at the facility-level, in stock supply is all on-site).
27.	On hand supply (DURATION IN DAYS) a) Ventilator supplies b) N95 respirators c) Other respirators such as PAPRs or elastomerics d) Surgical and procedure masks e) Eye protection including face shields and goggles f) Single-use gowns g) Gloves	Provide calculated days of supply in stock for ventilator supplies and each PPE category. Calculation may be provided by your hospital's ERP system or by utilizing the CDC's PPE burn rate calculator assumptions*: • Ventilator supplies (any supplies, including flow sensors, tubing, connectors, valves, filters, etc.) • N95 masks • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns • Gloves
28.	On hand supply (INDIVIDUAL UNITS/"EACHES"): a) N95 respirators b) Other respirators such as PAPRs or elastomerics c) Surgical and procedure masks d) Eye protection including face shields and goggles e) Single-use gowns f) Launderable gowns g) Gloves	Please report this information <u>if feasible</u>. For each listed supply item below, record the number of individual units (or "eaches") available in the facility on the date of data collection. For hospitals which are a part of a health system, do NOT include supplies at other system locations, including warehouses. • N95 masks • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns • Reusable/launderable gowns • Gloves

		Information can be obtained from materials management, infection prevention leader, operational leadership, or the COVID-19 incident command leadership in your facility.
29.	Are you able to obtain these items? (Y/N) a) Ventilator supplies (any supplies excluding medications) b) Ventilator medications c) N95 masks d) Other respirators such as PAPRs or elastomerics e) Surgical and procedure masks f) Eye protection including face shields and goggles g) Single-use gowns h) Gloves i) Are you able to maintain a sufficient supply of launderable gowns?	Select YES for each of the supply types that your facility is able to order and obtain. If you have placed an order but are not able to have that order filled, please answer NO. • Ventilator supplies (any supplies, including flow sensors, tubing, connectors, valves, filters, etc.) • Ventilator medications • N95 masks • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns • Gloves Information can be obtained from materials management, infection prevention leader, operational leadership, or the COVID-19 incidence command leadership in your facility.
30.	If YES above, are you able to maintain at least a 3 day supply of these items? (Y/N/NA) a) Ventilator supplies (any supplies excluding medications) b) Ventilator medications c) N95 masks d) Other respirators such as PAPRs or elastomerics e) Surgical and procedure masks	Enter YES for each supply type for which your facility is able to maintain at least a 3- day supply. Enter NO for those for which your facility is not able to maintain at least a 3- day supply. Enter N/A if the item is not applicable for your facility. • Ventilator supplies (any supplies, including flow sensors, tubing, connectors, valves, filters, etc.) • Ventilator medications • N95 masks • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns

	f) Eye protection including face shields and goggles g) Single-use gowns h) Gloves i) Laboratory – nasal pharyngeal swabs j) Laboratory –nasal swabs k) Laboratory –viral transport media	• Gloves • Laboratory – nasal pharyngeal swabs? • Laboratory –nasal swabs • Laboratory –viral transport media
31.	Does your facility use reusable/launderable isolation gowns for the care of any patients on transmission-based precautions?	□ Yes □ No
32.	Indicate any specific or critical medical supplies or medication shortages for which you are currently experiencing or anticipate experiencing in the next three days.	Free text entry

- Burn Calculator - https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

2. Capacity and utilization data: where/how to submit?

Hospitals and acute/post-acute medical facilities should report daily capacity and utilization data **through only one of the methods below**, to the Federal Government. Facilities can report to their State if they have received a written release from the State and the State has received written certification from their ASPR Regional Administrator to take over Federal reporting responsibilities. If the State assumes reporting responsibilities, the State can also choose to utilize one of the below channels or to follow a format similar to that in Appendix A through the State portal at Protect.HHS.gov.

Reporting options for hospitals and acute/post-acute medical facilities:

- If your state has assumed reporting responsibility, submit all data to your state each day and your state will submit on your behalf. Your state can provide you with a certification if they are authorized to submit on your behalf.

- Submit data to TeleTracking™ [https://teletracking.protect.hhs.gov]. All instructions on the data submission are on that site. To become a user in the portal: (This portal is will have the new and updated fields ready as of July 15, 2020)
    - Respond to the validation email sent to your administrator.
    - Visit https://teletracking.protect.hhs.gov and follow the specific instructions on how to become users.
        - Each facility is allowed to have up to 4 users for both data entry and visual access to aggregated data in the platform.
        - Users will be validated by the platform.
- Authorize your health IT vendor or other third-party to share information directly with HHS. Use one of the above alternate methods until your ASPR Regional Administrator or HHS Protect notifies you that this implementation is being received and is compliant.
- Publish to the hospital or facility's website in a standardized format, such as schema.org. Use one of the above alternate methods until your ASPR Regional Administrator or HHS Protect notifies you that this implementation is being received.

As of July 15, 2020, hospitals should no longer report the Covid-19 information in this document to the National Healthcare Safety Network site. Please select one of the above methods to use instead.

3. Capacity and utilization data: how often to submit?

Daily. ***The completeness, accuracy, and timeliness of the data will inform the COVID-19 Task Force decisions on capacity and resource needs to ensure a fully coordinated effort across America.*** Doing so will also ensure that hospitals are not facing data overlapping requests from a multitude of Federal, State, Local, and private parties, so that they can spend less time on paperwork and more time on patients. Consistent reporting daily will reduce future urgent requests for data.

Testing Data: Hospitals That Perform COVID-19 Tests Using an In House Laboratory

4. How should hospitals that perform "in house" laboratory testing report this data?

In an effort to promote data reporting choices to hospitals and other acute and post-acute care facilities, below are the options to report testing data:

- A unique link will be sent to the hospital points of contact. This will direct the POC to a hospital-specific secure form that can then be used to enter the necessary information. After completing the fields, click submit and confirm that the form has been successfully captured. A confirmation email will be sent to you from the HHS Protect System. This method replaces the emailing of individual spreadsheets previously requested.

  If your hospital did not receive a link, please contact Protect-ServiceDesk@hhs.govfor support.

- Provide directly to their State if the state is reporting complete information daily to the ASPR Regional Administrator and their state has shared a written notification from ASPR confirming the reporting requirements are being met. This file must follow the template provided by HHS Protect.

- Authorize their health IT vendor or other third party to submit the "in house" testing data to HHS/CDC. Until this is confirmed in writing to be working successfully, use one of the other methods mentioned above.

5. What data should hospitals with in-house laboratory testing expect to submit to the portal?

Diagnostic Test Data:

New Diagnostic Tests Ordered	Midnight to midnight cutoff, tests ordered on previous date queried.
Cumulative Diagnostic Tests Ordered	All tests ordered to date.
New Tests Resulted	Midnight to midnight cutoff, test results released on previous date queried.
Cumulative Tests Performed	All tests with results released to date.
New Positive COVID-19 Tests	Midnight to midnight cutoff, positive test results released on previous date queried.
Cumulative Positive COVID-19 Tests	All positive test results released to date.
New Negative COVID-19 Tests	Midnight to midnight cutoff, negative test results released on previous date queried.
Cumulative Negative COVID-19 Tests	All negative test results released to date.

Serology Test Data:

New Serological Tests Ordered	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, tests ordered on previous date queried.
Cumulative Serological Test Ordered	Total antibody, IgG, IgM, IgA if applicable. All tests ordered to date.
New Tests Performed	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, test results released on previous date queried.

Cumulative Tests Performed	Total antibody, IgG, IgM, IgA if applicable. All tests with results released to date since the beginning of COVID-19 testing.
New Positive Serological Tests	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, positive test results released on previous date queried.
Cumulative Positive Serological Tests	Total antibody, IgG, IgM, IgA if applicable. All positive test results released to date.
New Negative Serological Tests	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, negative test results released on previous date queried.
Cumulative Negative Serological Tests	Total antibody, IgG, IgM, IgA if applicable. All negative test results released to date.

6. How often should hospitals submit the data?

This data should be submitted by 5PM ET daily. All testing data should include test results that were completed during the previous day with a midnight cutoff.

Testing Data: Hospitals that Perform a Portion of COVID-19 Tests Using an In House Laboratory

7. How should hospitals that perform a portion of tests "in house" and send a portion of tests to commercial labs and/or State Public Health Labs report this data?

The portion of tests that are performed "in house" should be reported through the HHS Protect System. See above for reporting details concerning "in house" tests. The portion of tests that are sent to one of the six commercial labs listed below or that are sent to your State Public Health lab do not need to be reported through the HHS Protect System. However, if your hospital send tests to a commercial lab not listed on the below list, you should report those tests using the HHS Protect System.

Testing Data: Hospitals that Send COVID-19 Tests to Commercial Laboratories

8. Do hospitals that send tests to commercial laboratories need to report data using this system?

All hospitals should report data on COVID-19 testing performed in Academic/University/Hospital "in house" laboratories. If all of your COVID-19 testing is sent out to private labs and performed by one of the commercial laboratories on the list below, you do not need to report using the HHS Protect System.

If you have COVID-19 testing that is sent out to private labs and performed by a commercial laboratory not listed, you should report this testing using the HHS Protect System.

Commercial laboratories:

- LabCorp
- BioReference Laboratories
- Quest Diagnostics
- Mayo Clinic Laboratories
- ARUP Laboratories
- Sonic Healthcare

Testing Data: Hospitals that Send COVID-19 Tests Data to State Public Health Laboratories

9. Do hospitals that send tests to State Public Health Laboratories need to report data using this system?

All hospitals must report data on COVID-19 testing performed in Academic/University/Hospital "in house" laboratories. If all of your COVID-19 testing is sent out to and performed by State Public Health Laboratories, you do not need to report using the HHS Protect System.

10. How should hospitals that perform a portion of tests "in house" and send a portion of tests to commercial labs and/or State Public Health Labs report this data?

The portion of tests that are performed "in house" should be reported through the HHS Protect System. The portion of tests that are sent to one of the six commercial labs listed above or that are sent to your State Public Health lab do not need to be reported through the HHS Protect System. However, if your hospital send tests to a commercial lab not listed on the above list, you should report such tests using the HHS Protect System.

Technical Assistance for Hospitals

11. Who do hospitals contact if they experience any technical issues?

Please email your question to the HHS Protect Service Desk. Your question will be answered as soon as possible.

EXHIBIT D

Centers for Disease Control and Prevention

CDC Newsroom

CDC Director Dr. Robert R. Redfield and HHS Chief Information Officer Jose Arrieta Remarks on HHS Protect

On Wednesday, July 15, CDC Director Robert Redfield and HHS Chief Information Officer Jose Arrieta provided an update for members of the media on HHS efforts to gather and disseminate real-time hospital data on COVID-19. Below are their statements as prepared for delivery.

[Director Redfield]

Thank you everyone for joining us today for an update on how we are working to collect, organize, and use real-time data for our fight against COVID-19. We at CDC know that the lifeblood of public health is data. Collecting and disseminating that data as rapidly as possible is our top priority, and the reason for the policy change we're discussing today.

As many of you know, CDC operates a system called the National Health Safety Network. This is an important surveillance system in our nation's hospitals, which focuses on fighting antibiotic resistance.

In April, HHS leaders, with input from CDC, created a new system, called HHS Protect, that allows us to combine data through systems like NHSN, as well as other public and private sources. The data reported from hospitals that went into HHS Protect either came through the NHSN, directly to HHS Protect from the states, or through a system called TeleTracking.

What we have now asked is that, going forward, states provide data from hospitals directly through the TeleTracking system or directly to the HHS Protect system.

First, this reduces the reporting burden—it reduces confusion and duplication of reporting. Streamlining reporting enables us to distribute scarce resources using the best possible data.

TeleTracking also provides rapid ways to update the type of data we are collecting—such as adding, for instance, input fields on what kind of treatments are being used. In order to meet this need for flexible data gathering, CDC agreed that we needed to remove NHSN from the collection process, in order to streamline reporting.

This streamlining will allow the NHSN to increase its focus on another critical area for COVID-19, the nursing home and long-term care facility reporting needs—which, as we know, is also an absolutely central element of our pandemic response. All elements of our public health system are being stretched right now, and streamlining the hospital reporting system allows NHSN to concentrate its COVID-19 activity on the high-priority area of protecting the vulnerable in nursing homes.

To accomplish this, we have not changed the data ecosystem; we have merely streamlined the data collection mechanism for hospitals on the frontlines.

On the back end, whether collected by the CDC's system, the third party vendor, or the states, the data ends up aggregated in the HHS Protect platform, where the CDC team and other federal response teams still have access to this information for their use in the response. Additionally, state and local public health departments also have access to this information in HHS Protect which allows them to access and use the same information that the federal response teams are using.

No one is taking access or data away from CDC.

I want to emphasize that having the fastest possible access to this data, as well as easy ways to analyze it, has very real benefits to our public health response. When we need to collect insights about emerging symptoms, for instance, which we are constantly learning more about, we can do that incredibly rapidly through TeleTracking.

This has no effect on CDC's ability to use this data and continue churning out the daily data, the MMWRs, and the guidance we publish. In fact, the new infrastructure we have now actually provides our CDC team with easier access to a much broader variety of data sets than they would have without it.

Approximately 1,000 CDC experts have, and continue to have access to the raw data collected in HHS Protect—in addition to thousands of other public health professionals across HHS.

Our experts at the CDC are essential to our response, and that is why they have always had and continue to have access to all of the data we are collecting. That access is the same today as it was yesterday.

All of you have heard me say repeatedly—including before Congress—we need to dramatically improve public health data and case reporting in America. Everyone at CDC at and every member of our team at HHS knows that data is the fuel of any effective public health response. The need to modernize these systems was one of the key goals I identified as soon as I arrived at CDC. HHS Protect was a way to provide real-time data during this crisis. In the long term, we will be working with all of our partners across HHS, as well as states and hospitals, to determine how we can build a system that provides this capability for the long term.

I look forward to providing updates to all of you on that in the future.

[Jose Arrieta]

I want to begin by describing for you the purpose of HHS Protect, the system to which we are now asking that hospitals directly report their COVID-19 data. One of my key roles at HHS is helping all of our vital public health institutions share and use the immense data assets we have—that includes data collected not just by CDC, but CMS, HRSA, and others. We created HHS Protect as part of that work, and Teletracking is a collection component of the HHS Protect ecosystem. All 50 states and 6 territories have access to Protect data at this time.

During the pandemic, it became clear that we needed a central way to make this data visible to first responders at federal, state, and local levels and we needed to collect this data as fast as possible. That's why we created HHS Protect, a secure set of capabilities powered by eight commercial technologies for sharing, parsing, housing, and accessing COVID-19 data, based on the 225 datasets and reporting avenues we had. The system was developed based on four principles: transparency, sharing, privacy, and security.

Before HHS Protect, CDC NHSN received data regularly from 3,000 hospitals related to COVID 19. However there are approximately 6,200 hospitals in the United States. Through Teletracking, HHS was able to start collecting additional data from 1,100 hospitals. HHS Protect collects data directly from 20 states and approximately 2,000 hospitals for COVID data. The additional capabilities provided by Protect and TeleTracking provided increased visibility rapidly.

The goal of HHS Protect was to provide confidentiality, integrity, and availability of data while ensuring security, transparency, data sharing, and privacy to as many first responders as possible. Visibility into what's happening at a zip code level across the United States helps us allocate resources and respond in real time. The HHS Protect platform enables easy access for all of our public health experts and leaders across HHS, as well as our other partners beyond HHS, including states and tribal partners. We are working with Congress to give all elected officials access to the data as well.

HHS Protect gathers data from federal, state, and commercial sources. Each of these sources has a role to play, combining to create more than 4 billion data elements. There is no manipulation of this data possible within the system. Let me explain this in more detail.

You heard me mention security, which I want to emphasize we take very seriously.

Access is only granted to authorized federal/military employees and contractors, who are granted access as necessary by mission need. We authenticate and authorize every user to ensure only mission essential activity is occurring within HHS Protect. All data in HHS Protect is de-identified, meaning that there is no personally identifiable information attached. HHS has made the security and protection of the data involved a top priority. Least-privilege and National Institute of

HHS has made the security and protection of the data involved a top priority. Least privilege and National Institute of Standards and Technology (NIST) cybersecurity frameworks have been applied to support confidentiality, integrity, and availability. These are actually higher standards than are applied to protecting healthcare data in many other parts of the American healthcare system. Controls and platforms are tested for vulnerabilities, which are mitigated quickly, and mechanisms are in place to prevent exfiltration of data.

CDC has complete control of who access their data and what users at CDC log into HHS Protect. Currently, we have 1,200 users and approximately 950 state CDC partners and CDC partners.

