STRAC
Southwest Texas Regional Advisory Council

Testimony to the Texas Senate Committee on Health and Human Services
Data collection processes in the Covid-19 Pandemic
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Thank you, Madam Chair Kolkhorst and the members of the Senate Health and Human Services Committee for the opportunity to testify today. My name is Eric Epley. I am the Executive Director and CEO of the STRAC, in San Antonio. STRAC is one of 22 regional advisory councils statewide and consists of 22 counties. STRAC's members include 65 hospitals, over 70 ground EMS providers, 13 air medical helicopters, and academic institutions that cooperate to provide high quality emergency care for patients in southwest Texas.

I am delighted to testify today, alongside many long-time friends and colleagues, about my perspective as a RAC Executive Director concerning the data collection activities during the current COVID-19 response, including testing, hospital bed status, resource availability and other critical measures.

I believe that Regional Advisory Councils play a critical role in acute healthcare data. RACs are ideally situated to serve as the convener of hospitals and EMS, where local and regional plans are developed and implemented and where data is critical to guide decisions in near real time.

There have been incredible successes for COVID-19. Obstacles have been overcome; innovative solutions created. But we know more now, and sustained funding for consistent and timely data sharing needs to be the focus.

Three themes have emerged surrounding data collection and distribution for COVID-19.

1. Lack of alignment and lack of understanding of need related to mission, goals and methods for data collection and reporting between Local, State and Federal govt.
2. Lack of results and feedback, including adequate and timely reporting, especially with respect to patient resulting and compliance with federal requirements
3. Changing methods and systems, which require building and rebuilding systems, and thousands of manual data input man-hours.

1. Lack of alignment and lack of understanding of need related to mission, goals and methods for data collection and reporting between Local, State and Federal Government.

In the Spring, COVID-19 testing was underway at a feverish pace. The Texas Military Department, Texas Emergency Medical Task Force and local EMS and Fire Department teams were conducting testing in nursing homes and at community sites throughout Texas. Viral testing has two key goals; First, to inform

the patient, family and treating physician of the test result, and second, to provide local leaders with situational awareness to address the spread in their jurisdiction. Attachment A is an example of the data systems that were created literally in days to support these efforts.

In March, the Community-based Testing System (CBTS) program was created by the Federal Health and Human Services (HHS) COVID-19 Task Force and provided to TDEM and DSHS to assign to the largest jurisdictions in Texas. At last count, the CBTS program provided over 250,000 tests in Texas, but timely test results were difficult to obtain for patients and physicians and local leaders. Attachment B demonstrates the challenges we faced to get results from the federal lab vendors. Both lab vendors had a requirement to report to the State Health Departments but the Electronic Lab Reporting linkages to DSHS were not in place when the testing began, and it took nearly 6 weeks to get this information flowing correctly. I was directly involved in over 30 hours on conference calls, sometimes with 20-25 people from DSHS, HHS, FEMA, LabCorp and Quest trying to align the processes to get the results flowing. The results were sent to HHS Task Force but were not being sent to DSHS or TDEM and certainly were not to the local jurisdictions.

Additionally, the lab vendors did not include the test site location in the file export to DSHS, which prevented DSHS from providing the information to the jurisdictions. Adding those fields required federal approval again through the HHS Task Force.

2. Lack of results and feedback, including adequate and timely reporting, especially with respect to patient resulting and compliance with federal requirements

The public health lab reporting system needs a comprehensive upgrade including the sustained funding to have well-trained IT staff to support it. Our collective "system of systems" must be reliable and resilient with the right folks providing the care and feeding of the IT system day in and day out.

For the past decade at least, the Federal Hospital Preparedness Program (HPP) participants, which are comprised of most of the hospitals in Texas have relied on WebEOC for hospital data collection about available beds, ventilators, etc. In the Spring, this system was swapped to EMResource. The Federal COVID-19 Reporting System, HHS Protect, added additional data reporting requirements, however it was not clear if the state data being submitted would make it into the Federal system. RACs and Hospitals got our first confirmation from the Federal system that we are submitting correctly on Thanksgiving week, nearly 5 months after the start of the HHS Protect system.

3. Changing methods and requirements, which require building and rebuilding systems, and thousands of manual data input man-hours.

Recognizing the Pandemic response is the first we have done in the modern age, there are obviously data collection systems to be created. However, the pattern of behavior between State and Federal officials and the nearly daily changes to the data sets and requirements is incredibly onerous, especially for hospitals that are actively involved in surge operations, trying to care for critical patients while trying to maintain compliance with ever-changing State and Federal data collection requirements.

