COVID-19 Guidance for Hospital Reporting and FAQs
For Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting
Updated December 8, 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 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.

States that are certified are listed here.

*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:

[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).

- Short-term Acute Care Hospitals
- Medicaid Only Short-term Hospitals
- 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 on 10/6/2020 (IDs 33-38) are mandatory starting **12/18/2020**. The new therapeutic fields that have been allocated (39 a - d) will be optional starting 12/16/20 and mandatory starting 1/8/21. These new fields were added to the end of the existing templates, and the current templates will continue to work until states and hospitals adopt the new fields.

The remaining therapeutic fields (40 a - p) are placeholders that can be added to templates and reporting systems in preparation for new therapeutics. As a therapeutic is assigned, facilities will have two weeks before reporting is mandatory, so preparation for reporting these should begin now.

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, 40 a - p are optional and IDs 39 a - d are optional starting 12/9/20 and mandatory starting 1/8/21. IDs 40 a - p will become mandatory as therapeutics are assigned)

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	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

	g) TeleTracking ID (Optional)	• The identifier assigned by TeleTracking (Optional)
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, observation, and active 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 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, observation, 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 Subset: b) Hospitalized adult 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. 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: b) Previous day's pediatric admissions with suspected 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. 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 **if feasible**. 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/N/A) 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/N/A) 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) Laboratory – nasal pharyngeal swabs j) Laboratory – nasal swabs k) Laboratory – viral transport media	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.) • 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 and mandatory starting 12/18/20

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. For hospital reporting, laboratory-confirmed influenza is defined as Influenza A and B [this includes their subtypes and lineages (e.g., A(H1N1), A(H3N2), B/Victoria, B/Yamagata)]. Parainfluenza and Haemophilus Influenza should not be reported. Any result in the prior 14 days whether completed inpatient or outpatient can be used as the laboratory confirmation.

33.	Total hospitalized patients with laboratory-confirmed influenza	Patients (all ages) currently hospitalized in an inpatient bed who have laboratory-confirmed influenza virus infection. 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 virus infection at the time of admission. This is a subset of #33 and should not exceed the value in #33.
35.	Total ICU patients with laboratory-confirmed influenza	Patients (all ages) currently hospitalized in a designated ICU bed with laboratory-confirmed influenza virus infection. This is a subset of #33 and should not exceed the value in #33.
36.	Total hospitalized patients with both laboratory-confirmed COVID-19 and influenza	Patients (all ages) currently hospitalized in an inpatient bed who are co-infected with both laboratory-confirmed COVID-19 AND laboratory-confirmed influenza virus infection. This is a subset of #9b/10b and #33. This value should not exceed the value in #33 or the value in 9b+10b.
37.	Previous day's influenza deaths	Number of patients with laboratory-confirmed influenza virus infection 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 who are co-infected with both laboratory-confirmed influenza virus infection 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 and should not exceed the value in #37.
Therapeutic Course Inventory and Usage – Report Once Weekly for Wednesday's Date To allow for facilities, states, and IT vendors to prepare for the unknown number of therapeutics that will be approved and have a need for tracking, we are proactively adding designated fields for 10 possible therapeutics. At this time, only A and B have been assigned. However, this method enables everyone to create the ability now for all 10 so that we can add new therapeutics as needed. Therapeutic A and B are optional until 1/8/21 when they will become mandatory. When a therapeutic is approved that needs to be reported, we will provide two weeks for hospitals to prepare before it becomes mandatory.		
39.	a) Therapeutic A Courses on Hand	Enter the number of therapeutic A courses currently in inventory. **This field has been designated as Casirivimab/Imdevimab** and will be mandatory on 1/8/21.
	b) Therapeutic A Courses Administered in Last Week	Enter the number of therapeutic A courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic. **This field has been designated as Casirivimab/Imdevimab** and will be mandatory on 1/8/21.

	c) Therapeutic B Courses on Hand	Enter the number of therapeutic B courses currently in inventory. **This field has been designated as Bamlanivimab** and will be mandatory on 1/8/21.
	d) Therapeutic B Courses Administered in Last Week	Enter the number of therapeutic B courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic. **This field has been designated as Bamlanivimab** and will be mandatory on 1/8/21.
Future Therapeutics – Weekly Reporting for Wednesday These fields are placeholders for potential future therapeutics. They do not need to be reported until an approved therapeutic is designated.		
40.	a) Therapeutic C Courses on Hand	Enter the number of therapeutic C courses currently in inventory.
	b) Therapeutic C Courses Administered in Last Week	Enter the number of therapeutic C courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.
	c) Therapeutic D Courses on Hand	Enter the number of therapeutic D courses currently in inventory.
	d) Therapeutic D Courses Administered in Last Week	Enter the number of therapeutic D courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.
	e) Therapeutic E Courses on Hand	Enter the number of therapeutic E courses currently in inventory.
	f) Therapeutic E Courses Administered in Last Week	Enter the number of therapeutic E courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.
	g) Therapeutic F Courses on Hand	Enter the number of therapeutic F courses currently in inventory.
	h) Therapeutic F Courses Administered in Last Week	Enter the number of therapeutic F courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.

	i) Therapeutic G Courses on Hand	Enter the number of therapeutic G courses currently in inventory.
	j) Therapeutic G Courses Administered in Last Week	Enter the number of therapeutic G courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.
	k) Therapeutic H Courses on Hand	Enter the number of therapeutic H courses currently in inventory.
	l) Therapeutic H Courses Administered in Last Week	Enter the number of therapeutic H courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.
	m) Therapeutic I Courses on Hand	Enter the number of therapeutic I courses currently in inventory.
	n) Therapeutic I Courses Administered in Last Week	Enter the number of therapeutic I courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.
	o) Therapeutic J Courses on Hand	Enter the number of therapeutic J courses currently in inventory.
	p) Therapeutic J Courses Administered in Last Week	Enter the number of therapeutic J courses used in the previous calendar week in an inpatient, ED, overflow, or outpatient location, such as an urgent care, infusion center, or outpatient clinic.

- 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.

10. Influenza and COVID-19 combination fields: Which fields are inclusive of each other?
    - When the field asks for COVID-19 patients (e.g. 9, 10, 12, 16, 17, 18), enter all patients who have COVID-19 regardless of whether they have other conditions (e.g. influenza, hypertension, diabetes, etc.)
    - When the field asks for influenza patients (33, 34, 35, 37), enter all patients who have influenza regardless of whether they have other conditions (e.g. COVID-19, hypertension, diabetes, etc.)
    - For the fields that ask for both COVID-19 and influenza (e.g. 36, 38), enter only those patients who are co-infected with BOTH COVID-19 and influenza.

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.