You also heard me mention transparency: We recognize that experts creating and using these data sets want to know their sources and the lineage of the data sets and how they're being used. We do that through HHS Protect, and we also give the actual owners of data sets—CDC for NHSN, for instance—control over who within HHS Protect has access to those data sets.

As you heard Director Redfield mention, this system is being used just for COVID-19 data. It was an incredibly rapid response, created by players across HHS and the federal government, to provide the capabilities we need. HHS Protect would not be possible without support from CDC.

Every leader at HHS shares Director Redfield and CDC's desire for building a much strong public health data system to counter other health threats in the long term, and we look forward to working with partners across the federal government and HHS to do that in the future.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC works 24/7 protecting America's health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Page last reviewed: July 16, 2020

EXHIBIT E

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE ATTORNEY GENERAL
ONE ASHBURTON PLACE
BOSTON, MASSACHUSETTS 02108

MAURA HEALEY
ATTORNEY GENERAL

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July 28, 2020

By Email and United States Mail

The Honorable Alex M. Azar II, Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Secretary@HHS.gov

Dear Secretary Azar,

We write to urge you to immediately withdraw your directive[1] that hospitals stop reporting COVID-19 data to the Centers for Disease Control (CDC) and to restore the CDC to its rightful role as the primary repository for and source of information about the nation's public health data. Your abrupt decision to bypass the CDC in this national crisis – made without public input and apparently without planning by public health and hospital experts – harms the nation's ability to track and respond to the pandemic, hampers state and local public health authorities' efforts to address the crisis in their communities, risks compromising the health data of millions of Americans, and undermines public confidence in any reports about COVID-19 coming from the federal government.

The CDC is the nation's authority on infectious disease. Its National Healthcare Safety Network (NHSN) has been a key national public health data resource for fifteen years. Trained experts at the CDC lead the analysis and reporting of that data, protect its accuracy and guard against its misuse. Hospitals and nursing homes across the country have invested in systems to report COVID-19 data to the NHSN. State and local public health authorities and researchers rely on CDC data sources for responding to the pandemic in their communities and informing the science that will help us understand and eventually vanquish the disease. Importantly, disaggregated data provided by the CDC has revealed the disparate impact of COVID-19 on communities of color and informed efforts to address racial and ethnic health inequities.

Any challenges with data reporting, analysis and tracking should be addressed by increasing support for the CDC and investing in its systems – not by circumventing our nation's top public health experts. The CARES Act included $500 million for the CDC Modernization

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

Initiative for just this purpose.[2] Instead, the new system you have put into place puts hospital data in an entirely separate system than nursing home data and places critical information about hospitals, patients, and the spread of COVID-19 in the hands of private contractors without the assurance that it will be protected and that public health authorities and researchers will have full access to the complete data they need to continue their vital work. Moreover, hospitals and state public health departments are incurring substantial costs and operational challenges in trying to respond to the new data requests and reporting system. This sudden disruption threatens to further undermine the nation's already chaotic response to the pandemic.

An effective COVID-19 response depends on transparency and collaboration with clinical and public health experts. Relying on private contractors without expertise in epidemiological analysis or government accountability to manage the national data about the pandemic will result in rapid deterioration in public confidence in any reports from or actions by the federal government concerning COVID-19.[3] Public confidence in government leaders and the guidance they issue is the most important and effective tool available to control this pandemic.

We strongly urge you to rescind the July 10, 2020 data reporting directive, to restore the CDC as the primary repository for public health data, and to collaborate with hospital leaders, as well as national, state and local public health authorities in crafting data reporting requirements.

The COVID-19 pandemic is a public health crisis the likes of which Americans have not experienced in our lifetimes. The health and safety of all Americans depend on the analysis and guidance of experts, effective government leadership, transparency and effective communication. Please act quickly to restore confidence that your agency will uphold those vital aspects of a national response to the pandemic.

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[2] CARES Act, Pub.L. 116–136, Title VIII.

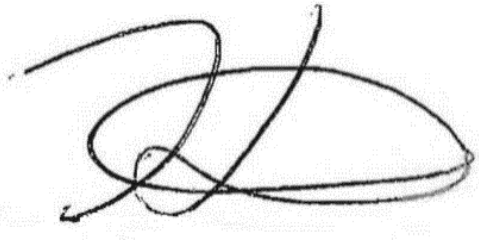
[3] The architect of the system, Palantir, is primarily known, not for public health expertise, but for building data systems for military intelligence and for Immigration and Customs Enforcement. Members of Congress and others have raised serious concerns about how data collected pursuant to this directive might be misused for purposes other than combating the COVID-19 Pandemic. *See* Reed Albergotti, Lawmakers Call for More Transparency In Health Agency's Pandemic Data Collection Practices, Washington Post July 21, 2020, https://www.washingtonpost.com/technology/2020/07/01/warren-hhs-data-collection/; Sara Morrison, Everything You Need To Know About Palantir, The Secretive Company Coming For All Your Data, Vox/Recode July 16, 2020, https://www.vox.com/recode/2020/7/16/21323458/palantir-ipo-hhs-protect-peter-thiel-cia-intelligence.

Sincerely,

Maura Healey
Massachusetts Attorney General

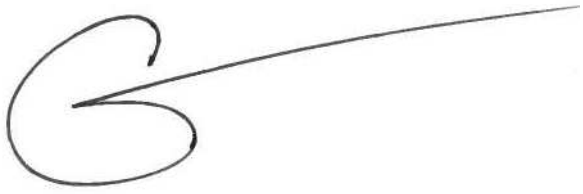
Xavier Bacerra
Attorney General of California

William Tong
Connecticut Attorney General



Karl A. Racine
Attorney General for the District of Columbia

Kathleen Jennings
Delaware Attorney General



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Tom Miller
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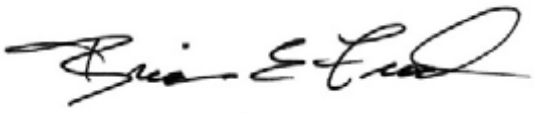
Aaron M. Frey
Maine Attorney General



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Joshua H. Stein
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Ellen F. Rosenblum
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Josh Shapiro
Pennsylvania Attorney General

Peter F. Neronha
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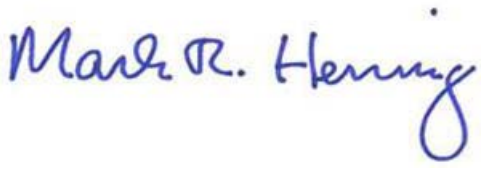
Thomas J. Donovan, Jr.
Vermont Attorney General



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Virginia Attorney General

Bob Ferguson
Washington State Attorney General

EXHIBIT F

Testimony of Lisa L. Maragakis, MD, MPH,

On behalf of

The Society for Healthcare Epidemiology of America

House Science, Space, and Technology – Subcommittee on Oversight and Investigations

September 23, 2020

Good morning Chairman Foster, Ranking Member Norman, and members of the committee. Thank you for the opportunity to appear before you to discuss the experiences of experts in infection prevention and control across the United States who are on the front lines of the pandemic response, leading hospitals and health systems in their efforts to accurately and effectively report and utilize COVID-19 data.

I am Dr. Lisa Maragakis and I serve as the Senior Director of Infection Prevention for the Johns Hopkins Health System. Today, in my testimony, I represent the members of the Society for Healthcare Epidemiology of America, the professional society of experts in infection prevention. Our members work tirelessly to protect patients by detecting and preventing healthcare-associated infections and combating the threat of antibiotic-resistant organisms. Having access to accurate, timely, and transparent data from a variety of sources is vital to our infection prevention work. Accurate data helps us detect infectious disease transmission in healthcare settings, understand the effectiveness of infection prevention interventions, and devise innovative solutions to prevent infectious disease transmission.

Our members serve a critical role on the frontlines of the COVID-19 pandemic response by collecting, analyzing, and utilizing data to inform critical decisions about policies, procedures, and hospital resource allocation to keep healthcare personnel, patients, and our communities safe. Healthcare epidemiologists and infection preventionists are highly skilled in utilizing data to detect and respond to infectious disease threats. Epidemiologists, public officials and career staff scientists share the common goal of wanting to make sure accurate and timely information gets into the right hands at the right time for evidence-based, strategic decision-making.

For decades, our experts have worked closely with and relied upon experts at the Centers for Disease Control and Prevention's National Healthcare Safety Network, known as NHSN. This is a sophisticated data surveillance system that collects, analyzes, and reports healthcare-associated infection data. Our expert counterparts at the CDC and NHSN are indispensable in their expertise and understanding of the nuances and intricacies of validating and processing these consequential data.

The NHSN system works very well and, for my colleagues and me, it seemed natural for the CDC to build upon and expand the standardized and validated NHSN system to handle COVID-19 surveillance data. The NHSN data reporting was largely automated, minimizing the burden on healthcare facilities to collect and report the data. It therefore came as a shock when hospitals were abruptly informed in mid-July that they had to stop using NHSN for COVID-19 data reporting and instead utilize the Teletracking System, a new data collection system that was not automated and which was wholly unfamiliar.

The abrupt transition was made without working with hospitals, associations, or the electronic medical record vendors to automate the data reporting process. Within 48 hours, all healthcare facilities had to scramble to manually report the COVID-19 data elements into the new system, find new data that had previously not been required, and create new workflow processes to accommodate the reporting. This created immediate chaos and confusion, and diverted critical resources to accomplish the new reporting requirements. All of this occurred under a cloud of fear that critical federal support could be withheld if hospitals failed to meet the new requirements. Although the transition took place several weeks ago, this chaos persists and multiple changes continue to occur.

The data in the new system are not validated by CDC experts prior to being used to inform decisions made by the Coronavirus Task Force and HHS officials. Data irregularities and inconsistencies have been detected in the publicly reported data. My colleagues and I have concerns over the accuracy of the data that is being used for decision making at the federal and state levels. I am here today to share SHEA colleagues' and my experiences and to ask for your help to ensure that our country, our hospitals, researchers, and the public has access to accurate, timely, and transparent data to help guide our COVID-19 response.

Thank you. I look forward to your questions.

EXHIBIT G

Opinion

Diverting COVID-19 Information from the CDC to DHHS: Another Strike Against Science
A Statement from Past and Present CDC HICPAC Members

July 31, 2020

In a July 10, 2020 memo from the Department of Health and Human Services (DHHS), all US hospitals were ordered to report all COVID-19 patient information to a new centralized database. As a result, the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) COVID-19 module was retired as of Wednesday, July 15, 2020.

As past and current members of the Healthcare Infection Control Practices Advisory Committee (HICPAC), a federal advisory committee that provides guidance to DHHS and CDC on not only strategies for infection prevention and control, but also surveillance strategies, we are extremely concerned about this abrupt change in COVID-19 reporting. Retiring NHSN's COVID-19 surveillance system will have serious consequences on data integrity.

We are experts in the fields of healthcare epidemiology, infection prevention and control, infectious diseases, and related fields. HICPAC serves as advisors to CDC's Division of Healthcare Quality Promotion (DHQP), which maintains NHSN. Thus, HICPAC members have a deep understanding of NHSN; it is not simply a software system, an information technology system, or a surveillance system. It is a complex patient safety and quality improvement system, backed by a team of public health physicians, epidemiologists, infection prevention and control professionals, and other data experts.

CDC first established the National Nosocomial Infection Surveillance (NNIS) System in 1970, to track healthcare-associated infections (HAI). This robust system, now named NHSN, is the country's most widely used HAI tracking system; NHSN also provides hospital surveillance for healthcare personnel influenza vaccination rates and blood safety errors. As a result, hospitals are well-versed in submitting data to NHSN, and have established trust that this system will safeguard and appropriately analyze and report the submitted data. In fact, most electronic health records and commercial HAI tracking software systems provide a seamless data feed to CDC, allowing hospitals to focus on patient safety rather than the tedious role of collecting and entering data.

Instead, hospitals are now scrambling to determine how to meet daily reporting requirements to DHHS. To do so, some are relying on their state health departments, while others have partnered with their hospital associations to assist with quickly meeting reporting requirements. Still other hospitals are on their own to report to DHHS TeleTracking portal. As each hospital (or state) re-creates its COVID-19 reporting structure, the data's precision is at risk. Moving forward, it will be even more challenging to perform meaningful inter-state

comparisons, and to understand which COVID-19 mitigation strategies were successful (or failed).

As past and present HICPAC members, we are troubled by the Administration's unexpected decision to divert COVID-19 data reporting from CDC to DHHS. NHSN is considered one of the most robust healthcare surveillance systems in the U.S., as it ensures national standardization while ensuring data security and integrity. CDC DHQP experts have devoted their careers to gathering and providing transparent and actionable data. The U.S. cannot lose their decades of expertise in interpreting and analyzing crucial data with the goal of developing interventions that improve the public's health. We strongly advise that the CDC's DHQP data experts be allowed to continue their important and trusted work in their mission to save lives and protect Americans from health threats.

Note: The views expressed here are solely our own, and not those of our employers or the CDC.

Signed,
Past and Current HICPAC Members:

Judith A. Guzman-Cottrill, DO, FSHEA
Kristina Bryant, MD
Hilary Babcock, MD, MPH
Lisa Maragakis, MD, MPH
Selwyn O. Rogers, JR., MD, MPH
Thomas R. Talbot, MD, MPH
Neil O. Fishman, MD
Elaine Larson, RN, PhD, FAAN, FIDSA, FSHEA, FAPIC
Vineet Chopra, MD, MSc
Mary Hayden, MD
Deborah Yokoe, MD, MPH, FIDSA, FSHEA
Susan S. Huang, MD, MPH
JoAnne Reifsnyder, PhD, MBA, MSN, FAAN
Alexis Elward, MD, MPH
Elaine Marie Dekker, RN, BSN, CIC
Loretta Litz Fauerbach, MS, CIC
Deverick J. Anderson, MD, MPH, FSHEA, FIDSA
Daniel Diekema, MD, MS
William A. Rutala, PhD, MPH, CIC
Michael Anne Preas, MS, RN, CIC, FAPIC
Jan E. Patterson, MD, MS
Marjorie Underwood, BS, RN (retired)
Michael Lin, MD, MPH
Ruth Carrico, PhD, DNP, APRN, FSHEA, CIC
Robert Weinstein, MD

Jane D. Siegel, MD
Beth H. Stover, RN (retired)
Lynn Janssen, MS, CIC
W. Charles Huskins, MD, MSc
Mark E. Rupp, MD
Patrick J. Brennan, MD
Nalini Singh, MD, MPH
Raymond Chinn, MD, FIDSA, FSHEA
E. Patchen Dellinger, MD

EXHIBIT H

August 5, 2020

The Honorable Mike Pence
The White House
Office of the Vice President
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Vice President Pence:

We write on behalf of the Infectious Diseases Society of America (IDSA) and the HIV Medicine Association (HIVMA) to thank you for your ongoing leadership in our nation's COVID-19 response and to urge the White House Coronavirus Task Force to adopt a uniform policy about mask wearing to control the pandemic, protect the economy and allow for the safe reopening of schools. IDSA and HIVMA represent over 12,000 infectious diseases and HIV physicians, scientists, and other health care and public health professionals on the frontlines of the COVID-19 response. **Specifically, we urge you to publicly issue a strong federal directive calling for mask requirements in all states, to launch a public education campaign about the importance of wearing masks or face coverings, and to require all individuals in the White House complex to wear a mask at all times when they are in the company of others, both for their own protection and to serve as role models for our country.**

In March, the White House Coronavirus Task Force took decisive and effective action in launching the *15 Days to Slow the Spread* campaign that provided strong and consistent guidance to everyone in the country on how to protect themselves, their families and their communities. As our country approaches 5 million COVID-19 cases and 160,000 deaths, **unified national action is again urgently needed to save lives**. As we quickly approach influenza season, we have a critical window of time to reduce the rapid spread of COVID-19 cases across the country through universal masking and physical distancing. If we fail to dramatically curtail transmission, it is likely that hospitals will become overwhelmed and lives will be lost due to a shortage of ICU beds, ventilators and other essential equipment. In addition, a significant reduction in cases will spur public confidence in the safety of our communities, greatly increasing the number of people who will feel comfortable patronizing businesses and supporting the economy.

National Masking & Social Distancing Requirements: We strongly support the July 14 White House Coronavirus Task Force report to governors that recommended that states with more than 100 new cases per 100,000 population in the previous week should ask residents to wear masks at all times, limit social gatherings to 10 people or fewer, and close bars and gyms.

Strong and consistent national policy and messaging makes a difference. One report indicates that use of face coverings increased following the April 3, 2020, announcement by the White House Coronavirus Task Force and the Centers for Disease Control and Prevention that recommended their adoption in

public to slow the spread of COVID-19.[1] We strongly urge you to call for all states to require individuals to wear masks when outside the home, including in outdoor settings when physical distancing of 6 feet cannot be maintained, with exceptions for those for whom masks are medically or developmentally inappropriate.

