ENDEMIC COVID: DHSS TRANSITION TTX

Scenario: DHSS announces will transition to influenza-like reporting for COVID-19 effective in 30 days from the announcement. This transition is envisioned and communicated as an initial step toward dealing with COVID-19 as an endemic infectious disease.

Reporting:

- What is different with regard to reporting? What is discontinued, added or changed?
- What is lost in this transition that may impact a future response? How can we plan to mitigate any negative impact?
- How does this change impact DHSS and LPHA workforce and schedule?
- How is this perceived by LPHA partners? How/at what level were LPHAs engaged in the decision to transition to this reporting?
- How is this perceived by the public?
- What communication strategies might enhance this reporting transition to be understood and accepted by the public and all stakeholders?

What is different with regard to reporting? What is discontinued, added or changed?

Amend reporting rule from being case-based to cases being reported on aggregate basis
Likely also end waivers requiring negative, named case-based data

Impact?
Cannot calculate positivity rate if don't have negative test
Essentially eliminates case investigation
If another variant emerges, would require substantial change to go back to case reporting.
Impact our ability to investigate breakthrough cases and re-infections; could still get MHA data on hospitalizations for breakthroughs
Regulations for novel influenza: still have this capability re: novel variant – reportable on individual basis; would need to modify regulatory language to include COVID
Some flexibility in rule for anything emerging fairly quickly – may give us option if rule not changed or change doesn't occur quickly/finalize
Labs could say no longer required to send sequencing surveillance – may not be likely due to partnering
Would probably need to increase # of specimens tests and positives reported as surrogate for COVID reporting – would need labs willing to partner with us (Dr. T – BJC agreed to push labs to send more samples) – part of solution is to have labs reporting from broad, representative geographic regions of state – Mercy does own virological reports so doing this but Mercy-Springfield not reporting to DHSS
Often challenge with geographic representation of laboratories – right now difficulty getting northwest and north central market participation – are there options for incentivizing? ARPA? Recognition?
Adam to Mindy – Dept of Ag/how track – ongoing system – may help us with future communications – 12/14 any information from follow-up? Dept of Ag does not have any specific tracking processes (other than one specific), work

What is lost in this transition that may impact a future response? How can we plan to mitigate any negative impact?

Try to increase sewershed surveillance – tell us if virus emerges again
Continue to build bridge of hospitalizations data – more timely, sensitive (biweekly or every other day?) and sophisticated than currently have now – tells us how bad virus is impacting – need more granularity-
1/4/22 – assure data agreement is mutually beneficial/symbiotic – data used consistent with agreement – best to have projection model built in case needed in future
ESSENCE? Or direct mandate to hospitals for daily reporting of COVID and ICU hospitalizations? Any mandate likely struck down by General Assembly so best strategy may be incentivizing
MHA not receiving COVID hospitalization information so may be rationale for mandate or incentivizing; work to create system more timely, more accurate
Efforts on federal side that hospitals to report into NHSN, effort to make more accessible to states (data modernization – ELC) – skeptical that NHSN is quick and accurate enough, likely required dedicated DHSS staff
John B. – inquired of MHA about current influenza reporting with regard to hospitalizations
Continue to build lab sentinel sites
Consider rule change to include COVID in individual reporting
Need to continue monitoring vax rates, perhaps not as robust as currently for COVID but more advanced than influenza vax rates
12/14 – John W. confirming that all hospitals using TeleTracking rather than NHSN – NHSN goal is HAIs, Dr. T skeptical of NHSN

How does this change impact DHSS and LPHA workforce and schedule?

