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 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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