Educate the Public: In addition, we encourage you to launch a public education campaign to help everyone understand the importance and effectiveness of wearing masks and the proper way to wear them. Clear, consistent messaging from our nation's highest leaders and trusted health experts is essential to normalize masking as we have normalized other critical health and safety measures, such as wearing seatbelts and bicycle helmets. By requiring masks within the White House complex, you can protect the health and safety of our nation's leaders and lead by the power of example.

Save Lives & Keep the Economy Open: Compelling scientific data indicate that masks are highly effective at preventing the spread of COVID-19 and should be worn by everyone, as asymptomatic transmission is a critical driver in this pandemic.[2] An analysis published by Goldman Sachs Research suggests that expanding community masking by 15% could prevent the need to bring back stay-at-home orders that would otherwise cost an estimated 5% of gross domestic product, or a projected cost of $1 trillion.[3] While state and local requirements are particularly effective at increasing the use of masks, this is the time for national solidarity as COVID-19 has made significant inroads into rural areas that were initially considered 'safe'.

Policies to greatly increase the use of masks are integral to a broader national strategy to control the COVID-19 pandemic, which must also include increasing testing capacity and its timeliness to bolster the impact of contact tracing. Further, we must ensure the availability of personal protective equipment and other medical supplies; continue to support the discovery, development and equitable distribution of vaccines and therapeutics; and ensure a strong public health and infectious diseases workforce. We appreciate opportunities to work with you to strengthen the nation's response.

Sincerely,

Thomas M. File, Jr., M.D., MSc, FIDSA
President, IDSA

Judith Feinberg, M.D., FIDSA
Chair, HIVMA

[1] Fisher KA, Barile JP, Guerin R, et al. Factors associated with cloth face covering use among adults during the COVID-19 pandemic—United States, April and May 2020. *MMWR Morb Mortal Wkly Rep*. Published online July 14, 2020. https://www.cdc.gov/mmwr/volumes/69/wr/mm6928e3.htm?s_cid=mm6928e3_w

[2] Brooks JT, Butler JC, Redfield RR. Universal Masking to Prevent SARS-CoV-2 Transmission—The Time Is Now. JAMA. Published online July 14, 2020. doi:10.1001/jama.2020.13107 https://jamanetwork.com/journals/jama/fullarticle/2768532

[3] Hatzius J, Struyven D, Rosenberg I. Face Masks and GDP. Goldman Sachs Research. Published June 29, 2020. https://www.goldmansachs.com/insights/pages/face-masks-and-gdp.html

EXHIBIT I

Hospitalization Data Reported by the HHS vs. the States: Jumps, Drops, and Other Unexplained Phenomena

In mid-July the federal government began requiring hospitals to report COVID-19 data to the HHS rather than to the CDC. We compared current hospitalization data reported by the federal government and state health departments since the switch, and found contradictions that suggest the federal data continue to be unreliable, while the state datasets face their own challenges.

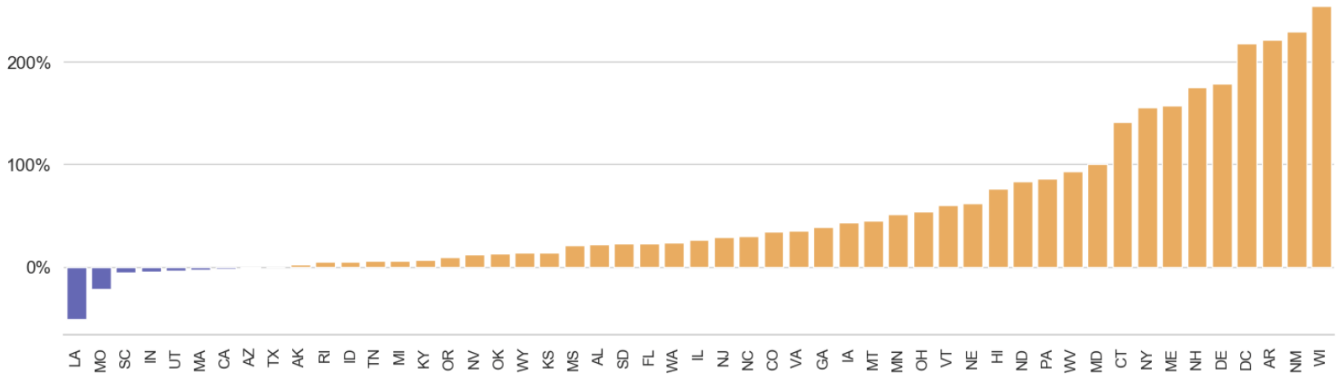

By Rebecca Glassman & Betsy Ladyzhets
August 11, 2020

Last month, the Trump administration instructed hospitals to stop reporting the number of hospitalized COVID-19 patients to the Centers for Disease Control and Prevention (CDC). Instead, hospitals were to report their COVID-19 patient counts and supply needs to the Department of Health and Human Services (HHS), using a new data service developed by the health technology company TeleTracking. These changes took effect on July 15. You can read more about the reporting change, its early impact on state public health departments, and our initial analysis of the hospitalization data published by the HHS in our blog post published last week.

Our initial analysis found that, between July 20 and July 26, the HHS reported an average of 24 percent more currently hospitalized patients nationwide than was reported by the states.

Difference between State-Reported and HHS Hospitalization Data: A Snapshot

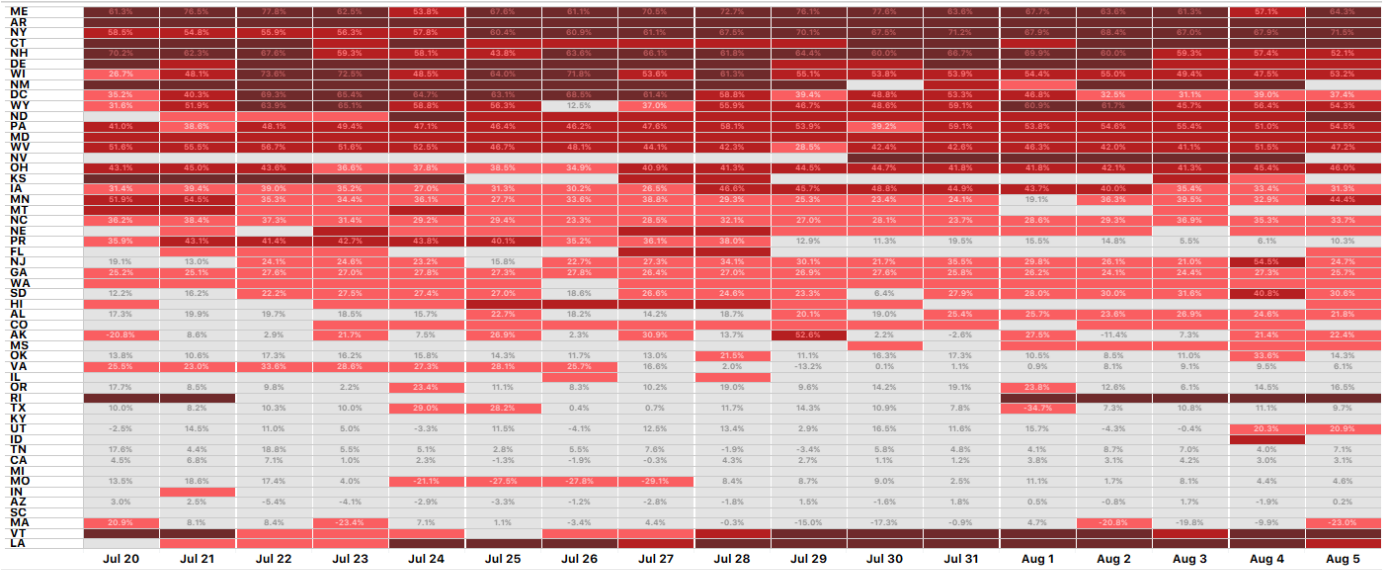
There are large discrepancies in the hospitalization counts reported by the HHS and the data from each state's public health agency.
Data shown is for July 26, 2020.



Notes: All units are in percentages, sorted by percentage difference between hospitalization numbers from the HHS and from the state.
Source: The COVID Tracking Project.

The data have continued to be erratic: In some states, the HHS reports far more hospitalized patients than the state does, and in others, the two sets of data rise and fall at different rates. In an effort to better understand the discrepancies between the data released by the states and the HHS, we are digging deeper into the data and comparing the data definitions used at the state and federal levels.

Difference between HHS and CTP by Day



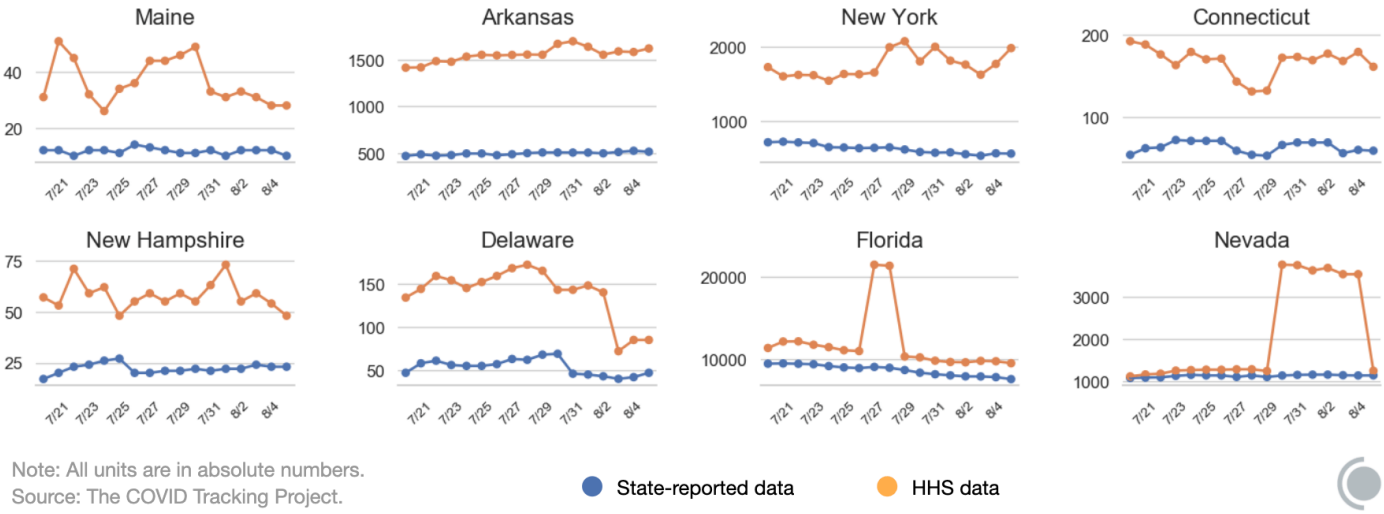
Source: The COVID Tracking Project

Under 20% 20% - 40% 40% - 60% Over 60%

For this analysis, we compared the HHS's counts of currently hospitalized COVID-19 patients, published from July 20 to August 5, to the same metric compiled by The COVID Tracking Project from each state's publicly available data. In six states (Maine, Arkansas, New York, Connecticut, New Hampshire, Delaware), the HHS data is, on average, at least 150 percent higher than the data from these states' dashboards. Maine and Connecticut's hospitalization figures include only confirmed cases. It is unclear what the reporting criteria are for Arkansas, New York, New Hampshire, and Delaware.

Time Trend Difference Between HHS and State-Reported Hospitalization Data

For some states, there are consistently large or spiky discrepancies between HHS and state-reported hospitalization data.



The HHS reports all patients with confirmed and suspected cases of COVID-19. This definition includes both patients who have received a positive result from a polymerase chain reaction (PCR) test, the gold standard for diagnosing a case of COVID-19, as well as patients who have not yet received a confirmatory test result but have exhibited distinct COVID-19 symptoms and/or have received a positive antibody or antigen test. This latter group constitutes what the HHS calls "suspected cases"; these unconfirmed cases are also called "probable cases" by the CDC and other public health departments.

Many states, on the other hand, have more restrictive definitions for which patients are included in their counts of currently hospitalized COVID-19 patients. While some states report all currently hospitalized patients with a confirmed or suspected case of COVID-19, others report only current patients with a confirmed case of COVID-19. Arizona's hospitalization counts, for example, include patients with both confirmed and suspected cases of COVID-19, similar to the HHS's criteria; the state's counts are within

5 percent of the HHS's counts for each day of our comparison.

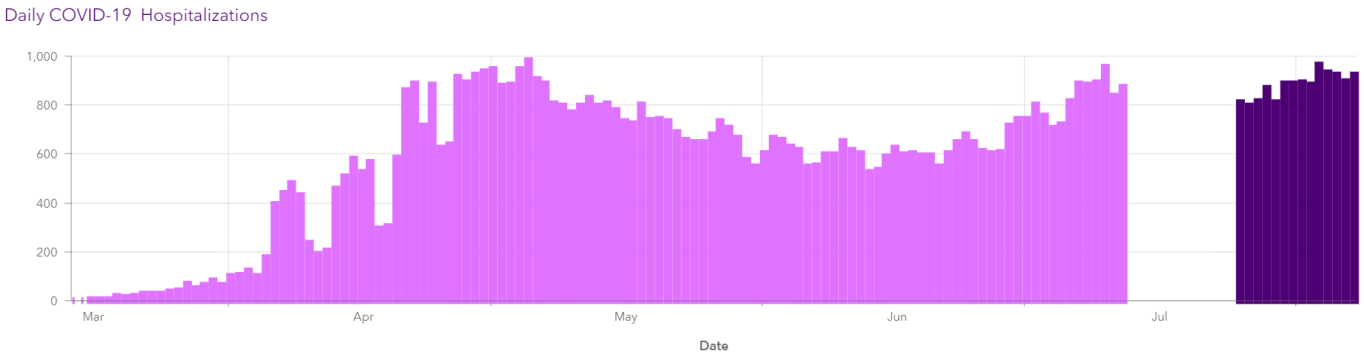
Meanwhile, in Connecticut, the state's counts only include patients who are confirmed to have contracted SARS-CoV-2, the virus that causes COVID-19, through diagnostic PCR testing. The HHS has counted about 2.6 times more COVID-19 patients than the state has in the 17 days of our analysis. This amounts to between 77 and 138 more patients reported by the HHS each day. For context, the state has reported 2,170 confirmed COVID-19 cases during these 17 days and very few probable cases. The definitional discrepancy alone does not explain this difference between Connecticut's state and federal hospitalization numbers.

The HHS reports on average 30 percent fewer patients currently hospitalized in Vermont and Louisiana than The COVID Tracking Project's data. According to Louisiana's public dashboard, the state's current count of hospitalized patients includes those who are "COVID-positive," and the state does not report probable or suspected COVID-19 cases. Because the HHS reports COVID-positive and suspected patients who are currently hospitalized, we would expect to see the federal agency report more cases than the state rather than less.

Florida saw an unexplained two-day spike in hospitalizations in the HHS data that did not match the state's own reporting. Florida's HHS counts for July 27 and July 28 were, on average, 137 percent higher than the data reported by the state. The HHS reported an average of 21,438 currently hospitalized patients in Florida during this time, while the state reported an average of 9,045 patients hospitalized with a primary diagnosis of COVID-19. On July 29, the HHS reported 10,356 confirmed and suspected COVID-19 patients hospitalized in Florida. It seems unlikely that the hospitals in Florida doubled the number of COVID-19 patients they were caring for, then discharged nearly half of these patients in a single day.

Nevada, which reports both confirmed and suspected COVID-19 patients, saw a similarly unexplained spike. Nevada's two sets of hospitalization figures were largely close together between July 20 and July 29: The state count averaged 1,124 current COVID-19 patients while the HHS count averaged 1,241 patients. On July 30, however, the HHS's count jumped to 3,761 patients, and it remained in the 3,536 to 3,685 range until August 4. The HHS's count returned to 1,256 patients on August 5. Nevada reported an average of about 1,000 new cases a day during this period.

reported an average of about 1,000 new cases a day during this period.



*Hospitalizations is total occupancy due to COVID-19

Due to variation in the interpretation of the definition of suspected COVID-19 patients, there may be slight discrepancies in the reporting of this measure. The Missouri Hospital Association (MHA) has sought clarification from the U.S. Department of Health and Human Services and are awaiting formally documented clarification, which will be shared with DHSS.

Please note, due to an abrupt change in data measures and the reporting platform issued by the White House on Monday, July 13, and effective Wednesday, July 15, Missouri Hospital Association (MHA) and the State of Missouri were unable to access hospitalization data that met quality standards during the transition. As such, hospitalization data from the period of July 13 through July 24 will remain unavailable.

