CSTE-CDC COVID-19 Core Epi Workgroup Meeting:

Date:	**Wednesday May 4, 2022**
Start/End Time:	1-2:30p

CSTE-CDC Core Epi COVID-19 WG Meeting Minutes

#	Topic	Items
1.	Introductions	**Open and Welcome – Katie Brown, MA**

2.	CSTE COVID-19 Hospital Classification Guidance	**CSTE COVID-19 Hospital Classification Guidance – Liz Dufort, Hutton Health Consulting, Marci Layton, CSTE**
		• We received further input into the document on the classification of hospitalizations
		• Also, during a recent ASE call, CSTE did a poll to capture what methods jurisdictions are using to capture hospitalizations. Wanted to share back with this group for input and discussion.
		• Document is guidance only. Purpose of definition is to create criteria for classifying hospitalizations using readily available data without chart reviews or case investigations.
		• Current draft of definition is: hospitalized within 14 days before or 14 days after positive test. Trying to be consistent with COVID-NET with 14 days prior, but COVID-NET includes anytime during hospitalization for the tail, however, those jurisdictions investigate to confirm discharge dates.
		• Received feedback that 14 days is too long after hospitalizations and could likely capture hospitalizations that were incidental to COVID-19. Do we want to reduce the timeframe to 2-3 days after discharge?
		• Discussed that the COVID-NET definition is ideal– hospitalized within 14 days of positive test or during admission.
		• Discussed shortening the 'tail' to at most within a week of admission better than 14 days
		• Also, for one COVID-NET site, based on surveillance officer feedback, found that 14 days before is too long to attribute to causality, a shorter timeframe such as 7 days may be better with more recent variants and testing practices. Though, others feel 14 days may still be appropriate for lab test before admission for time to develop condition leading to hospitalization (immunologic, other).
		• COVID-NET may have data on length of stay, and parameters which more likely identify associated admissions versus incidental to help inform a reasonable duration.
		• For discussion of the tail: STLTs note that many hospitals are now screening everyone for COVID-19 upon admission, rather than the challenges in the epicenter early on where testing was not available therefore 14 days may have been a more reasonable window after admission given limited testing availability early in the pandemic with testing shortages. Therefore, STLT discussion about a shorter time now would be appropriate and may even think shorter than 7 days now.
		• Discussion re: difference between reporting and case investigation. Still need to investigate to see if a hospitalization is associated with COVID-19. Though many other STLTs report limitations in staffing/resources to do this.
		• CSTE will request CDC COVID-NET to present data on our next Core Epi WG call that might inform this approach. *Submit any additional questions that we want to ask CDC to Marci at mlayton@cste.org*
		  • *Average LOS*
		  • *Whether cases with a positive 7-14 days prior to admission were more likely to be incidental than those 0-6 days prior to admission.*
		  • *Similar questions for the tail*
		• Average LOS for one state is 7.4 days, but range is large (1-84 days) and varies by time-period under analysis. It was longer during Delta surge compared with Omicron surge.

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		• In summary, it seems the groups wants a longer window before admission (7-14 days) and consensus to shorten time window after discharge, but not clear if it should be 7 or maybe shorter number of days, such as 3 days after admission.
		• Clarify if ED stays longer than a day should be included or excluded?
		• For some jurisdictions, it may be difficult to distinguish ED or "observation" overnight stays from inpatient admissions.
		• Discussed and suggested that CSTE could present the gold standard for these definitions and acknowledge that not all jurisdictions may have those resources with second tier approaches listed for those without resources.
		• ED stay more than 24 hours is equivalent to a 1-day hospital stay, but some jurisdictions will not be able to capture this.
		• Shared results of ASE poll on hospitalization methods used by jurisdictions - 42 total deduplicated responses (34 states, 1 territory, 7 LHDs/large cities)
		  • 71% receive hospital aggregate data directly
		  • 52% use HHS protect aggregate data for surveillance
		  • 50% receive hospital line-level data directly
		  • 40% syndromic surveillance with disposition (14% of jurisdictions can match Syndromic with lab data (35% of those who use SyS with disposition can match to ELR))
		  • 33% can match case data with EHRs or HIEs
		  • 17% eCR
		  • 21% were part of a jurisdiction that participates in COVID-NET (however, did not report that this data is used for hospitalization surveillance). Survey could not capture why, perhaps due to timeliness?
		  • Continuing collection of hospital data will be useful after this PHE ends
		  • Some have established an eCR connection, but few health systems have been onboarded and not yet using these data