Dedicated HHS Protect data and data mining – FTE in Transformation re: HAI, may meet some of this need
Verify MHA satisfied with HHS Protect (TeleTracking?) data – would decrease duplication of effort on our end too – still some concern with data consistently and timeliness of data entry
Movement away from contact tracing and case investigation would be significant burden decreased for regional DHSS epis and LPHAs – funding also freed for other uses that are dedicated to this staff
DHSS move to weekly COVID reports (or other frequency as determined) – probably choose different day than influenza reporting – Dr. T encourages daily in endemic phase for COVID
What's ideal landscape for epi reporting for all infectious diseases? Depends upon disease and public health impact
DHSS – Venkata's shop – reduction in workload if go to aggregate; 12/15 last day for MONG – likely not sustainable for Venkata's group with temps/contractors
CDC does not seem to be predisposed to dropping positivity rate – MO willing to be 'trend setter'
CDC moving toward at-home tests widely available – will impact reporting and positivity rates
Impact of at-home antigen positive result on mAb infusions? Discussion at CSTE – unclear how CDC intends to incorporate at-home tests into recommendations for isolation/quarantine – Public frustration!
Does DHSS incorporate natural immunity
Would still need a system/data solution to capture and manage aggregate reporting, as well as process for COVID reporting – suspect commercial availability of such system with modifications – Can do aggregate in WebSURV but that would be step back; can EpiTrax do aggregate reporting? What would it

How is this perceived by LPHA partners? How/at what level were LPHAs engaged in the decision to transition to this reporting?

Many LPHAs been asking from start when transitioning to aggregate positivity reporting; some concern from primarily metro LPHAs (6-7 county jurisdictions primarily have issues)
Current legal environment may impact
Including LPHAs in this decision – maybe use MoCPHE as conduit for this communication 1/4/22 update: Don discuss with Spring and Clay
Hearing LPHAs don't have capacity to do traveler notification already so some have already transitioned functionally
May free up ARPA and ELC-EDE funding from staff for contact tracing/case investigation to redirect for workforce enhancement and capacity building (still issue with CDC agreeing to workforce enhancement and capacity building) – will CDC question if meeting deliverables ELC-EDE grant deliverables – may be more White House's perspective than CDC's
Once have clarity of Omicron impact, we may just need to move to this reporting – once several states make this shift, CDC likely to acknowledge and shift to this as well

How is this perceived by the public?

Probably some criticism from media, but if virus stays quiet then DHSS is exposed and criticized even if not directly related to change in reporting
Likely should do some education and media work prior to transition, preparatory work – Don, any movement we make needs to include education to partners, media and public
Don – not fearful if first or last to this transition, just concerned that we are convinced it's the right decision for MO, CDC will not make this decision – maybe bring forward to Region VII states (SHOs) to discuss as interim step and then perhaps advance to ASTHO discussion
Dr. T – likely this will snowball really quickly once a few states move in this direction
Impact of LPHAs stepping away from some elements due to judicial ruling – swings things toward aggregate reporting
John B. – Not sure if can be distinguished from public's perceived threat/risk to COVID – if perceive as lessened risk, then will perceive this move as favorable and vice versa
Coincide with 2 year aniversary of pandemic – may be reasonable to expect change from public perspective

What communication strategies might enhance this reporting transition to be understood and accepted by the public and all stakeholders?

MoCPHE – sounding board for transition to this?
Carefully crafted message, need to include communications expert – include what has been accomplished?
Where have we been and where are we now?
Will require waiver or rule change, if rule change then needs to be very clear – that will help with communication to stakeholders and public
Use Health Advisories once communication is crafted? – maybe more of press release?
Will Governor wish to announce? Don to re-engage with GO on this issue
Be clear that this change is flexible, DHSS will make changes if things change, system will be sensitive to significant changes
Needs to be an entire outreach campaign – lots of communication with partners before go public, timeline, etc.
Hopefully, can announce as joint decision – DHSS, LPHAs
Identify key strategic partners to bring into decision-making
Don to provide overview to MHA – not the week of 1/4/22
Identify all key partners

What other questions or considerations come to mind?

Based upon this discussion, is this a recommendation to the Department?

Next steps?