Idaho, Missouri, Texas, California, Wyoming, Wisconsin, and South Carolina have each reported that the change in hospitalization reporting requirements have caused disruptions or challenges in their public hospitalization data reporting. Other states, such as Alabama, reported incomplete or unstable data after July 15, but did not report that the HHS transition was the cause. Most of the states' data issues were resolved quickly, but others, including California and Texas, have had a more difficult time getting their hospitalization data back online. As we noted in our previous blog post, The COVID Tracking Project's data entry team chose to "freeze" current hospitalization data points—meaning we carried numbers forward from previous days and made notes in our public annotations—when these states reported poor hospitalization data quality. While The COVID Tracking Project's count for current hospitalization in Texas was frozen at 10,893 patients from July 22 to July 27, the HHS's count rose from about 12,140 to 15,335 patients, then dropped back to 10,941 patients.

Reporters affiliated with The COVID Tracking Project have reached out to state public health departments to ask how the CDC-to-HHS switch impacted their hospital reporting. A representative from Arkansas stated that hospitals in the state are submitting reports through TeleTracking, and both the public health department and the Arkansas Hospital Association are tracking hospital compliance. Yet the HHS counts for hospitalized patients in Arkansas have consistently been about three times the state's counts: The HHS reports an average of 1,552 patients, while the state reports an average of 497.

As we discussed in our previous blog post on the HHS's hospitalization figures, the

switch from a CDC-run reporting system to an HHS-run reporting system has likely been difficult for many hospitals. Hospitals must now report more data points to the HHS than the CDC had required; bureaucratic changes have required some hospitals to make two reports (one to the state and one to the HHS); and hospitals with limited staff and technological capability must spend hours entering data. It is also worth noting that we expect hospitals to report more reliable information to the HHS than to their state health departments, or to report to only the HHS and not their state health

departments, because the HHS-reported data is used to inform allocation of remdesivir, PPE, and other supplies.

As we continue to track both sets of hospitalization data, many unknowns remain. Many state public health departments have yet to report how the CDC-HHS switch impacted their hospital tracking, if at all. For 20 states, the data labels or definitions used to classify currently hospitalized COVID-19 patients are not publicly available or easily accessible, making it difficult for us to contextualize the differences between their data and the federal counts. One state, Hawaii, no longer officially releases the count of patients currently hospitalized on their state website. The HHS has not described any kind of system it is using to track or catch errors in reports from stressed hospitals, making it difficult for us to contextualize irregular numbers, such as the July 27-28 spike in Florida. We also have no context for why the HHS's counts on August 6 were very low across the board, other than the fact that, in the majority of states, the number of hospitals reporting dropped significantly on August 6 compared with the previous and following days.

Hospitalization data used to be a reliable metric demonstrating the stress COVID-19 is causing state health systems. Now, these data are spotty and difficult to interpret. We encourage states to be transparent about when they are encountering issues with hospital reporting and why. And, as always, we request all public health institutions in the US standardize their definitions and communicate with one another.

Special thanks to Julia Kodysh for analysis and graphics support in this post.

Rebecca Glassman has a Master's in Public Health and is a public health researcher in academia. Opinions expressed are her own.
@NotoriousRSG

Betsy Ladyzhets is a Research Editor at Stacker and works on data quality and the COVID Racial Data Tracker at the COVID Tracking Project.
@betsyladyzhets

More "Hospitalization and Death Data" posts

COVID-19 Deaths Are Rising, But Fatality Rates Have Improved

As COVID-19 cases and hospitalizations once again rise across the United States so, inevitably, will deaths. But there is reason to hope that we will not see the devastating fatality rates of the initial spring surge.

By The COVID Tracking Project
October 28, 2020

Cases Matter

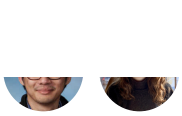
As COVID-19 cases rise across the United States, claims are circulating that case increases are (mostly or entirely) due to expanded testing, and do not indicate a spike in infections. The data does not support this conclusion.

By The COVID Tracking Project
October 27, 2020

Confirmed and Probable COVID-19 Deaths, Counted Two Ways

We're up to 24 states publishing both confirmed and probable COVID-19 deaths, and we're adding those data points into our API. But states are also using two different ways of deciding which deaths to count as COVID-19 deaths.

By Quang P. Nguyen & Kara W. Schechtman



July 8, 2020

See all blog posts →

EXHIBIT J

https://www.wsj.com/articles/covid-19-data-reporting-system-gets-off-to-rocky-start-11597178974

HEALTH

Covid-19 Data Reporting System Gets Off to Rocky Start

New data system run by Health and Human Services faces delays, quality-control issues

The chief medical officer at United Memorial Medical Center in Houston speaking with a Covid-19 patient on July 10. An HHS official says nearly twice as many hospitals are reporting data about the pandemic under its system.

PHOTO: CALLAGHAN O'HARE/REUTERS

By Robbie Whelan

Aug. 11, 2020 4:49 pm ET

Public release of hospital data about the coronavirus pandemic has slowed to a crawl, one month after the federal government ordered states to report it directly to the Department of Health and Human Services and bypass the Centers for Disease Control and Prevention.

Key indicators, such as estimates of the portion of inpatient beds occupied by Covid-19 patients, are lagging by a week or more, making it harder for citizens and local officials to get a handle on how the pandemic is progressing and for agencies to allocate supplies of antiviral drugs and personal protective equipment, public-health experts say.

The decision to switch data reporting in the middle of a public-health crisis was reckless, researchers and former public-health officials say.

"The transition has been a disaster," as hospitals typically take time to adjust to new data systems, said Jeffrey Engel, senior adviser to the Council of State and Territorial Epidemiologists, an association that represents state public-health officials. "What HHS said was that the CDC was not nimble enough and couldn't handle new data elements, and that's simply not true."

HHS officials say the new system is more complete because more hospitals are reporting a more thorough set of statistics. But because the system is so new, it is taking time to ensure the quality of the data and control for variations in numbers such as the quantity of cases reported each day. The quality-control process has led to some delays in reporting hospital capacity estimates, HHS says.

Under the CDC, between 2,900 and 3,000 hospitals were reporting coronavirus-related data each day, while now, nearly twice as many hospitals are reporting, a senior HHS official said. But HHS needs more time to analyze the data to establish confidence in the results, this person said.

"We've been at it for a month now, so we're starting to see the data stabilize and shake out. It's why the data has only been updated on a weekly basis," the official said. "In being more transparent, it creates some level of confusion [in the short term]."

The data hospitals report to the federal government is important in part because it helps determine how officials allocate supplies of remdesivir, an antiviral drug manufactured by Gilead Sciences Inc. that has been distributed by the U.S. since it was authorized for emergency use in May.

The government also uses the hospital data to allocate supplies such as N95 face masks and protective body suits distributed through the Federal Emergency Management Agency.

Key indicators, such as estimates of the portion of inpatient beds occupied by Covid-19 patients, are lagging by a week or more.

PHOTO: CALLAGHAN O'HARE/REUTERS

But more importantly, the data is the most publicly available information used by businesses, local elected officials, hospitals and contractors to gauge how stressed the U.S. hospital system is, said Thomas Frieden, who was director of the CDC from 2009 to 2017.

HHS switched the data reporting system too abruptly, he said, "and the result has been chaotic."

"There's been inconsistent reporting, there have been serious lags in the reporting. The last time I reviewed it, some data was 11 days old, and now it's three days old," Dr. Frieden said. "They pulled it away from CDC because it was updated three times a week, and now they update it once a week. Give me a break."

HHS's estimated patient impact and hospital-capacity statistics, for example, weren't updated between Aug. 3 and Aug. 10, according to a review of HHS data by The Wall Street Journal. That data set includes indicators such as inpatient and intensive-care beds occupied by Covid-19 patients, which researchers say are key to understanding the pandemic.

"We're not doing a good job of tracking either the virus or our response to it, and because of that we're flying blind," Dr. Frieden said. "That's the big picture."

Twenty-two state attorneys general, led by Maura Healy of Massachusetts, sent a letter in late July to HHS Secretary Alex Azar, demanding that the agency reverse the decision and return to the old data collection system.

"This sudden disruption...harms the nation's ability to track and respond to the pandemic, hampers state and local public health authorities' efforts to address the crisis in their communities, risks compromising the health data of millions of Americans, and undermines public confidence in any reports about COVID-19 coming from the federal government," the letter said.

In early July, the White House coronavirus task force asked the CDC to add dozens of new elements to its National Health Safety Network system, which has been in place for about 15 years. The White House gave the CDC a deadline of two to three days, the HHS official said, but the CDC said it needed two to three weeks to implement changes.

HHS, on orders from the White House task force, on July 10 instructed hospitals to switch from the CDC's system to a new one operated by a private contractor called TeleTracking Technologies Inc., the HHS official said.

The CDC didn't immediately respond to a request for comment.

In mid-July, Congressional Democrats requested documents related to the switch from HHS to conduct an investigation into potential political interference in how coronavirus data is collected. In a letter to Mr. Azar, Select Subcommittee on Coronavirus Chairman James Clyburn, a representative from South Carolina, wrote that "delays or problems in transitioning to the new system could have serious consequences on infection control and patient care at hospitals."

Jennifer Nuzzo, senior scholar at the Johns Hopkins Center for Health Security, said her team has tracked inconsistencies between HHS's reporting and state-level hospital occupancy data.

"This switch happened at a very vulnerable moment, and there is a data consistency and quality problem," Ms. Nuzzo said.

Some states, however, say the transition to the new data system has been smooth.

"Like any new system that requires a change in process, there is a period of adjustment," said a spokesman for the state health department in Arkansas, where hospitals have reported one of the country's highest levels of inpatient bed occupancy by Covid-19 patients. "But we're confident that we can work through any issues that may arise."

The switch “has not impeded ability to address the pandemic,” Dean Sidelinger, a public-health official in Oregon, said Friday. In Rhode Island, a health-department official said the change hasn’t been disruptive, and it is “just a matter of rerouting it to a different entity at the federal level.”

Write to Robbie Whelan at robbie.whelan@wsj.com

Appeared in the August 12, 2020, print edition as '.'

EXHIBIT K

July 17, 2020

The Honorable Mike Pence
The White House
Office of the Vice President
1600 Pennsylvania Avenue, NW
Washington, DC 20500

The Honorable Deborah Birx, MD
Coronavirus Task Force Response Coordinator
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Vice President Pence, Ambassador Birx and Secretary Azar:

The undersigned organizations write with urgency to strongly recommend that the administration immediately reverse its decision to bypass the Centers for Disease Control and Prevention (CDC) in the collection and analysis of COVID-19 patient data. Our organizations represent healthcare providers, public health professionals, researchers and scientists, other healthcare professionals and patient advocates who have been central in responding to the pandemic.

Maintain the integrity of COVID-19 data. The administration's abrupt decision to establish a new data collection procedure that bypasses the CDC as a recipient of data on patients hospitalized with COVID-19 is alarming and will undermine efforts to control the pandemic at a time when COVID-19 cases and hospitalizations are surging across the country. A core function of the CDC is to collect and report public health data and this important work is led by trained experts with the infrastructure necessary to ensure the validity and accuracy of the data in addition to protecting data from misuse. Placing medical data collection outside of the CDC puts the quality and integrity of the data at risk threatening to seriously undermine our country's response to COVID-19.

Keep public health data public. COVID-19 data collection and reporting must be done in a transparent manner and must not be politicized, as these data are essential to informing an effective response to the pandemic and to establishing public trust in the response. Data transparency is particularly critical in the midst of an unprecedented national health crisis that is disproportionately impacting certain segments of the U.S. population, including Black/African American, Latinx and Native American communities. Widely accessed COVID-19 tracking sites have already lost access to ICU hospitalization data – a key indicator for monitoring the state of the pandemic.

Invest in CDC data reporting. Rather than investing in a new data collection mechanism and reporting infrastructure, we strongly urge the administration to provide funding to enhance data collection and

strengthen the role of CDC to collect and report COVID-19 data by race and ethnicity, hospital and ICU capacity, total number of tests and percent positive, hospitalizations and deaths. This critical function belongs with our nation's top public health agency.

Data is critical to the state and local response. The availability of accurate hospital data, coupled with other public health indicators, is essential for the state and local response. Jurisdictions need situational awareness about bed availability, shortages of supplies and personal protective equipment, and other healthcare needs in order to coordinate the response. Creating duplicate, siloed data reporting systems may make it harder for jurisdictions to get an accurate picture of the pandemic and limit visibility across neighboring states and localities

Reliable, comprehensive and timely data are essential to monitor and evaluate the state of the pandemic and to inform an effective response, including the distribution of essential supplies and treatment. We urge you not to advance the new data collection plan any further and instead consult with the public health and healthcare communities to discuss effective strategies for ensuring the availability of the data we all need and want to bring the pandemic under control in the U.S.

Sincerely,

AcademyHealth
AIDS Alabama
American Academy of HIV Medicine
AIDS Foundation of Chicago
AIDS Research Consortium of Atlanta
AIDS United
Alabama Arise
American Association for Anatomy
American Association for the Advancement of Science
American Association for Dental Research
American Association of Geographers
American Association on Health and Disability
American Association of Immunologists
American College of Nuclear Medicine
American College of Physicians
American Educational Research Association
American Institute of Biological Sciences
American Lung Association
American Medical Informatics Association (AMIA)
American Psychological Association*
American Public Health Association
American Society for Microbiology
American Society of Pediatric Nephrology
American Society of Transplantation*
American Society of Tropical Medicine and Hygiene
American Sociological Association
American Statistical Association
American Thoracic Society
American Urological Association
amfAR, Foundation for AIDS Research
APIC – Association for Professionals in Infection Control and Epidemiology
Arab American Community Center for Economic and Social Services (ACCESS)*
Association for Prevention Teaching and Research
Association for Women in Mathematics
Association of Nurses in AIDS Care
Association of Population Centers
Association of Public Data Users
Association of Schools Advancing Health Professions
Association of Schools and Programs of Public Health
AVAC
Big Cities Health Coalition
Biophysical Society
Black AIDS Institute
Broom Center for Demography
Cascade AIDS Project
Center for Population Health and Aging
Center for Studies in Demography & Ecology, University of Washington

Centro de Comunidad y Justicia*
Community Catalyst*
Conference Board of the Mathematical Sciences
Consortium of Social Science Associations
Council of Professional Associations on Federal Statistics
CUNY Institute for Demographic Research, City University of New York
Duke Population Research Center
Endocrine Society
Entomological Society of America
Epilepsy Foundation
Every Texan
Georgians for a Healthy Future
GLMA: Health Professionals Advancing LGBTQ Equality
GO2 Foundation for Lung Cancer
HealthHIV
Health Care for All (Massachusetts)
HIV Medicine Association
Hoosier Action
Infectious Diseases Society of America
International & American Associations for Dental Research
IRMA - International Rectal Microbicide Advocates
Kentucky Voices for Health*
Lakeshore Foundation
Lambda Legal
Mathematical Association of America
MDRC
Medical Care Section – American Public Health Association
Mercy Care
Missouri Health Care For All*
National Association of State Emergency Medical Services Officials*
National Black Nurses Association
National Coalition of STD Directors*
Natural Science Collections Alliance
Neighborhood Health
New Mexico Center on Law & Poverty
North Carolina AIDS Action Network
Northwest Health Law Advocates
Oklahoma Policy Institute
Population Association of America
Prevent Blindness
Prevention Access Campaign
Prevention Institute
Protect Our Healthcare RI
Research!America
Ryan White Medical Providers Coalition
San Francisco AIDS Foundation
Social Science Research Institute, Duke* University*
Society of General Internal Medicine
Society of Infectious Diseases Pharmacists
Southern AIDS Coalition
Spina Bifida Association
TB Alliance*
Tennessee Health Care Campaign
Tennessee Justice Center
Tennessee Primary Care Association
Texas Interfaith Center for Public Policy/ Texas Impact
The AIDS Institute*
The Hopkins Population Center
The Society for Healthcare Epidemiology of America
The Society for Public Health Education
The Well Project
Thrive Alabama
Trust for America's Health
University of Colorado Population Center
Utah Health Policy Project
UW Population Health Institute
WNAR, International Biometrics Society

*Endorsement added after July 17, 2020.

EXHIBIT L

U.S. Hospital Reporting Dashboard

IMPORTANT: Data displayed on this page was submitted directly to HHS TeleTracking and HHS Protect.