3.	Case Investigation and Contact Tracing ELC Metrics Update	**Case Investigation and Contact Tracing ELC Metrics Update – Bradford Greening, CDC** • Currently 6 performance measures w/ 16 data points. • Proposing to reduce to 2 with 5-6 data points • Discussed need to add a 'denominator indicator', 'Number of cases referred', or 'indicated for a CI'. • These metrics are to have an indication of what is the being done in this space. It is understood that some stopped and some have continued somewhat with CI/CT. This is expected. OK to say '0' if not doing CT. • Consider rather than number of contacts notified by the health department, rather consider reason for testing of a case. • Feedback from STLTs: Definitely support the reduction. • Can we count exposure notifications through our Exposure Notification Apps as contact tracing? • Also, some STLTs send text messages to cases not sampled for investigation with a link to a web survey. Would probably want to capture these numbers differently. • For some STLTs, contact tracing has evolved from following contacts to a single notification such as through text messages to contacts identified by multiple sources including schools, etc. • If CDC wants to understand what is going on currently in STLTs for CI/CT, consider a short survey to understand HOW jurisdictions are addressing these functions as it would help to refine the standardized reporting language. • Discussed that If STLTs are not doing CT would be better to a "Not Applicable" option as an answer, rather than "0". Having an option to say why or what is being done in this space would be great.

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		• Discussed that it is important to disentangle CI and CT. As CI is still occurring for some, severe disease, or VOCs-assocated. So, having a way to say why/who is getting CI and it is not for CT. Or to offer therapeutics. Would be good to capture how are you reaching and for what purpose? How do we do that without being burdensome? • Jurisdictions have identified metrics that are accessible and useful for them, and they may not be available to all jurisdictions. • Consider having some questions about specific priority areas with CT being handled by staff of those facilities/areas, but numbers are not formally reported back. So, consider addressing that. The numbers are relatively low for CT, but that is because they are not reflective of facilities where it is being done in-house. Same for schools, correctional settings, etc. • Consider a survey of jurisdictions to report WHAT they are doing rather than trying to put it into an ELC quarterly metric. • CDC will consider rather than a Yes/No for priority groups targeted, which is less useful, a free text field as a middle ground. • Is it important to clarify what better ways we are using the ELC funds than contact tracing? • Discussed that the visualization example shared here, while it might be useful for internal CDC use in the context of understanding what pivots are occurring at the jurisdictional level with regard to case/contact outreach efforts, if shared more publicly would generate a lot of confusions over what health departments are/aren't doing. In our jurisdiction, staff who used to perform contact notifications are now focused on establishing and maintaining relationships with businesses, schools, and other entities to provide the technical assistance they need to manage COVID-19 exposures in their settings effectively. STLTs feel this has equal if not more impact than public health directly contact tracing all these individuals, but how do we capture data on this and communicate what it is that public health is doing here? • Depending how this will be used could include a set of populations/categories that are being prioritized (with a free text option). Prioritization: One suggestion is to include a free text field along with 'cases referred' to capture a response to 'what criteria/prioritization definition/ priority populations are being use to guide referral for case investigation'? • STLTs discussed that they are not targeting/prioritizing because we are not using the case investigation as an intervention but rather to understand the case characteristics so randomly sampling for investigations. • Others targeted investigation of clusters reported to the HD. • ELC used to ask for "Success Stories" – consider a success story of how funds were used to transition to more efficient activities.
4.	COVID-19 Community Levels Report Mock-up	**COVID-19 Community Levels Report Mock-up, Ally Binder, CDC** • Weekly summary that would accompany the weekly updates on the website. • Compiled Thurs or Friday each week, send via best distribution list, by jurisdiction (state or territory) • Firstly, Table 1 with categories, with current week and previous week by all Counties in State. • Each component of the CCL (cases per 100K), admissions per 100K, and COVID-19 inpatient occupancy for the current week, previous week, and absolute difference by county, will be presented. • Table 3. Look at each county with the state current category, previous, change, levels for each metric by county, with red font for those that are shifting to a higher category that week. • STLTs feedback – This would be very helpful - could save a lot of digging for us and the local health departments trying to understand why the county moved up or down a level. • Discussed - Is the CCL Change based on a statistically significant change, or just whether the level changed across a threshold?

