CSTE COVID-19 Consultancy Project

CSTE-CDC Core Epi COVID-19 Mtg Minutes:

Date:	**Wednesday March 9, 2022**
Start/End Time:	1-2:30p

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#	Topic	Items
1.	Introductions	Welcome and introductions to Hutton Health Consultants

2.	MIS-C Position Statement Update	Angela Campbell, lead of MIS-C CDC Unit over the last one year
		• CDC understands that MIS-C surveillance is more demanding than other lab-based surv
		• It is passive voluntary surveillance with a standardized case report form (not nationally notifiable condition)
		  ○ Feedback: Are there models CDC has looked at of optimal surveillance given demands?
		  ○ Some jurisdictions are better able to capture than others and unclear if there are clear models or guidance to help states increase their captures without high burden. (CDC has not yet engaged in evaluating this).
		• 7,459 MIS-C cases reported, 63 deaths (incr of 600 cases from the prior month's report)
		• It is one of the most severe complications of COVID-19 in children/adults
		• Data has been really important to present on website as well as to present to ACIP, etc.
		• They sometimes use hospital data through EPIC Cosmos (data mining from EHR) which can be correlated with national surveillance data.
		• Impact of omicron on MIS-C cases are yet to be seen due to delay in presentation of condition and delay in reporting.
		• Important surveillance with new variants, in relation to vaccination, etc.
		• Also used for vaccine safety monitoring (among other surveillance systems such as VAERs)
		• There are new materials for parents on the website
		• Overcoming COVID-19 Network (used to be a flu network), pivoted to include COVID-19, and there are a number of COVID-19 and MIS-C studies in this network. Using this data, paired with national surveillance, allowed the paper to be done on incidence (1 MIS-C case per every 3,200 COVID-19 infections (pre-omicron).
		• VE of two doses of Pfizer against MIS-C was 91% and none of the fully vaccinated patients with MIS-C required ventilation/etc.
		
		Michael Melgar CDC
		• CDC recognizes that the case definition is burdensome to apply, more has been learned, and not all criteria are helpful in identifying cases
		• Revisions presented (all still yet to be finalized, not to be circulated).
		• No change:
		  ○ Age: <21 yrs
		  ○ ≥ 2 multisystem organ involvement
		  ○ Absence of a more likely diagnosis.
		• Increased specificity (*new in italics*):
		Organ systems
		  ○ Illness requiring hospitalization ≥*24 hrs (or death, if did not get to the hospital).*
		  ○ Detection of SARS-CoV-2 RNA/Ag *up to 60 days prior to illness* onset (including home based testing, per provider/parent history)
		  ○ Detection of antibody *during present illness*
		  ○ Or close contact of a confirmed/probable case *in 60 days prior to illness onset* (rather than last 4 wks)