COVID-19 Hospital Reporting Dashboard: Overview HHS Protect provides timely and accurate data for the nation's COVID-19 response with hospitals reporting:

- COVID-19 Reported Patient Impact and Hospital Capacity by State
- COVID-19 Estimated Patient Impact and Hospital Capacity by State
- COVID-19 State Health Department Reported Testing Timeseries

Multiple reporting pathways exist for all U.S. acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, inpatient psychiatric hospitals, and long-term acute care hospitals. Hospitals that reported COVID-19 data to HHS TeleTracking have access to data previously reported and data-analysis tools.

For more information about current hospital COVID-19 reporting, please refer to the July 29, 2020 HHS Guidance for Hospital Reporting and FAQ [PDF - 1 MB]

reporting hospitals for the collection date. Hospitals reporting data varies by collection date.

Data Source: HHS Protect, U.S. Department of Health & Human Services

Hospitals Reporting: This reported hospital list is derived by starting with a baseline of all hospitals registered with Centers for Medicare & Medicaid Services (CMS) as of June 1, 2020. It includes non-CMS hospitals that have reported since July 15, 2020. It does not include psychiatric, rehabilitation, Indian Health Service (IHS) facilities, U.S. Department of Veterans Affairs (VA) facilities, and religious non-medical facilities.

For more information: https://healthdata.gov/

Accessibility: View a table version of the percentage of hospitals reporting by state.

Data Dashboards

Estimated Hospital Utilization

Estimated hospital utilization data are available for the U.S. states, and territories. This data is estimated from hospital submissions, either reported through their state or reported through HHS Protect.

Explore

HHS

Toll Free Call Center: 1-877-696-6775
Contact HHS

200 Independence Avenue, S.W.
Washington, D.C. 20201

State

The following display shows the percentage of hospitals reporting one or more elements into HHS Protect for the most recent collection date (during the last 7 days).

Map State Table Territory Table

EXHIBIT M

https://www.wsj.com/articles/trump-says-he-played-down-coronaviruss-severity-in-bob-woodward-interview-11599675374

POLITICS

Trump, in Bob Woodward Interview, Said He Played Down Coronavirus's Severity

'I don't want to create a panic,' president said in recordings for new book; public-health experts say the move harmed efforts to prevent virus's spread

President Trump told journalist Bob Woodward the coronavirus is 'more deadly than even your strenuous flus' but played down its danger publicly.

PHOTO: CHRIS KLEPONIS/CNP/ZUMA PRESS

By Rebecca Ballhaus

Updated Sept. 9, 2020 8:23 pm ET

Listen to this article
6 minutes

WASHINGTON—President Trump told journalist Bob Woodward in March that he was deliberately playing down the severity of the coronavirus to avoid inciting panic as he publicly dismissed the virus's threat in a way public-health experts say harmed the ability to restrict its spread.

"I wanted to always play it down," Mr. Trump told Mr. Woodward on March 19, according to audio recordings of the interview aired by CNN on Wednesday. "I still like playing it down, because I don't want to create a panic."

Weeks earlier, on Feb. 7, Mr. Trump told Mr. Woodward the virus was "deadly stuff" and "more deadly than even your strenuous flus," according to the recordings.

Yet in public in the weeks that followed, the president routinely compared the virus to the flu and predicted it would soon disappear. On Feb. 26, he said the number of cases in the U.S. "within a couple of days is going to be down to close to zero."

The interviews were among 18 conducted with the president for Mr. Woodward's book "Rage," which is scheduled to be released Sept. 15. CNN and the Washington Post published audio excerpts of those interviews, but the full transcripts and recordings haven't been released.

Public-health experts have said the president's mixed messages on the threat posed by the virus, combined with his initial reluctance to wear a mask and urge others to do so, hampered the effort to slow its spread.

Mr. Trump, asked about his comments at the White House later Wednesday, defended his remarks and said it was important to express confidence. He called Mr. Woodward's book a "political hit job."

"We had to show calm," he said. "The last thing we can show is panic or excitement or fear or anything else. We had to take care of the situation we were given."

Since the first known case of coronavirus arrived in the U.S. in late January, the pandemic has swept across the nation, killing more than 190,000 people and infecting more than six million.

The coronavirus pandemic has also dominated the presidential campaign. Democrat Joe Biden has emphasized what he has called the Trump administration's failure to blunt the virus and prevent American deaths, while the president has touted himself as uniquely capable of restoring the economy, which has been battered by the virus and lockdowns.

On Wednesday, Mr. Biden said Mr. Trump's comments to Mr. Woodward showed he had lied to the American people.

"He knowingly and willingly lied about the threat posed to the country for months," Mr. Biden said during a campaign event with auto workers in Warren, Mich. "He failed to do his job on purpose. It was a life-and-death betrayal of the American people."

Nearly half the country believes Mr. Biden would be better at handling the pandemic, according to a Wall Street Journal/NBC News poll taken last month, while a third believe Mr. Trump would be better.

The poll found that 58% disapprove of Mr. Trump's pandemic management and that 53% said he didn't take the threat seriously enough early on and still wasn't handling it well. Six in 10 said the nation's response to the virus outbreak has been unsuccessful.

The president's public comments show that he was publicly minimizing the threat of the virus at the time he privately expressed concerns to Mr. Woodward.

On Feb. 7, the day he told Mr. Woodward the virus was "deadly stuff," he said in a tweet that Chinese President Xi Jinping would be successful in getting rid of the virus, "especially as the weather starts to warm & the virus hopefully becomes weaker, and then gone." At an event later that evening, he said it was a "tough situation" but that Mr. Xi had "handled it really well."

A few weeks after that Woodward conversation, in which he called the coronavirus worse than "strenuous flus," Mr. Trump said the new virus was in some ways easier to manage. "I asked the various doctors. I said, 'Is this just like flu?'" Trump said at a White House briefing on Feb. 26. "It is a little bit different, but in some ways it's easier and in some ways it's a little bit tougher."

At a campaign rally two days later, Mr. Trump accused Democrats of exaggerating the severity of the virus. "This is their new hoax," he said.

In early March, about two weeks before he told Mr. Woodward he was deliberately playing down the virus's threat, Mr. Trump said he was "not concerned at all" about the virus spreading closer to Washington.

Two days before the March 19 interview with Mr. Woodward, Mr. Trump said he had sounded the alarm early on the virus, saying he "always viewed it as very serious." At a briefing, he told reporters: "I felt it was a pandemic long before it was called a pandemic."

On March 31, he said at a briefing where he was asked about his comments that the virus would "magically disappear": "I want to be positive...I want to give people hope. I'm a cheerleader for the country." Also that day, he characterized the virus as considerably more dangerous than the flu. "It's not the flu. It's vicious," he said.

Mr. Woodward's book also includes criticism of the president's handling of the coronavirus response from other administration officials. Anthony Fauci, the administration's infectious-disease expert, told associates Mr. Trump's "attention span is like a minus number" and that his "sole purpose is to get re-elected," the book says.

Dr. Fauci, asked about his alleged comments in the book in an interview with Fox News, noted that Mr. Woodward said he had made the comments to others. "You should ask others," he said. "I don't recall that at all."

MORE ON THE CORONAVIRUS

- U.S. Coronavirus Cases Rise Slightly After Labor Day Weekend
- Covid-19 Deaths Tick Lower, for Now
- Safety Experts Probe Event Pausing AstraZeneca Covid-19 Study
- U.S. Job Openings Leveled Off Late in the Summer

Some journalists on Wednesday criticized Mr. Woodward for not publishing his interviews with Mr. Trump sooner, arguing that if the material had been released in the spring, Americans would have been able to more quickly grasp the severity of the virus.

Mr. Woodward told the Washington Post, where he is an associate editor, that when he interviewed Mr. Trump in February about the virus, he didn't know where the president's information was coming from or whether it was true. He said he didn't learn that the information had come from a high-level intelligence briefing until May. Mr. Woodward said he believed it was important to publish his book well before the election.

Write to Rebecca Ballhaus at Rebecca.Ballhaus@wsj.com

Appeared in the September 10, 2020, print edition as 'Trump Says He Played Down Severity of Covid-19 in Public.'

EXHIBIT N

COVID-19 Guidance for Hospital Reporting and FAQs
For Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting
Updated October 6, 2020

On March 29, 2020, Vice President Pence sent a letter to hospital administrators across the country requesting daily data reports on testing, capacity and utilization, and patient flows to facilitate the public health response to the 2019 Novel Coronavirus (COVID-19). Many separate governmental entities are requesting similar information, resulting in stakeholder requests to reduce duplication and minimize reporting burden. This document details the Federal Government's data needs, explains the division of reporting responsibility between hospitals and states, and provides clear, flexible options for the timely delivery of this critical information. The objective is to allow states and hospitals either to leverage existing data reporting capabilities or, where those capabilities are insufficient, to provide guidance in how to build upon existing capabilities. These FAQs will be posted to the various HHS and HHS division websites, and will be updated as necessary.[1]

It is critical to the COVID-19 response that all of the information listed below is provided **on a daily basis (except as indicated below)** to the Federal Government to facilitate planning, monitoring, and resource allocation during the COVID-19 Public Health Emergency (PHE). These data will be used to inform decisions at the federal level, such as allocation of supplies, treatments, and other resources. **We will no longer be 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 from the institutions indicated below are needed daily to ensure accurate calculations.**

As information is received on a complete, and daily basis, HHS and the Administration can turn to moving away from a manual entry process and toward an automated one to ultimately reduce the burden on data collection.

Who is responsible for reporting?

Hospitals are required to report the detailed information listed in the table below *on a daily basis (except as noted below)** through one of the prescribed methods. Hospitals that do not have the staffing or ability to report on weekends may update their information by end of day Monday or by the end of the business day following a holiday. We also recognize that many states currently collect this information from the hospitals. Therefore, hospitals may be relieved from reporting directly to the federal government if they receive a written release from the State indicating that the State is certified and will collect the data from the hospitals and take over the hospital's federal reporting responsibilities. Additionally, states who report on behalf of hospitals must also report their information by end of day Monday or the by the end of the business day following a holiday.

*Psychiatric and Rehabilitation hospitals are required to submit once a week on Wednesdays

Facilities should report at the individual hospital level, even if hospitals share a CCN.

For the purposes of this request, hospitals to report include:

- Short-term Acute Care Hospitals
- Medicaid Only Short-term Hospitals

[1] CMS recently issued finalized Conditions of Participation requiring the reporting of this information by hospitals and critical access hospitals at 85 FR 54873 (CMS-3401-IFC).

- Long-term Care Hospitals
- Medicaid Only Long-term Hospitals
- Critical Access Hospitals
- Children's Hospitals
- Medicaid Only Children's Hospitals
- General Hospitals (including acute, trauma, and teaching)
- Woman's Hospitals
- Oncology Hospitals
- Orthopedic Hospitals
- Military Hospitals
- Indian Health Service Hospitals
- Veteran's Administration Hospitals
- Distinct Part Psych Hospitals
- Psychiatric Hospitals (One weekly report)
- Medicaid Only Psychiatric Hospitals (One weekly report)
- Medicaid Only Children's Psychiatric Hospitals (One weekly report)
- Rehabilitation Hospitals (One weekly report)
- Medicaid Only Rehabilitation Hospitals (One weekly report)

When are states permitted to provide such a written release to hospitals?

States must first receive written certification from their Assistant Secretary for Preparedness and Response (ASPR) Regional Administrator affirming that the State has an established, functioning data reporting stream to the Federal Government that is delivering all of the information shown in the table below at the appropriate daily frequency. States that take over reporting must provide these data, regardless of whether they are seeking immediate federal assistance.

Capacity and Utilization Data

1. Capacity and utilization data: what to submit?

The following data elements will greatly assist the federal COVID-19 response in tracking the movement of the virus, identifying potential strains in the healthcare delivery system, and informing distribution of supplies. If reporting multiple facilities at once, it is critical that these data be reported at the facility and county level of detail rather than just a total summary. Data must be submitted in accordance with the definitions and formats specified. Data that is submitted directly as a file instead of through an online portal should be sent in Excel or CSV format using the same column headings as in the template provided by HHS Protect. A scanned image or any other format that is not directly importable is not acceptable. Submit data once per calendar day.

Note: The new influenza fields added with the 10/6/20 update will be available for optional reporting on October 19th with the intention to have these be mandatory fields within the coming weeks. These new fields will be added to the end of the existing templates, and the current templates will continue to work until states and hospitals adopt the new fields.

General notes for the fields below:

- For all references of "adult" and "pediatric" below, "adult" references adult-designated equipment and locations and "pediatric" references pediatric-designated equipment and locations.

- When considering ICU beds, use the designated intended use to determine if a bed is an ICU bed or whether a patient currently occupies an ICU bed. This designation should be used over acuity.
- Unless specified for a specific time (e.g. previous day), hospitals can select a time of day that is convenient to report each day (e.g. can be midnight to midnight or a time that is convenient that is relatively consistent).
- The term "suspected" is defined as a person who is being managed as though he/she has COVID-19 because of signs and symptoms suggestive of COVID-19 as described by CDC's Guidance but does not have a laboratory positive COVID19 test result. This may include patients who have not been tested or those with pending test results. The count may also include patients with negative test results but whom continue to show signs/symptoms suggestive of COVID-19. Do not include those who are waiting for a screening test result as suspected cases unless they meet the signs and symptoms criteria described above.
- When answering questions on staffed beds, the number of staffed beds in the facility is flexible and may change from day to day as the facility's needs change.
- When answering supply questions when the hospital is part of a health system, do NOT include supplies at other system locations, including warehouses. A health system may report on behalf of the facilities, but the information needs to be reported at the individual facility level, even if the system divides the counts equally among the facilities.
- For supply categories that may have varying quantities, days on hand, or ability to obtain and maintain, base your response on the item that has the lowest stock on hand. If an item has multiple parts, such as a Power Air Purifying Respirator (PAPR), a shortage of one part indicates a shortage of that item.
- When considering total and inpatient beds, only consider specialty beds, such as psychiatric and rehab beds, if they are part of the surge workflow and could be used for inpatient needs.
- For items that are reported one time per week (26-32 below), it is **critical** that the data is reported on Wednesday in order to be counted as compliant. This also applies to psychiatric and rehabilitation facilities who are only required to report once a week.

All fields are required except as noted below (IDs 25, 28, 32, 33-38 are optional with 33 – 38 anticipated to become mandatory in the coming weeks).

ID	Information Needed	Definition
Items 1 – 25 are to be reported daily (except psychiatric and rehabilitation hospitals who are to report these weekly)		
1.	Hospital information (in separate fields) a) Hospital name b) CCN c) OrgID (Optional) d) State e) County f) ZIP g) TeleTracking ID (Optional)	Provide the information about the hospital (in separate fields) • Name of hospital • Hospital CMS Certification Number (CCN) • NHSN OrgID (Optional) • State where the hospital is located • County where the hospital is located • ZIP where the hospital is located • The identifier assigned by TeleTracking (Optional)
2.	a) All hospital beds	Total number of all staffed inpatient and outpatient beds in your hospital, including all overflow, observation, and active surge/expansion beds used for inpatients and for outpatients (includes all ICU, ED, and observation).

	Subset: b) All adult hospital beds	Total number of all staffed inpatient and outpatient adult beds in your hospital, including all overflow and active surge/expansion beds for inpatients and for outpatients (includes all ICU, ED, and observation).
3.	a) All hospital inpatient beds Subset: b) Adult hospital inpatient beds	Total number of staffed inpatient beds in your hospital including all overflow, observation, and active surge/expansion beds used for inpatients (includes all ICU beds). This is a subset of #2. Total number of staffed inpatient adult beds in your hospital including all overflow and active surge/expansion beds used for inpatients (includes all designated ICU beds). This is also a subset of #2.
4.	a) All hospital inpatient bed occupancy Subset: b) Adult hospital inpatient bed occupancy	Total number of staffed inpatient beds that are occupied. Total number of staffed inpatient adult beds that are occupied.
5.	a) ICU beds Subset: b) Adult ICU beds	Total number of staffed inpatient ICU beds. This is a subset of #2 and #3. Total number of staffed inpatient adult ICU beds. This is also a subset of #2 and #3.
6.	a) ICU bed occupancy Subset: b) Adult ICU bed occupancy	Total number of staffed inpatient ICU beds that are occupied. This is a subset of #4. Total number of staffed inpatient adult ICU beds that are occupied. This is also a subset of #4.
7.	Total mechanical ventilators	Enter the total number (in use and not in use) of all mechanical ventilators, including adult, pediatric, neonatal ventilators, anesthesia machines and portable/transport ventilators available in the facility. Include BiPAP machines if the hospital uses BiPAP to deliver positive pressure ventilation via artificial airways.
8.	Mechanical ventilators in use	Enter the total number of mechanical ventilators in use at the time the data is collected, including adult, pediatric, neonatal ventilators, anesthesia machines and portable/transport ventilators. Include BiPAP machines if the hospital uses BiPAP to deliver positive pressure ventilation via artificial airways.
9.	a) Total hospitalized adult suspected or confirmed positive COVID patients	Patients currently hospitalized in an adult inpatient bed who have laboratory-confirmed or suspected COVID-19. Include those in observation beds.