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		• Sending after the community levels were made public is suboptimal both for STLT ability to manage effective and transparent communications as well as to address any inconsistencies (it would be too late at that point in time). • CDC will also send a companion excel file to do your own sorting and analyses. • Feedback – That would be great. The Excel file is really the most helpful for further manipulation. • STLTs discussed that it would be ideal if STLTs can get this information before the data go live on the CDC site. Because the CCLs are updated Thursdays would be great to have at least the same day, if not beforehand, before public. Before making public would help us address concerns and understand potential reasons for the change especially if they are not "real" changes (e.g., data dumps). • It would also be helpful to have a summary page with the current week's map along with the prior map for the past 1-2 weeks. • Feedback for streamlining the tables. • A graph showing the last four weeks would be ideal to look for trends versus the changes week by week, especially important for more rural counties where things are changing week to week. A graph with levels and metrics (cases per 100K and hospital admissions) over time with changes in color, levels by county. • CDC shared a trajectory plot that potentially can be added. They will gauge feasibility of adding maps. CDC will create a new draft with fewer columns to share for further review. • The change is based on whether the level changed or not (not statistically significant change) • CDC plans to send on Thursday afternoons (will confirm with the team), and will aim for before the levels are made public • Trajectory plot is great for internal health department use, but not sure whether wider consumption is helpful as it is a bit complicated. Might need to make simpler graphs over time for some audiences to consume. • Can share US or state graphs with percentage of counties by CCLs category
5.	Future Topics	• Future Call Topics and Tentative Agendas ○ *11 May*: ▪ Long-COVID Surveillance Strategies and COVID-NET re: CSTE ▪ Hospital Classification Guidance Update ○ *18 May*: ▪ CDC National School COVID-19 Prevention Study ▪ CORHA Guidance Update ○ (Date TBD) ▪ Vaccine Planning for Fall, including future booster recommendations (CDC VTF) ▪ CDC Center for Forecasting & Outbreak Analytics – data needs, addressing key epi questions; data sources (NSSP, immunization, ELR, etc.) ▪ CDC COVID-19 Community Levels Evaluation (compared to other surveillance indicators) ▪ CSTE Death Classification Guidance Update

Action Items

#	Activities/ Deliverables	Action Item/Responsible	Due Date	Status
1.	Next meeting	☐ COVID-NET to join next meeting re: data related to the CSTE COVID-19 Hospital classification guidance	5/11/22	Pending
2.	Trends in Vaccine Impact and Breakthrough Surveillance by Vaccine Status	☐ Consider stratification analyses and reconvene at a future meeting. ☐ Discuss with CDC communication messages for STLTs on this issue.	5/11/22	Pending
3.	New CMS Proposed Rule	☐ CSTE will coordinate preparation of written comments on Rule with member input.	6/17/22	Pending
Next meeting: Wednesday 5/11/22 1-2:30p Eastern				