An example of this would be the EEI and HPP data sets that hospitals have been reporting in one fashion or another. In the last 6 months, the reporting requirements have changed so many times I have lost count. These data exist and are available in the electronic systems of healthcare today, we must find a long-term bridge solution that will allow easier, automated reporting in crisis.

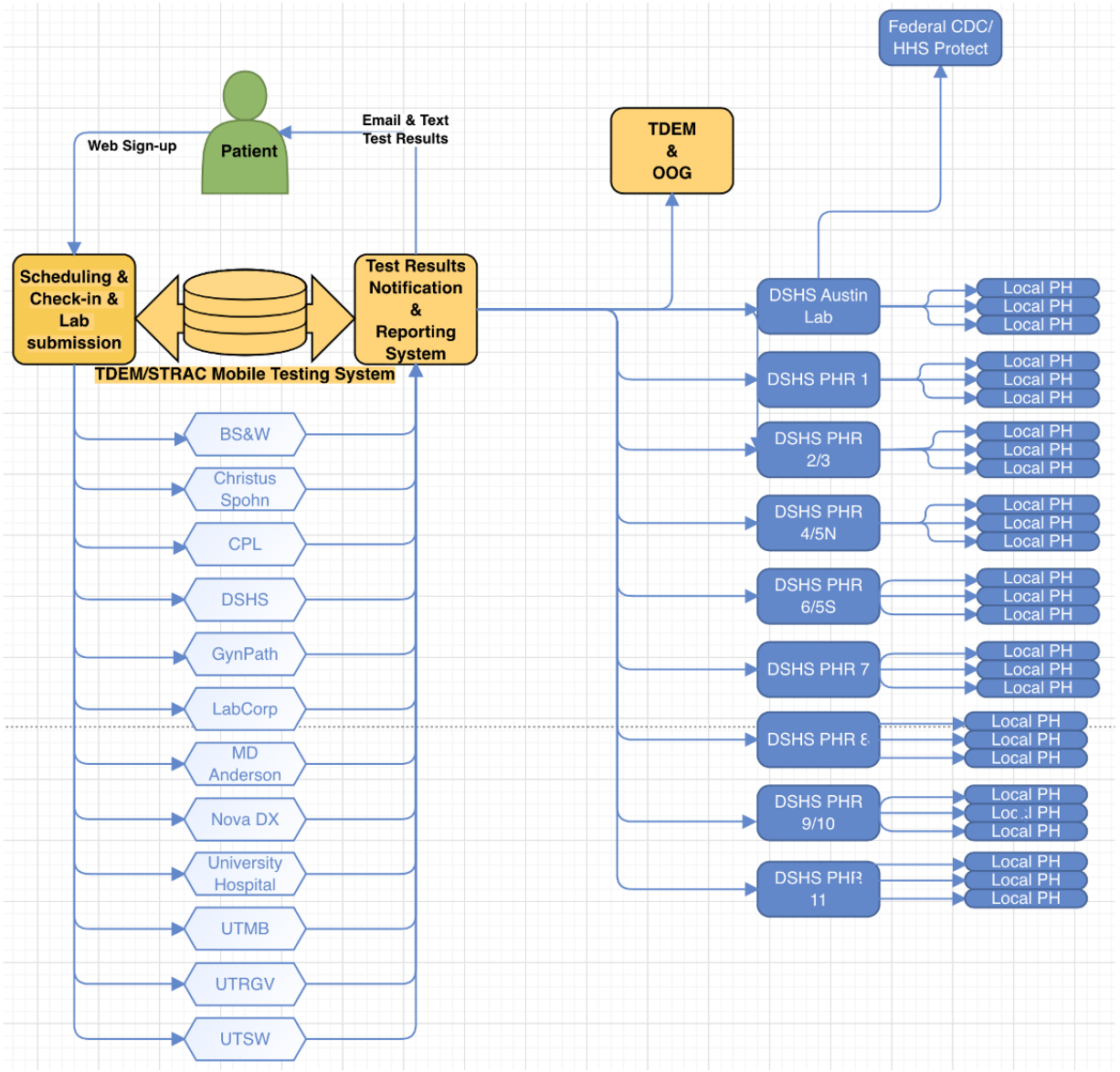
In summary, I feel that RACs have been consistent and dedicated partners with the DSHS and TDEM to produce actionable data for the response to the COVID-19 Pandemic Emergency. I thank you for the time to speak to you today and for your continued support. I am happy to answer any questions you may have.