	Subset: b) Hospitalized adult confirmed-positive COVID patients	Patients currently hospitalized in an adult inpatient bed who have laboratory-confirmed COVID-19. Include those in observation beds. Include patients who have both laboratory-confirmed COVID-19 and laboratory-confirmed influenza in this field.
10.	a) Total hospitalized pediatric suspected or confirmed positive COVID patients Subset: b) Hospitalized pediatric confirmed-positive COVID patients	Patients currently hospitalized in a pediatric inpatient bed, including NICU, PICU, newborn, and nursery, who are suspected or laboratory-confirmed-positive for COVID-19. Include those in observation beds. Patients currently hospitalized in a pediatric inpatient bed, including NICU, PICU, newborn, and nursery, who have laboratory-confirmed COVID-19. Include those in observation beds. Include patients who have both laboratory-confirmed COVID-19 and laboratory-confirmed influenza in this field.
11.	Hospitalized and ventilated COVID patients	Patients currently hospitalized in an adult, pediatric or neonatal inpatient bed who have suspected or laboratory-confirmed COVID-19 and are on a mechanical ventilator (as defined in #7 above).
12.	a) Total ICU adult suspected or confirmed positive COVID patients Subset: b) Hospitalized ICU adult confirmed-positive COVID patients	Patients currently hospitalized in a designated adult ICU bed who have suspected or laboratory-confirmed COVID-19. Patients currently hospitalized in a designated adult ICU bed who have laboratory-confirmed COVID-19. Include patients who have both laboratory-confirmed COVID-19 and laboratory-confirmed influenza in this field.
13.	Hospital onset	Total current inpatients with onset of suspected or laboratory-confirmed COVID-19 fourteen or more days after admission for a condition other than COVID-19. For this field only, a patient should no longer be counted once they are no longer symptomatic and are removed from COVID-19 isolation precaution.
14.	ED/overflow	Patients with suspected or laboratory-confirmed COVID-19 who currently are in the Emergency Department (ED) or any overflow location awaiting an inpatient bed.
15.	ED/overflow and ventilated	Patients with suspected or laboratory-confirmed COVID-19 who currently are in the ED or any

		overflow location awaiting an inpatient bed and on a mechanical ventilator. This is a subset of #14.
16.	Previous day's COVID-19 Deaths	Number of patients with suspected or laboratory-confirmed COVID-19 who died on the previous calendar day in the hospital, ED, or any overflow location.
17.	Previous day's adult admissions: a) Previous day's adult admissions with confirmed COVID-19 and breakdown by age bracket: b) Previous day's adult admissions with suspected COVID-19 and breakdown by age bracket:	Enter the number of patients who were admitted to an adult inpatient bed on the previous calendar day who had confirmed COVID-19 at the time of admission. This is a subset of #9. As a subset, provide the breakdown by age bracket: 18-19 20-29 30-39 40-49 50-59 60-69 70-79 80+ Unknown Enter the number of patients who were admitted to an adult inpatient bed on the previous calendar day who had suspected COVID-19 at the time of admission. This is a subset of #9. As a subset, provide the breakdown by age bracket: 18-19 20-29 30-39 40-49 50-59 60-69 70-79 80+ Unknown
18.	Previous day's pediatric COVID-19 admissions: a) Previous day's pediatric admissions with confirmed COVID-19:	Enter the number of pediatric patients who were admitted to an inpatient bed, including NICU, PICU, newborn, and nursery, on the previous calendar day who had confirmed COVID-19 at the time of admission. This is a subset of #10.

	b) Previous day's pediatric admissions with suspected COVID-19	Enter the number of pediatrics patients who were admitted to an inpatient bed, including NICU, PICU, newborn, and nursery, on the previous calendar day who had suspected COVID-19 at the time of admission. This is a subset of #10.
19.	Previous day's total ED visits	Enter the total number of patient visits to the ED who were seen on the previous calendar day regardless of reason for visit. Include all patients who are triaged even if they leave before being seen by a provider.
20.	Previous day's total COVID-19-related ED visits	Enter the total number of ED visits who were seen on the previous calendar day who had a visit related to COVID-19 (meets suspected or confirmed definition or presents for COVID diagnostic testing – do not count patients who present for pre-procedure screening).
21.	Previous day's remdesivir used (Required until November 4th and then Optional)	Enter the number of remdesivir vials used on the previous calendar day in an inpatient, ED, and/or overflow location
22.	Current inventory of Remdesivir (Required until November 4th and then Optional)	Enter the number of remdesivir vials in inventory at 11:59pm on the previous calendar day in the hospital pharmacy
23.	Critical staffing shortage today (Y/N) (Required until November 4th and then Optional)	Enter Y if you have a critical staffing shortage today. Enter N if you do not have a staffing shortage today. If you do not report this value, the default is N. If you have a shortage, report this daily until the shortage is resolved. Each facility should identify staffing shortages based on their facility needs and internal policies for staffing ratios. The use of temporary staff does not count as a staffing shortage if staffing ratios are met according to the facility's needs and internal policies for staffing ratios. (Environmental services, nurses, respiratory therapists, pharmacists and pharmacy technicians, physicians, other licensed independent practitioners, temporary physicians, nurses, respiratory therapists, and pharmacists, phlebotomists, other critical healthcare personnel).
24.	Critical staffing shortage anticipated within a week (Y/N) (Required until November 4th and then Optional)	Enter Y if you anticipate a critical staffing shortage within a week. Enter N if you do not anticipate a staffing shortage within a week. If you do not report this value, the default is N. If you have a shortage, report this daily until the shortage is resolved.

		Each facility should identify staffing shortages based on their facility needs and internal policies for staffing ratios. The use of temporary staff does not count as a staffing shortage if staffing ratios are met according to the facility's needs and internal policies for staffing ratios.
25.	Staffing shortage details (Optional)	If Y to #23 or #24, specify type of shortage (Environmental services, nurses, respiratory therapists, pharmacists and pharmacy technicians, physicians, other licensed independent practitioners, temporary physicians, nurses, respiratory therapists, and pharmacists, phlebotomists, other critical healthcare personnel).
For items 26 – 32, report one time a week on Wednesday		
26.	Are your PPE supply items managed (purchased, allocated, and/or stored) at the facility level or, if you are part of a health system, at the health system level (or other multiple facility group)? (SYSTEM or FACILITY)	Check the response below which reflects the management of PPE for your facility (including purchasing, allocation, and/or storage). • Health system level or multiple-hospital group (e.g., PPE purchased at the health system level, par levels managed centrally, in stock supply available at another system location such as a central warehouse). Enter SYSTEM for this choice. • Facility level (e.g., PPE purchased by your individual facility, par levels managed at the facility-level, in stock supply is all on-site). Enter FACILITY for this choice.
27.	On hand supply (DURATION IN DAYS) a) Ventilator supplies b) N95 respirators c) Surgical and procedure masks d) Eye protection including face shields and goggles e) Single-use gowns f) Exam gloves (sterile and non-sterile)	Provide calculated range of days of supply in stock for ventilator supplies and each PPE category. For supply categories that may have varying quantities, days on hand, or ability to obtain and maintain, reply for the item that has the lowest stock on hand. • 0 days • 1-3 days • 4-6 days • 7-14 days • 15-30 days • >30 days Calculation may be provided by your hospital's ERP system or by utilizing the CDC's PPE burn rate calculator assumptions*: • Ventilator supplies (any supplies, including flow sensors, tubing, connectors, valves, filters, etc.) • N95 respirators • Surgical masks • Eye protection including face shields and goggles

		• Single-use gowns • Exam gloves
28.	On hand supply (INDIVIDUAL UNITS/"EACHES"): (Optional) a) N95 respirators b) Other respirators such as PAPRs or elastomerics c) Surgical and procedure masks d) Eye protection including face shields and goggles e) Single-use gowns f) Launderable gowns g) Exam gloves (single)	Please report this information **<u>if feasible</u>**. For each listed supply item below, record the number of individual units (or "eaches") available in the facility on the date of data collection. For hospitals that are a part of a health system, do NOT include supplies at other system locations, including warehouses. • N95 respirators • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns • Reusable/launderable gowns • Exam gloves (single) Information can be obtained from materials management, infection prevention leader, operational leadership, or the COVID-19 incident command leadership in your facility.
29.	Are you able to obtain these items? (Y/N/NA) a) Ventilator supplies (any supplies excluding medications) b) Ventilator medications c) N95 respirators d) Other respirators such as PAPRs or elastomerics e) Surgical and procedure masks f) Eye protection including face shields and goggles g) Single-use gowns h) Exam gloves i) Are you able to maintain a supply of launderable gowns?	Select YES for each of the supply types that your facility is able to order and obtain. If you have placed an order but are not able to have that order filled, please answer NO. Enter N/A if item is not applicable at the facility. • Ventilator supplies (any supplies, including flow sensors, tubing, connectors, valves, filters, etc.) • Ventilator medications • N95 respirators • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns • Exam gloves Information can be obtained from materials management, infection prevention leader, operational leadership, or the COVID-19 incidence command leadership in your facility.
30.	Are you able to maintain at least a 3-day supply of these items? (Y/N/NA) a) Ventilator supplies (any supplies excluding medications) b) Ventilator medications	Enter YES for each supply type for which your facility is able to maintain at least a 3-day supply. Enter NO for those supply types your facility is not able to maintain at least a 3-day supply. Enter N/A if the item is not applicable for your facility. • Ventilator supplies (any supplies, including flow sensors, tubing, connectors, valves, filters, etc.)

	c) N95 respirators d) Other respirators such as PAPRs or elastomerics e) Surgical and procedure masks f) Eye protection including face shields and goggles g) Single-use gowns h) Exam Gloves i) Laboratory – nasal pharyngeal swabs j) Laboratory – nasal swabs k) Laboratory – viral transport media	• Ventilator medications • N95 respirators • Other respirators such as PAPRs or elastomerics • Surgical masks • Eye protection including face shields and goggles • Single-use gowns • Exam Gloves • Laboratory – nasal pharyngeal swabs? • Laboratory – nasal swabs • Laboratory – viral transport media
31.	Does your facility re-use or extend the use of PPE? a) Reusable/launderable isolation gowns b) PAPRs or elastomerics c) N95 respirators	Enter YES for each supply type your facility re-uses or extends use of. Enter NO for those supply types your facility does not re-use or extend use of. Enter N/A if the item is not applicable for your facility.
32.	Indicate any specific or critical medical supplies or medication shortages you are currently experiencing or anticipate experiencing in the next three days. (Optional)	Free text entry
Influenza fields 33 - 38 to be reported every day except for psychiatric and rehabilitation hospitals who report weekly – Optional starting 10/19/20 with the intention to have these be mandatory fields within the coming weeks. Existing upload templates will continue to work during transition. Laboratory confirmation includes detection of influenza virus through molecular tests (e.g., polymerase chain reaction, nucleic acid amplification), antigen detection tests, immunofluorescence tests, and virus culture.		
33.	Total hospitalized patients with laboratory-confirmed influenza	Patients (all ages) currently hospitalized in an inpatient bed who have laboratory-confirmed influenza. Include those in observation beds.
34.	Previous day's influenza admissions	Enter the number of patients (all ages) who were admitted to an inpatient bed on the previous calendar day who had laboratory-confirmed influenza at the time of admission. This is a subset of #33.
35.	Total ICU patients with laboratory-confirmed influenza	Patients (all ages) currently hospitalized in a designated ICU bed with laboratory-confirmed influenza. This is a subset of #33.
36.	Total hospitalized patients with both laboratory-confirmed COVID-19 and influenza	Patients (all ages) currently hospitalized in an inpatient bed who have laboratory-confirmed COVID-19 and

		laboratory-confirmed influenza. This is a subset of #9b/10b and #33.
37.	Previous day's influenza deaths	Number of patients with laboratory-confirmed influenza who died on the previous calendar day in the hospital, ED, or any overflow location.
38.	Previous day's deaths with both COVID-19 and influenza	Number of patients with laboratory-confirmed influenza AND laboratory-confirmed COVID-19 who died on the previous calendar day in the hospital, ED, or any overflow location. This is a subset of #16.

- Burn Calculator - https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

2. Capacity and utilization data: where/how to submit?

Hospitals and acute/post-acute medical facilities should report daily capacity and utilization data **through only one of the methods below**, to the Federal Government. Facilities can report to their State if they have received a written release from the State and the State has received written certification from their ASPR Regional Administrator to take over Federal reporting responsibilities. If the State assumes reporting responsibilities, the State can also choose to utilize one of the below channels or to follow a format similar to that in Appendix A through the State portal at Protect.HHS.gov.

Reporting options for hospitals and acute/post-acute medical facilities:

- If your state has assumed reporting responsibility, submit all data to your state each day and your state will submit on your behalf. Your state can provide you with a certification if they are authorized to submit on your behalf.
- Submit data to TeleTracking™ [https://teletracking.protect.hhs.gov]. All instructions on the data submission are on that site. To become a user in the portal:
    - Respond to the validation email sent to your administrator.
    - Visit https://teletracking.protect.hhs.gov and follow the specific instructions on how to become users.
        - Each facility is allowed to have up to 4 users for both data entry and visual access to aggregated data in the platform.
        - Users will be validated by the platform.
- Authorize your health IT vendor or other third-party to share information directly with HHS. Use one of the above alternate methods until your ASPR Regional Administrator or HHS Protect notifies you that this implementation is being received and is compliant.
- Publish to the hospital or facility's website in a standardized format, such as schema.org. Use one of the above alternate methods until your ASPR Regional Administrator or HHS Protect notifies you that this implementation is being received.

As of July 15, 2020, hospitals should no longer report the COVID-19 information in this document to the National Healthcare Safety Network site. Please select one of the above methods to use instead.

3. Capacity and utilization data: how often to submit?

Daily. ***The completeness, accuracy, and timeliness of the data will inform the COVID-19 Task Force decisions on capacity and resource needs to ensure a fully coordinated effort across America.*** Doing so will also ensure that hospitals are not facing overlapping data requests from a multitude of Federal,

State, Local, and private parties, so that they can spend less time on paperwork and more time on patients. Consistent daily reporting will reduce future urgent requests for data.

4. **Capacity and utilization data: how can an organization, such as a hospital association, get access to the information?**

Written approval sent to the HHS Protect Service Desk is needed from the state public health department or an individual reporting hospital facility.

5. **Capacity and utilization data: how can we correct errors that we see in our data?**

Contact the HHS Protect Service Desk if you see any errors in your data that need to be corrected.

6. **Capacity and utilization data: what happens if we do not have staff to report on the weekend?**

While daily reporting is strongly preferred, we understand that some hospitals do not have staffing to report on the weekend. In those cases, we ask that the weekend data be reported as soon as possible on Monday. In order to report data for a past date, the information needs to be uploaded in the provided template with the appropriate reporting date noted in the spreadsheet.

7. **Capacity and utilization data: why did I get a call from an HHS Hospital Data Liaison?**

Starting the week of July 27th, Hospitalization Data Liaisons are working collaboratively with states to obtain information from their hospitals on barriers to reporting, frequency and completeness of data, and data reporting delays and discrepancies, such as those caused by potential data entry errors or by the misinterpretation of data element definitions. Once fully established, the liaison support can also provide a channel for the states and hospitals to obtain additional guidance and clarification of the data requests.

8. **Capacity and utilization data: how do I notify you that a hospital does not see COVID-19 patients or is no longer operational?**

Notify your state public health department or notify the HHS Protect Service Desk.

9. **Capacity and utilization data: how can I find the template to upload my information?**
    - If you are a state and want to upload to HHS Protect, use this HHS Protect template.
    - If you are an individual hospital or a hospital organization or state reporting many facilities, use this template for TeleTracking.

Testing Data: Hospitals That Perform COVID-19 Tests Using an In-House Laboratory

Laboratories are required to report to state and local public health authorities in accordance with applicable state or local law. Additionally, the Coronavirus Aid, Relief, and Economic Security (CARES) Act section 18115 and its implementation guidance require every laboratory to report every test it performs to detect SARS-CoV-2 or to diagnose a possible case of COVID-19 (e.g., viral, serology). On June 4, 2020, additional HHS guidance was issued that required specific data elements to be collected and reported. Under the new guidance, testing data should be sent to state health departments, which will then deidentify the data and report them to the CDC. This new guidance is effective August 1, 2020.

