Congress of the United States
Washington, DC 20515

November 6, 2020

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Azar,

As COVID-19 infections continue to rise, amounting to over 9 million cases in the United States, we write seeking greater transparency in data the Department of Health and Human Services (HHS) is collecting concerning hospital capacity. HHS has imposed several reporting requirements on hospitals, yet much of the data is not publicly available, thereby hampering efforts by state, local, and public health leaders to assess and respond to the crisis. Recently, NPR reported that HHS is completing daily analysis of data for internal purposes, but neither the analyses nor the underlying data are publicly disclosed.[1]

We strongly urge you to begin publishing the following data, and any accompanying internal analysis, on a daily basis on http://healthdata.gov:

1. Facility-specific capacities for all hospital inpatient beds and ICU beds. This information should be stratified by type of bed, including overflow, observation, and surge/expansion beds.
2. Facility-specific occupancy for all hospital inpatient beds and ICU beds. This information should be stratified by type of bed, including overflow, observation, and surge/expansion beds. This information should also be stratified by patient age as well as by patients hospitalized due to suspected or laboratory-confirmed COVID-19.
3. Facility-specific capacities and use of all mechanical ventilators, including adult, pediatric, neonatal ventilators, anesthesia machines, and portable/transport ventilators. This information should include the number of patients who have suspected or laboratory-confirmed COVID-19 who are using a mechanical ventilator.
4. Facility-specific number of patients with suspect or laboratory-confirmed COVID-19 who are in the Emergency Department or an overflow location awaiting an inpatient bed. This information should also include whether the patient is using a mechanical ventilator.
5. Facility-specific testing performed, including antibody, IgG, IgM, and IgA tests. This information should be stratified by test type and include tallies of positive and negative results.
6. Facility-specific number of patients with suspected or laboratory-confirmed COVID-19 admitted on the previous calendar day.
7. Facility-specific number of patients with suspected or laboratory-confirmed COVID-19 who died on the previous calendar day.

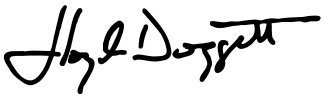
[1] https://www.npr.org/sections/health-shots/2020/10/30/929239481/internal-documents-reveal-covid-19-hospitalization-data-the-government-keeps-hid

8. Facility-specific number of patients with suspected or laboratory-confirmed COVID-19 14 or more days after admission for a condition other than COVID-19. Patients should no longer be included in this data when they are no longer symptomatic and have been removed from COVID-19 isolation precaution.
9. Facility-specific number of patient visits to the Emergency Department on the previous calendar day. This information should be stratified by patient visits related to COVID-19 and reasons unrelated to COVID-19.
10. Facility-specific supplies of ventilator supplies, N95 respirator masks, surgical and procedure masks, single-use gowns, exam gowns (sterile and non-sterile), and eye protection, including face shields and goggles. This information should include the number of individual units of each item, number of days supplies for each item are expected to last, and the ability of the facility to maintain a three-day supply of each item.
11. Facility-specific staffing shortages and anticipated staffing shortages based on each facility's needs and internal staffing ratio policies. The use of temporary staff should not be accounted as a staffing shortage if the facility's needs and staffing ratio policies are being met.

The publication of this data, which HHS is already collecting, will enable leaders to better coordinate across regions and effectively share resources. This information also informs difficult decisions public officials must make concerning limiting public gatherings, closing businesses, and other containment strategies. To effectively combat this virus, public officials and health care leaders need timely and comprehensive information.

We appreciate your timely attention to this important matter.

Sincerely,



Lloyd Doggett

Suzan DelBene

Donald S. Beyer, Jr.

John B. Larson

Daniel T. Kildee

Jimmy Panetta

Thomas R. Suozzi

Terri A. Sewell

Dwight Evans

Ron Kind

Linda T. Sánchez

Danny K. Davis