Meeting Minutes and Action Items for Lab/Epi CSTE/APHL/CDC Thought Leaders Call

Date:	**Tuesday April 5, 2022**
Start/End Time:	**3-3:30p EST**

Meeting Minutes and Action Items for Lab/Epi CSTE/APHL/CDC Thought Leaders Call

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1.	**Open Call**	**Tim Southern (SD), Sherri Davidson (AL)**
2.	**2-3PM CSTE/CDC Wastewater (WW) Surveillance Webinar**	

3.	**3-3:30PM Discussion on WW Surveillance:**	• **Amy Kirby, lead of NWSS, CDC**
		  ○ Program has grown rapidly since Sept 2020 when they were established
		  ○ Funded through 2025, and have sufficient funds to expand to all 50 states.
		  ○ Currently 43 states collecting data coming into the system with over 700 sites
		  ○ Captures 1/3rd of the population (not including the facility level testing)
		  ○ As clinical surveillance is changing, what is the role of WW surveillance?
		  ○ It is performing well as an indicator of increasing and decreasing cases
		  ○ Goal is to have community level WW surveillance
		  ○ Some jurisdictions are also doing WW surveillance at the facility level, such as universities, NHs, schools, correctional facilities
		  ○ One challenge is how do we deal with catchment areas being different than counties
		  ○ Most sites are testing twice weekly
		  ○ How does PH integrate these PH sources – WW surveillance and other data?
		  ○ All communities don't have WW surveillance coverage, how does PH account for that?
		• **Discussion:**
		• *Models/examples of use:*
		  ○ With academic partners, KY has used the WW data as a trigger for enhanced clinical genomic surveillance where they find a new or emerging variant.
		  ○ Targeted to zip code or a neighborhood. Overlay w/ the clinical data.
		  ○ If limited number of specimens received from area, ask LHDs and/or local facilities for more clinical samples for target genomic surveillance.
		• *What is the best practice or goal for turnaround time that is the goal?*
		  ○ CDC's perspective for TAT – Goal is six days from start of sample collection to data availability at CDC. Currently at an average of about 7 days, but has a very long tail. CDC is working to eliminate as many hurdles to data submission process and other hurdles as possible.
		  ○ Some STLTs have been aiming for within one week
		• *APHL produced a guidance document on WW surveillance.*
		  ○ Primarily for PHLs, published in March 2022, but there may be useful information for others as well.
		  ○ Link to APHL document: https://www.aphl.org/aboutAPHL/publications/Documents/EH-2022-SARSCoV2-Wastewater-Surveillance-Testing-Guide.pdf
		• *Limitations/challenges:*
		  ○ WW surveillance does not provide absolute numbers, rather a percentage of a variant. How best to correlate with the absolute numbers? Even small changes in the numbers skew %, and if the absolute number of the new variant is not sufficient, it will not show up in the %.
		  ▪ Some STLTs address through twice a week sampling. If the same increase in a variant is seen in the second sample of the week, it is an indicator. If there appears to be an emerging variant and it is not there on repeat the

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		next sampling, then overall amount is not enough or a person moved, and no PH action. ○ Estimating prevalence of variants from WW surveillance is uncertain currently. All of the approaches are not stable, they change over time within a site and between sites. CDC is not emphasizing this approach, because the CI is so broad, therefore not useful for policy approach. There is very little data on fecal shedding differences between variants and between vaccinated versus unvaccinated. Difficult to interpret. There is a risk that you can link mutations together in a way that is not true in people. Why it is looked for first in clinical specimens. ○ Use the term *detect* for known variants, not identify. Only look for something that we know is clinically relevant, we don't want to identify new variants in WW. ○ Human subjects/confidentiality can be an issue. One STLT was working with a university re: testing in a mobile van, for actionable timely data, however, cannot go to a septic tank or group of septic tanks as that would be too small a sample size and could be linked to people. Generally, try not to go smaller than a zip code. ○ Link from APHA, which relates to WW Surveillance: https://www.thenationshealth.org/content/52/2/1.2 ○ Data seems to show a correlation and/or at times a slight WW Surv data peak sooner, however, it really depends on WHEN you know this. These data were in retrospect. Is it sooner to PH than the case ELR data? Might be a tool in the toolbox. ○ Some STLTs are using WW data with hospital data, case data, etc. This helped with Sotrovimab and BA.2, esp in the metro area. WW Surveillance went to 50% omicron a few days before the CDC NOWCAST data. Then PH action as a result. ○ While WW surveillance is a useful tool, we should also start to spend more time and resources on establishing whether variants have impact on patients/populations? More resources are needed to link epi and case genomic data to understand therapy or vaccine escape and impact on severity, which WW cannot address. ○ Standardizing the testing methods across the nation? Without standardization our results may not be as reliable. ▪ CDC will be moving to a single method over the next few years as they expand to include targets other than covid. ○ This testing can be helpful to fill in blanks with the transition from PCR to at-home Ag testing. ○ May be more impactful once covid is less prevalent to look for a new signal.