Importantly, laboratories that need to continue to report aggregate laboratory totals to HHS as described below including any laboratory that is:

- Not reporting all testing data to their state health department, or

- Located in a jurisdiction that has not converted to COVID-19 electronic laboratory reporting to CDC.

Continue reporting aggregate totals to HHS until you have confirmed that the CDC is receiving your information**.** Contact your state health department or CDC (eocevent405@cdc.gov) to confirm you are able to discontinue reporting directly to HHS. For a list of state health departments that have converted to electronic line-level reporting, please see the CDC website.

1. **How should hospitals that perform "in-house" laboratory testing report this aggregate data to HHS until they have confirmed that the CDC is receiving their information through their state?**

In an effort to promote data reporting choices to hospitals and other acute and post-acute care facilities, below are the options to report testing data:

- A unique link will be sent to the hospital points of contact. This will direct the POC to a hospital-specific secure form that can then be used to enter the necessary information. After completing the fields, click submit and confirm that the form has been successfully captured. A confirmation email will be sent to you from the HHS Protect System. This method replaces the emailing of individual spreadsheets previously requested.

  If your hospital did not receive a link, please contact the HHS Protect Service Desk for support.

- Provide directly to their State if the State is reporting complete information daily to the ASPR Regional Administrator and their State has shared a written notification from ASPR confirming the reporting requirements are being met. This file must follow the template provided by HHS Protect.

- Authorize their health IT vendor or other third party to submit the "in house" testing data to HHS/CDC. Until this is confirmed in writing to be working successfully, use one of the other methods mentioned above.

2. **What data should hospitals with in-house laboratory testing expect to submit to the portal?**

Diagnostic Test Data:

New Diagnostic Tests Ordered	Midnight to midnight cutoff, tests ordered on previous date queried.
Cumulative Diagnostic Tests Ordered	All tests ordered to date.
New Tests Resulted	Midnight to midnight cutoff, test results released on previous date queried.
Cumulative Tests Performed	All tests with results released to date.
New Positive COVID-19 Tests	Midnight to midnight cutoff, positive test results released on previous date queried.
Cumulative Positive COVID-19 Tests	All positive test results released to date.
New Negative COVID-19 Tests	Midnight to midnight cutoff, negative test results released on previous date queried.
Cumulative Negative COVID-19 Tests	All negative test results released to date.

Serology Test Data:

New Serological Tests Ordered	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, tests ordered on previous date queried.
Cumulative Serological Test Ordered	Total antibody, IgG, IgM, IgA if applicable. All tests ordered to date.
New Tests Performed	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, test results released on previous date queried.
Cumulative Tests Performed	Total antibody, IgG, IgM, IgA if applicable. All tests with results released to date since the beginning of COVID-19 testing.
New Positive Serological Tests	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, positive test results released on previous date queried.
Cumulative Positive Serological Tests	Total antibody, IgG, IgM, IgA if applicable. All positive test results released to date.
New Negative Serological Tests	Total antibody, IgG, IgM, IgA if applicable. Midnight to midnight cutoff, negative test results released on previous date queried.
Cumulative Negative Serological Tests	Total antibody, IgG, IgM, IgA if applicable. All negative test results released to date.

3. How often should hospitals submit the data?

These data should be submitted by 5PM ET daily. All testing data should include test results that were completed during the previous day with a midnight cutoff.

Testing Data: Hospitals that Perform a Portion of COVID-19 Tests Using an In House Laboratory

4. How should hospitals that perform a portion of tests "in house" and send a portion of tests to commercial labs and/or State Public Health Labs report these data?

The portion of tests that are performed "in house" should be reported through the HHS Protect System. See above for reporting details concerning "in house" tests. The portion of tests that are sent to one of the six commercial labs listed below or that are sent to your State Public Health lab do not need to be reported through the HHS Protect System. However, if your hospital sends tests to a commercial lab not listed on the below list, you should report those tests using the HHS Protect System.

Testing Data: Hospitals that Send COVID-19 Tests to Commercial Laboratories

5. Do hospitals that send tests to commercial laboratories need to report data using this system?

All hospitals should report data on COVID-19 testing performed in Academic/University/Hospital "in house" laboratories. If all of your COVID-19 testing is sent out to private labs and performed by one of the commercial laboratories on the list below, you do not need to report using the HHS Protect System.

If you have COVID-19 testing that is sent out to private labs and performed by a commercial laboratory not listed, you should report this testing using the HHS Protect System.

Commercial laboratories:

- LabCorp
- BioReference Laboratories
- Quest Diagnostics
- Mayo Clinic Laboratories
- ARUP Laboratories
- Sonic Healthcare

Testing Data: Hospitals that Send COVID-19 Tests Data to State Public Health Laboratories

6. Do hospitals that send tests to State Public Health Laboratories need to report data using this system?

All hospitals must report data on COVID-19 testing performed in Academic/University/Hospital "in house" laboratories. If all of your COVID-19 testing is sent out to and performed by State Public Health Laboratories, you do not need to report using the HHS Protect System.

7. How should hospitals that perform a portion of tests "in house" and send a portion of tests to commercial labs and/or State Public Health Labs report these data?

The portion of tests that are performed "in house" should be reported through the HHS Protect System. The portion of tests that are sent to one of the six commercial labs listed above or that are sent to your State Public Health lab do not need to be reported through the HHS Protect System. However, if your hospital sends tests to a commercial lab not listed on the above list, you should report such tests using the HHS Protect System.

Technical Assistance for Hospitals

8. Who do hospitals contact if they experience any technical issues?

Please email your question to the HHS Protect Service Desk. Your question will be answered as soon as possible.

EXHIBIT O

Internal Documents Reveal COVID-19 Hospitalization Data The Government Keeps Hidden

npr.org/sections/health-shots/2020/10/30/929239481/internal-documents-reveal-covid-19-hospitalization-data-the-government-keeps-hid

Pien
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Internal Documents Reveal COVID-19 Hospitalization Data The Government Keeps Hidden

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- **Download**
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- **Transcript**

Internal Documents Reveal COVID-19 Hospitalization Data The Government Keeps Hidden 4:26

The Coronavirus Crisis

October 30, 20205:01 AM ET

Heard on Morning Edition

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- **Transcript**

Enlarge this image

The ICU at Tampa General Hospital in Tampa, Fla., was 99% full this week, according to an internal report produced by the federal government. It's among numerous hospitals the report highlighted with ICUs filled to over 90% capacity. **Michael S. Williamson/The Washington Post via Getty Images hide caption**

toggle caption

Michael S. Williamson/The Washington Post via Getty Images

The ICU at Tampa General Hospital in Tampa, Fla., was 99% full this week, according to an internal report produced by the federal government. It's among numerous hospitals the report highlighted with ICUs filled to over 90% capacity.

Michael S. Williamson/The Washington Post via Getty Images

As coronavirus cases rise swiftly around the country, surpassing both the spring and summer surges, health officials brace for a coming wave of hospitalizations and deaths. Knowing which hospitals in which communities are reaching capacity could be key to an effective response to the growing crisis. That information is gathered by the federal government — but not shared openly with the public.

NPR has obtained documents that give a snapshot of data the U.S. Department of Health and Human Services collects and analyzes daily. The documents — reports sent to agency staffers — highlight trends in hospitalizations and pinpoint cities nearing full hospital capacity and facilities under stress. They paint a granular picture of the strain on hospitals across the country that could help local citizens decide when to take extra precautions against COVID-19.

Withholding this information from the public and the research community is a missed opportunity to help prevent outbreaks and even save lives, say public health and data experts who reviewed the documents for NPR.

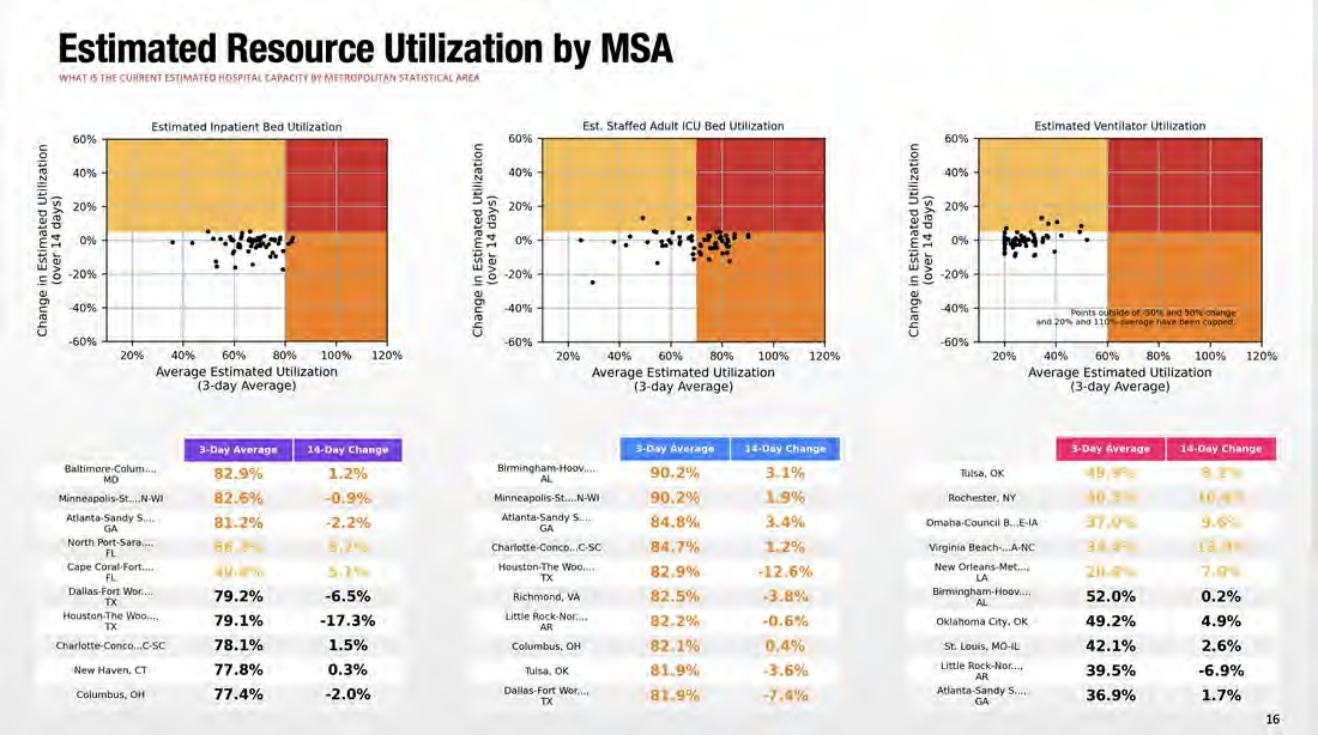
"At this point, I think it's reckless. It's endangering people," says Ryan Panchadsaram, co-founder of the website COVID Exit Strategy and a former data official in the Obama administration. "We're now in the third wave, and I think our only way out is really open, transparent and actionable information."

The documents show that detailed information hospitals report to HHS every day is reviewed and analyzed — but circulation seems to be limited to a few dozen government staffers from HHS and its agencies, including the Centers for Disease Control and Prevention and National Institutes of Health, according to distribution lists reviewed by NPR. Only one member of the White House Coronavirus Task Force, Adm. Brett Giroir, appears to receive the documents directly.

"Our goal is to be as transparent as possible, while still protecting privacy," an HHS spokesperson wrote in an email to NPR. "HHS and the White House Coronavirus Task Force utilize hospital capacity data to gain greater insights into how COVID-19 is spreading and impacting the population, and to better inform response efforts like staff deployments and supply shipments."

What data is being collected and shared internally?

The daily reports show county, city and hospital-level details, as well as national analyses that HHS does not post online.



A page from a report shared internally to HHS staffers presents hospital data from Oct. 27, including a list of cities where hospital and ICU beds are filling up. **HHS hide caption**

toggle caption
HHS

For instance, the most recent report obtained by NPR, dated Oct 27, lists cities where hospitals are filling up, including the metro areas of Atlanta, Minneapolis and Baltimore, where in-patient hospital beds are over 80% full. It also lists specific hospitals reaching max capacity, including facilities in Tampa, Birmingham and New York that are at over 95% ICU capacity and at risk of running out of intensive care beds.

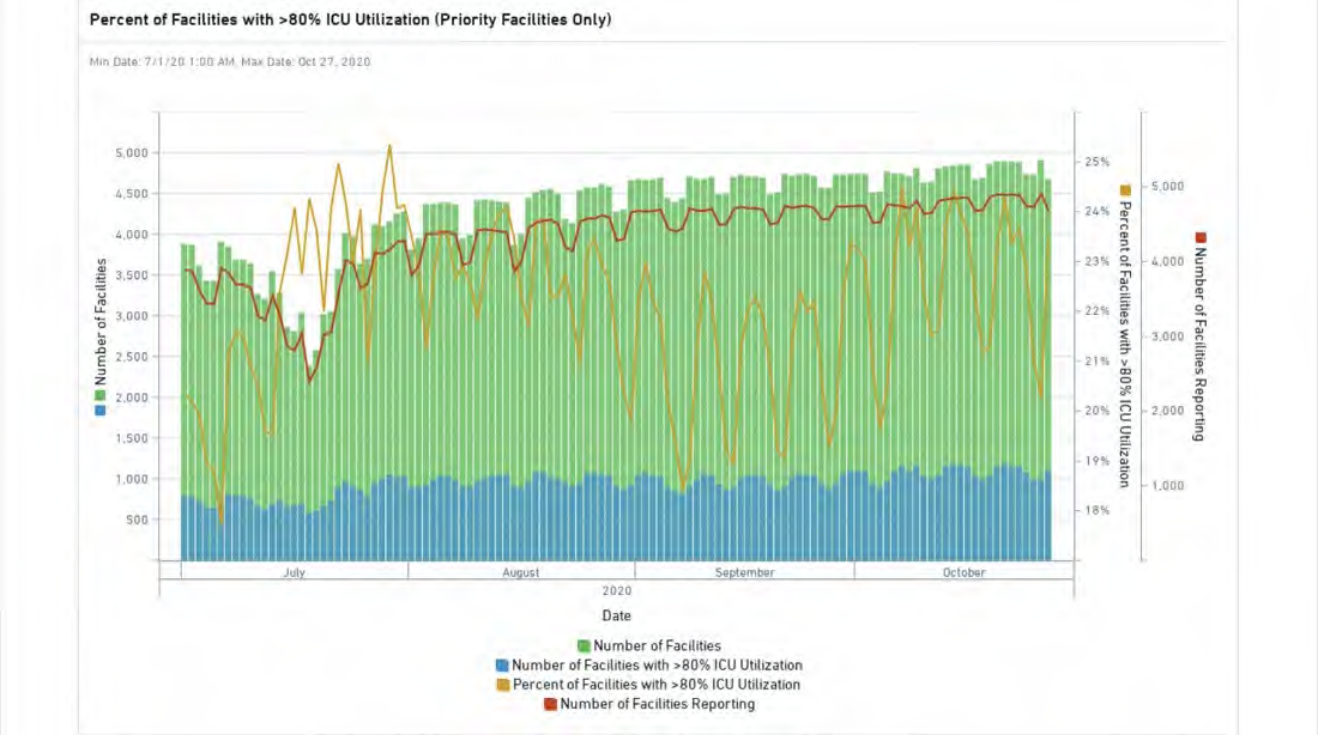
In reviewing the analysis obtained by NPR, Panchadsaram says the local and hospital-level data HHS is collecting would be very useful to researchers and health leaders. "That stuff isn't easy to find at a national level," he says. "There's no one place [publicly] you can go to get all that data."

Hospitalization data is invaluable in looking ahead to see where and when outbreaks are getting worse, says Dr. Christopher Murray, director of the Institute for Health Metrics and Evaluation at the University of Washington. "Right now, as we head into the fall and winter surge," Murray says, "we're trying to put more emphasis on predicting where systems will be overwhelmed."

But what's missing for this kind of planning, he says, is "exactly the information" that appears in the internal report.

NPR has reviewed several of these reports generated in the past month. They present trends in hospital use, including increases in ventilator usage, along with a growing number of inpatient and ICU beds being occupied by COVID-19 patients. The Oct. 27 report showed that all three measures have increased by 14%-16% in the past month.

About 24% of U.S. hospitals are using more than 80% of their ICU capacity, based on reporting from nearly 5,000 "priority facilities," and more hospitals have joined their ranks in recent weeks.