Attachment A

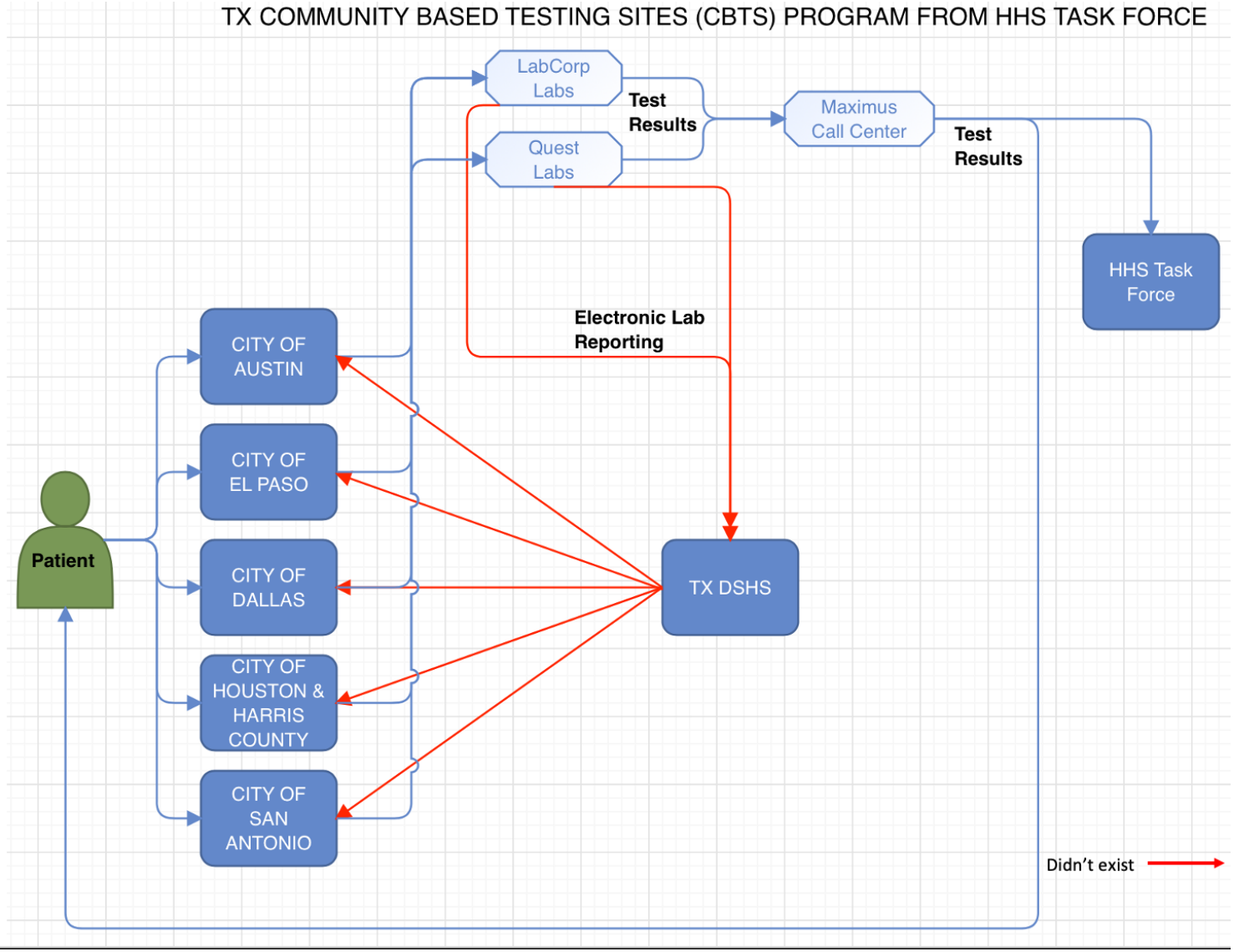
The TDEM/STRAC Mobile Testing System for Covid-19

Created in less than a week, the system provided:

- **Online patient registration**
- **Call center scheduling by TMD soldiers**
- **Check-in at Mobile Testing**
- **Electronic scanning of the sample and lab submission to 12 labs**
- **Sample tracking**
- **Secure Lab results reception**
- **Patient text and email results notification**
- **Tableau reporting tool to DSHS and PHRs daily**



Attachment B

TX CBTS Program

- Managed and operated by Local Jurisdiction
- Pt Registration Excel Sheets placed in Test Sample Shipping box – no electronic registration
- Shipped to Federal contract labs
- Results sent to Maximus, Federal call center for patient notification of results
- No Electronic Lab Reporting (ELR) between Labs and DSHS for Covid tests
- Delays were common, exacerbated by lack of data linkages
- Reporting from DSHS to Local govt hampered by Fed Lab exports not including Test location