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		○ Fever *'on at least 2 days'* rather than for ≥24 hrs (still subjective or objective, doesn't have to be consecutive) ○ Cardiac manifestations – *will list all – coronary artery aneurysm/dilatation, LV ejection fraction <50%, troponin elevated above normal (per lab values), BNP>300, or proBNP >1,000* (Previously had some examples, but not an exhaustive list, and no levels for BNP). ○ *Shock as its own category rather than as a cardiac manifestation* (so it would count as one 'organ system' as is not always CV related, this is similar to WHO case definition) ○ Dermatologic: More explanation of specifics: *oral mucosal inflammation, conjunctival injection or conjunctivitis, extremity findings (erythema/edema of the hands/feet)* ○ GI: limited to *abd pain, vomiting, diarrhea (and removing incr. bili, LFTs)* ○ Heme: *removing incr d-dimer as this is very common with acute covid, so proposing to narrow to PLT CT<150, ALC<1,000* ○ ~~*Neuro, Renal, Respiratory:*~~ *Remove these 'organ systems' entirely.* Resp system may be misclassifying patients with acute covid. And neuro and renal are not more common with MIS-C versus acute COVID, and don't uniquely identify pts with MISC w/out any of the above other findings. Lab findings: ○ By far most commonly performed test of systemic inflammation and the most commonly elevated out of all the other inflammatory markers listed is CRP. So proposing to *simplify to CRP >= 3.0 mg/dl only* in this category. ○ Will *propose a suspect case* as well as confirmed and probable categories. *Suspect: A person whose death certificate lists MIS-C or multisystem inflammatory syndrome as an underlying cause of death or a significant condition contributing to death.* • Feedback provided by members: ○ Increased specificity can increase complexity and labor needs. ○ What % of current MIS-C are based on Ab testing alone with no SARS-CoV-2 RNA/Ag test positivity? CDC: 87% of cases were Ab+ (97% of those tested with Ab testing were positive) and approximately 50% were SARS-Co-V-2 RNA/Ag test +, but these groups are not mutually exclusive. ○ Will this increase or decrease cases? CDC: It is uncertain because there is no gold standard, all current cases were assembled using the case definition. But, using that as a benchmark, it is ~85% sensitive. Hard to conclude that all of the cases lost are truly MIS-C when some of them may well be severe acute COVID-19 in children. Very few were added w/ this definition (out of those reported to national surveillance). ○ Would be good to share this draft with this group only, so they can give early feedback. • MIS-C team is updating the case report form.
3.	COVID-19 Position Statement Update	Marci Layton, CSTE • Summary of proposed recommended changes: ○ Member lead is Kathy Turner ○ This is the third revision of the position statement (initial early rapid 2020 version, revised through routine process during June 2021 conference, and now) ○ *Remove probable case definition that requires clinical symptoms and epi linkage* (esp w/ ending of CI/CT), and *remove sections on clinical symptoms and epi criteria* ○ Remove this completely or move it to suspect? Preference from the workgroup was to remove it completely (suspect isn't reported to CDC) ○ Remove serology from lab reporting criteria (as COVID has become more endemic) ○ Moved vital records criteria w/ no confirmatory lab criteria from probable to suspect (if change made, would impact on death classification guidance also) ○ Change national notification timeframe from 'immediate' to 'routine' ○ Changes will be going forward (no reclassifying back cases) • Retain / no changes: ○ Ag tests as presumptive and not confirmatory lab evidence (probably pretty good during high community transmission timeframes)

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		○ Keep timeframe for new case at 90 days after last case (data wasn't robust enough to make shorter, although this was a concern during omicron). (CDC will share data on this in two weeks at All State Epi call) ○ Propose to not add sections to this position statement on classification for deaths and hospitalizations, and keep these as separate guidance documents. Separate guidance documents won't be a requirement for states, rather would be guidance. • Feedback: ○ Concern re: VRs: A number of cases positive on home tests, not retested in hospital, and it shows up on the death certificate. We will see possibly a greater than current discrepancy between VRs and surveillance data. (Though note to be similar to challenges w/ other diseases). Note: the death classification guidance isn't binding and came out as omicron was beginning to spread and can be revised. This issue was discussed in the workgroup. Might want to readdress and continue to discuss. This is difficult to explain to the public. ○ Immediate to routine: Currently most are still doing daily reporting. Changing to routine would be delayed. While supportive, wondering what is that timeframe? NOTE: This will not go into effect until July after CSTE conference (or January if the routine process). CDC is working on updates for surveillance goals and methods currently. There is no one timeframe definition for 'routine'.

Action Items

[From last meetings, until closed]

#	Activities/Deliverables	Action Item/Responsible	Due Date	Status
1.	MIS-C Position Statement Update	☐ CSTE to send the CDC draft of proposed MIS-C changes to meeting/workgroup participants *(confidential, not to be distributed)* ☐ CSTE members to provide further feedback/edits in writing to CSTE (Marci)	3/11/22 3/16/22	Pending
2.	COVID-19 Position Statement Update	☐ CSTE to send the draft of proposed COVID-19 position statement changes to meeting/workgroup participants *(confidential, not to be distributed)* ☐ CSTE members to provide further feedback/edits in writing to CSTE (Marci)	3/11/22 3/16/22	Pending
3.	Next meeting agenda: Wednesday 3/16/22 1-2:30p	☐ Next meeting agenda topic: Hospital Surveillance: Levering Syndromic Surveillance and Health Information Exchanges (unable to discuss this meeting)	3/16/22	Pending