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A page from a report shared internally to HHS staffers shows the rising percentage of hospital ICUs that are at or above 80% capacity. It reflects data as of Oct. 27. **HHS hide caption**

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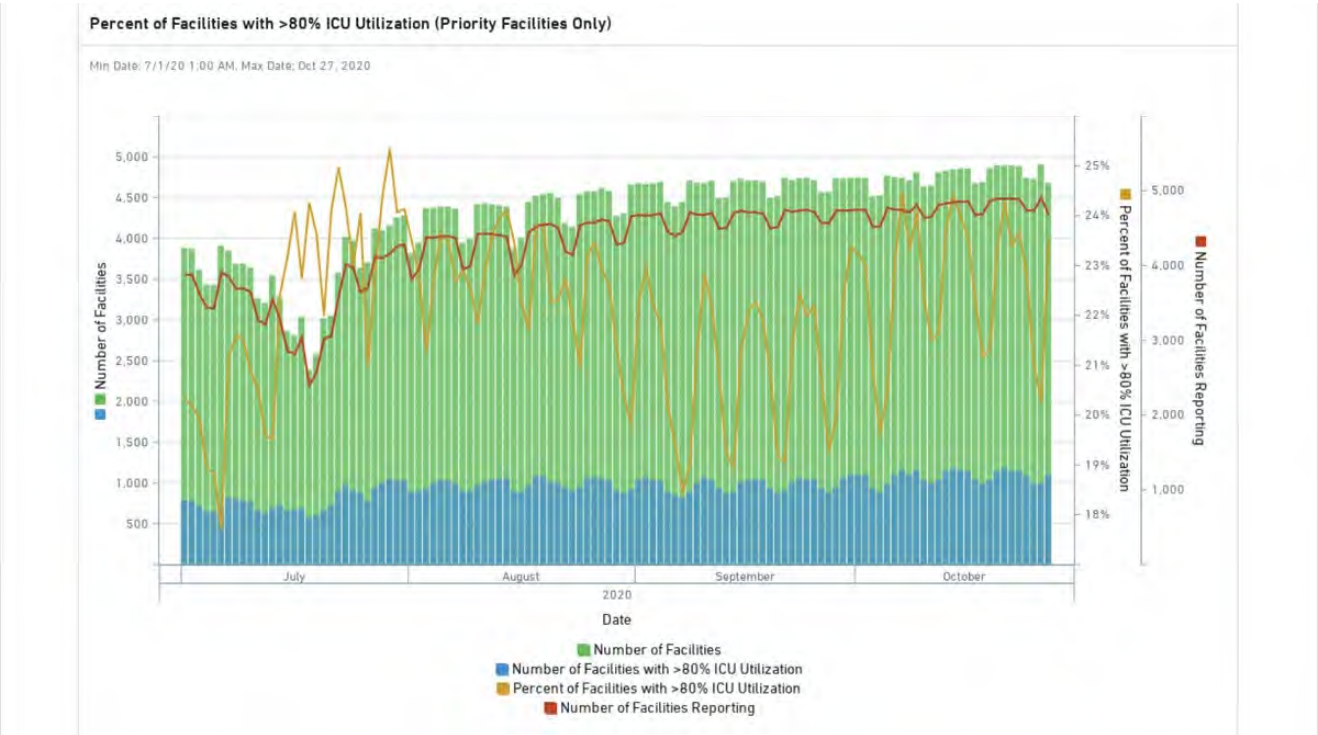
HHS



A page from a report shared internally to HHS staffers shows the rising percentage of hospital ICUs that are at or above 80% capacity. It reflects data as of Oct. 27.

HHS
Researchers say observing these trend lines can help the nation know how to prepare for surge and be ready to intervene before systems become overwhelmed.

Daily hospitalization numbers in particular are key measures for tracking pandemic hotspots, Murray says, because they reflect the number of severe COVID-19 cases in a community.

"The best possible measure of where we are in the pandemic, and the one we would want to anchor modeling to, is daily hospitalizations," he says, which give an early warning of deaths that will likely follow.

Panchadsaram's data-tracking site COVID Exit Strategy pulls state-level hospital capacity estimates from HHS when they're updated, which generally happens once a week. In reviewing the reports obtained by NPR, Panchadsaram says it's clear that vital data is flowing into HHS daily. "But sharing with the public seems to be an afterthought," he says.

Gaps in transparency for state and local leaders

HHS tells NPR that more than 800 state-level employees have access to the daily hospitalization data it gathers, but only for their own state, unless another state grants them permission to view its data.

Without a larger view into national or regional data, some states — like Tennessee, which has eight bordering states — are missing out on valuable regional data, says Melissa McPheeters, who directs the Center for Improving the Public's Health through Informatics at Vanderbilt University.

"Hospitals in Tennessee serve patients who are from Arkansas and Mississippi and Kentucky and Georgia and vice versa, and so we're a little bit blind to what's going on there," she says. "When we see hospitals that are particularly near those state borders having increases, one of the things we can't tell is: Is that because hospitals in an adjacent state are full? What's going on there? And that could be a really important piece of the picture."

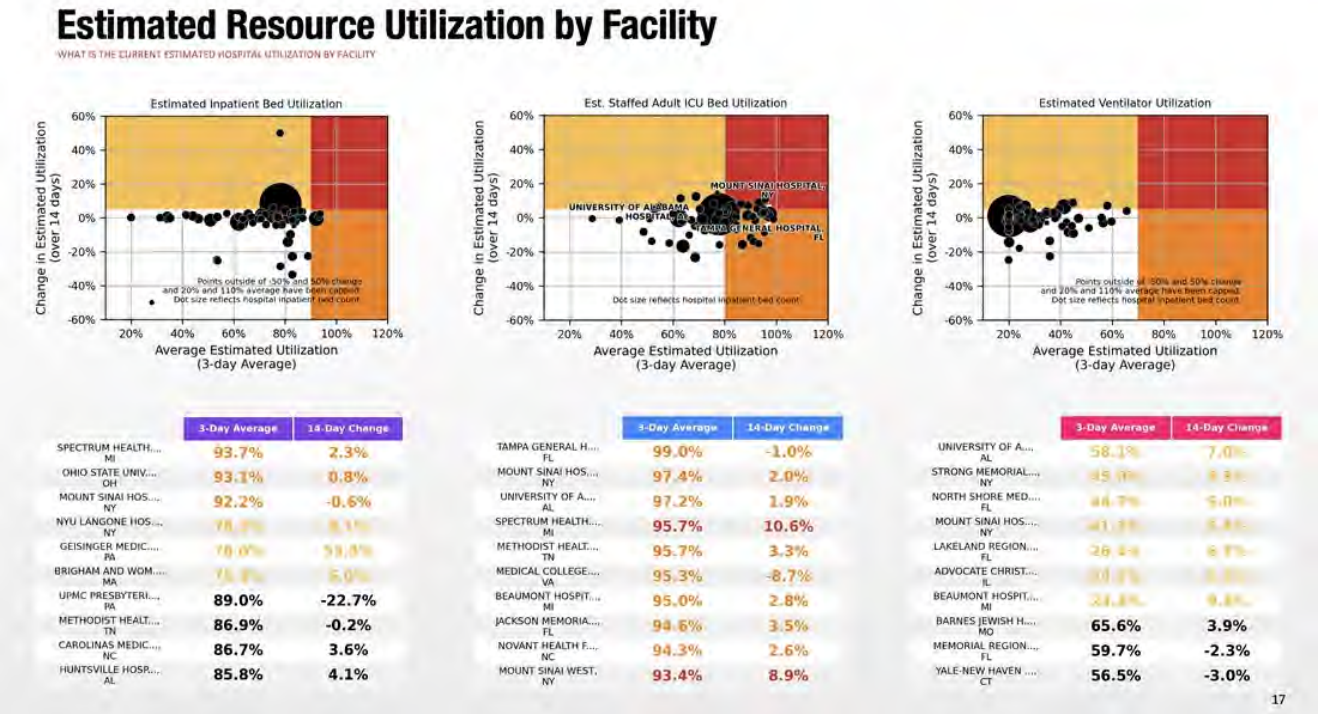
Lisa M. Lee, former chief science officer for public health surveillance at the CDC, now at Virginia Tech, says the federal government could help states work together across borders.

"It's very challenging for states to get the multistate view of things," she says. "It's just a lot easier when there's a knowledgeable third-party who can pull the data together, make them consistent across states and actually tell the story of what the information shows."

Typically, she says, this role would be fulfilled by the CDC, but the agency was stripped of its role in collecting COVID-19 hospital data in July.

This kind of visibility into data could help policymakers decide how best to curb the spread of the virus. McPheeters and colleagues at Vanderbilt put out a report this week that found that Tennessee counties without mask mandates had more rapid increases in hospitalizations. That kind of analysis and insight would be possible at a much larger scale if HHS shared more granular hospitalization data, she says.

It could influence behavior among the public, says Lee. "The neighborhood data, the county data and metro-area data can be really helpful for people to say, 'Whoa, they're not kidding, this is right here,'" she says. "It can help public health prevention folks get their messages across and get people to change their behavior."



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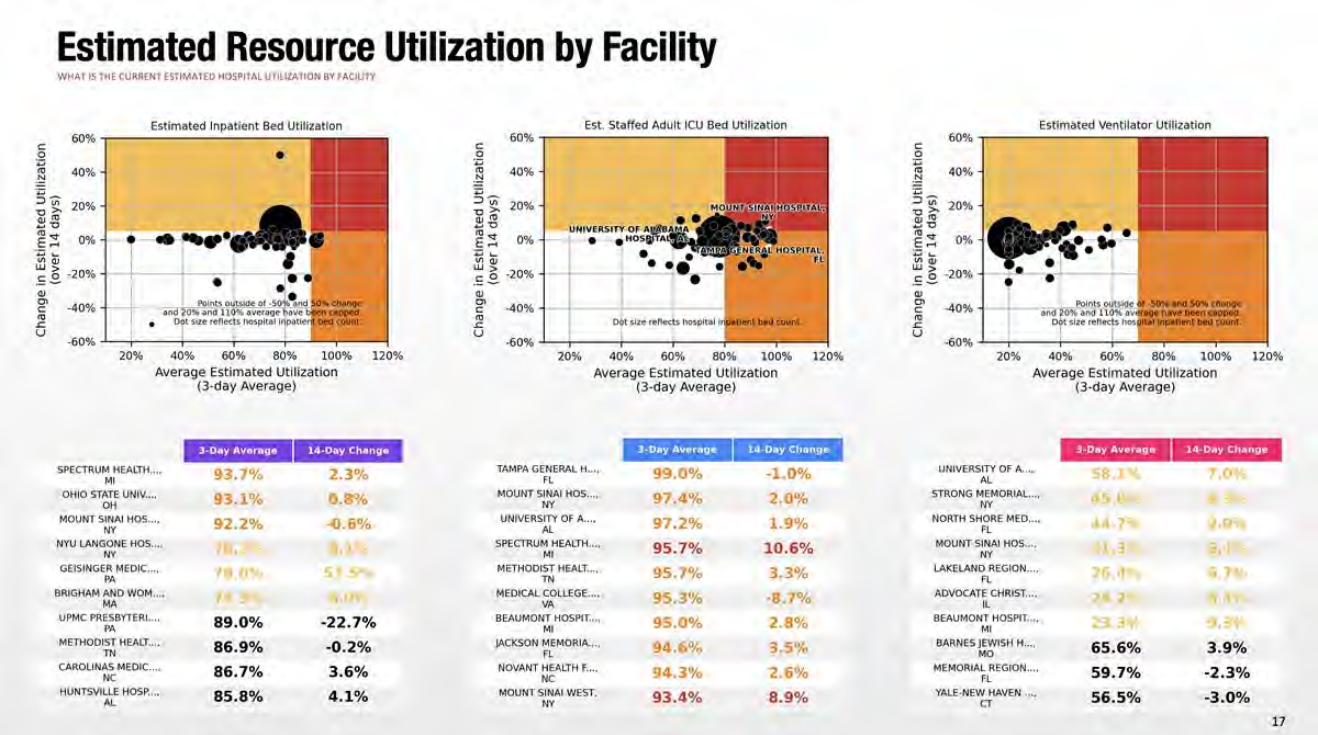
A page from a report shared internally to HHS staffers shows a list of health care facilities where beds are filling up, reflecting data as of Oct. 27. **HHS hide caption**

toggle caption

HHS



A page from a report shared internally to HHS staffers shows a list of health care facilities where beds are filling up, reflecting data as of Oct. 27.

HHS

A controversial data switch

Experts who reviewed the internal documents for NPR say that even for the limited group of federal employees who get them, the daily reports are not as useful as they could be.

"We're so focused on counting things but not contextualizing them," explains McPheeters. A community hospital might become overwhelmed at a different point than a big academic hospital, and without that context, she says, it's impossible to tell: "Is 75% [full] a good thing or is 75% a bad thing?"

Health data experts NPR consulted had ideas on how to improve the analysis. For instance, Panchadsaram suggested that some of the county-level charts, currently presented as raw numbers, would be more useful if analyzed per capita. "You really need to adjust it to the number of people [in an area] to get a sense of where things are being overwhelmed," he says.

And the quality of the underlying data is a concern. Health experts say the data quality was compromised by a controversial shift in data collection from the CDC to HHS in July, and that the issues with data quality have not been fully resolved.

Hospitals have had to adjust to onerous new reporting requirements, and the hospital data is no longer checked and analyzed by seasoned epidemiologists and other experts at CDC.

The daily trend documents circulated at HHS include this disclaimer: "This analysis depends on the data reported by hospitals. To the extent that the data is missing or inaccurate, this analysis will also reflect those issues."

According to HHS data posted on Monday, just 62% of the nation's hospitals reported all the required information last week.

But greater transparency, even of incomplete data, can be invaluable in a crisis, experts say.

HHS told NPR that since it took over collecting hospital capacity data, it has "consistently displayed state-level hospitalization data to help inform the public about COVID-19 prevalence in their communities."

But public health experts say the state level data isn't detailed enough — and since the government is putting the effort into generating more granular daily analyses, it should share them.

"Even though they're collecting all these things and putting so much effort behind it, it gets blocked when it tries to get out of the door," Panchadsaram says.

Shots

Health News From NPR

EXHIBIT P

FOR IMMEDIATE RELEASE
June 25, 2019

Contact: HHS Press Office
202-690-6343
media@hhs.gov

New Law Strengthens U.S. Efforts to Prepare, Respond and Recover from Disasters

A statement by Dr. Robert Kadlec, Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

The Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 (PAHPAIA), signed into law last night by the president, strengthens U.S. programs that are critical to protecting Americans from modern, evolving health security threats.

Congress passed the first Pandemic and All-Hazards Preparedness Act in 2006, in the wake of Hurricane Katrina, to drive better federal disaster health support for every American community. The goal was – and continues to be – ensuring that our nation is ready and able to withstand the adverse health effects of public health emergencies and disasters, whether a severe storm, a disease pandemic, or a bioterror attack. The 2019 reauthorization of the law, now called PAHPAIA, builds on work the U.S. Department of Health and Human Services has undertaken over many years to safeguard our nation's health security.

The newly signed law strengthens authorities for specific programs, including the Hospital Preparedness Program and the National Disaster Medical System, which are essential to our country's healthcare defenses. More than 31,000 healthcare entities across the country participate in Hospital Preparedness Program coalitions. These partnerships in every state and U.S. territory bring together healthcare facilities – not just hospitals – and healthcare services in local communities to provide coordinated medical care during disasters.

PAHPAIA also provides state health departments with flexibility in dedicating staff resources to meet critical community needs in a disaster. When the HHS Secretary declares a public health emergency, to meet immediate urgent needs, states may request temporarily deployment of state personnel whose salaries are funded by HHS in whole or in part under Public Health Service Act programs and whose day-to-day jobs are not related directly to emergency preparedness, response or recovery. For example, staff paid through a federal grant funding for HIV education could be deployed for a short time to support influenza vaccination campaigns during a pandemic.

We know, however, that disasters can be so catastrophic that direct federal support is needed, and with this law, communities can continue to count on our National Disaster Medical System. This system brings medical professionals, services and equipment from across the country to provide medical care in support of hospitals, shelters, and whole communities after a disaster. Over the past two hurricane seasons, these professionals collectively cared for more than 40,000 patients, providing basic medical care to residents who fled to emergency shelters and more complex medical care when local hospitals and nursing homes were damaged or destroyed.

The new law codifies coordination across federal agencies through a Public Health and Emergency Medical Countermeasures Enterprise so that these agencies more easily bridge gaps, avoid redundancy, and set priorities in developing the medical products needed in national security emergencies. The law also amends other legislation to provide a 10-year authorization for the Project BioShield Special Reserve Fund, which has been integral in the development of 10 medical products that now have earned FDA approval and has added 15 medications, vaccines and treatments to the Strategic National Stockpile.

PAHPAIA enables ASPR to continue enhancing health security; we look forward to using the new or renewed authorities in the law as we work with long-standing and new partners to build readiness and response capabilities against the very serious health security threats our nation faces.

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