1) **DHSS analyst provide analysis of TeleTracking data (COVID hospitalization, ICU admissions), what is available, what is still needed, how timely, how complete, how to take to daily basis – Designee by Venkata – 12/21 no designee yet – 1/18/22 no update**
2) **Does DHSS sign renewed agreement with Wash U. for hospitalization data/model? – Don to discuss with Jon D. of MHA, agree on general purposes – Don outreach 12/21 – 1/18 meeting with MHA, Dr. T and Paula this week**
3) **DHSS BCDCP research EpiTrax for aggregate reporting or modifications needs – John B./Nathan – 12/21 not something that's been discussed with EpiTrax consortium, DHSS taking it forward for discussion, likely an addition to the current platform, if interested would probably need to take on as a state – probably not overly complicated and no cost estimates – 1/18/22 Don wants to move forward with cost estimates; John will pull together appropriate group to develop parameters (Don says Illinois ready to drop negative reporting) Parameters: drop negative reporting, least # of hands touching it, transition flu to that as well – John bring back to this group 1/25/22**
4) **Seek or set Region VII discussion of moving to aggregate reporting – Don has said forum already exists (call week after Christmas) – 1/18/22 broad discussion with Spring/MOCPHE, willing to partner and receptive**
5) **Develop communication strategy and timeline – OPI – devote 12/28 meeting to beginning/draft – Adam to confirm available**
6) **Wording for rule change for aggregate COVID reporting – OGC (Adam/Don alert OGC), BCDCP – 1/18/22 Kick to OGC/Michael Oldweiler and John B. assist with general framework; options: novel influenza A still individually reported even though flu is aggregate reporting; catch-all of 'unusual or novel' requiring infections to be reportable that are not explicit in rule**

Communication Strategy with Public Health Partners:

- How to introduce and frame the discussion? Top down approach, new DHSS philosophy on communication with LPHAs, structured topic-focused discussions
- Identify trusted LPHAs for initial discussion – initial feedback, general comments
- Communicate through bi-monthly calls the final decision with broad message – goal February 2022
- Provide good background, where we are and proposed changes with rationale for change
- May experience concerns from Springfield/Greene and City of St. Louis – most others, particularly rural LPHAs, have been pushing for aggregate reporting
- Adam – 1/25/22 - draft message for use with public health partners (potentially public too) – maybe a chart or infographic
- John B. – 1/25/22 – bring forward what COVID surveillance looks like under flu model
- Timing of announcement – want to see some downturn with Omicron – tentatively March make the transition –
- Do we hold to aggregate even with future waves? Yes, similar to influenza reporting even during pandemic
- Will this – aggregate reporting - be our model for any future pandemics, regardless of type of pathogen? Dr. T – in initial stages, case-level reporting will likely be introduced – somewhat dependent upon pathogen, Ebola was individual cases but did not need positivity rate because so few cases – but this gives us a model of moving forward to aggregate reporting with a new pathogen
- Likely maintain EpiTrax long after used routinely as operational contingency

Communication Strategy with Public:

- Mirror what do with public health partners in comprehensive language – explain endemic, what we know, what we've learned, impact to individuals, dashboard itself is important for public communication and it will look drastically different
- Education to media on how we are transitioning, how to interpret and explain to public – all about timing of the announcement
- Nathan – took about month to build initial dashboard, paring down make take less time – need to loop Sarah Finley in – can start on this after John B./Nathan and team have parameters of model – target start week of 1/25/22 and after

Task Assignments for 1/25/2022 Meeting:

Adam – 1/25/22 - draft message for use with public health partners (potentially public too) – maybe a chart or infographic (2 pages) -

- Understanding complexities of COVID, responsibility as State Public Health Authority
- Process of looking at most effective tools: contact tracing (may delete now/CSTE guidance), use of testing
- Continued importance of vaccination, not everyone will engage and thus continued use of public health measures (e.g., hand washing, masks, social distancing)
- Recognizing public health has much larger responsibility – move into 'new normal', recognize importance of all reportable conditions
- Going forward, DHSS continuing to build on data, work with local partners to identify key issues
- COVID not going away, may be shifts in variants and rise/return of public health interventions – seeking to maintain agile public health system

John B. – 1/25/22 – bring forward what COVID surveillance looks like under flu model

DHSS BCDCP research EpiTrax for aggregate reporting or modifications needs – John will pull together appropriate group to develop parameters. Parameters: drop negative reporting, least # of hands touching it, transition flu to that as well – John bring back to this group 1/25/22

Week of 1/3/2022:

Continue discussion of Option 1 and Option 2 from John B's presentation

Begin development of timeline