Department of Health and Human Services |  Centers for Disease Control and Prevention | Office of the Director

[**Coronavirus Disease 2019 (COVID-19)**](https://www.cdc.gov/coronavirus/2019-nCoV/index.html)

**Show me the data! What numbers mean to COVID-19 messaging**

1

00:00:01,296 --> 00:00:02,496

>> Hello, everyone.

2

00:00:02,976 --> 00:00:04,226

My name is Haley McCalla.

3

00:00:04,556 --> 00:00:09,616

To locate me on the screen, I'm a

Black woman wearing a light blue shirt.

4

00:00:09,616 --> 00:00:14,646

I would like to welcome you to today's CDC

Emergency Partners Information Connection

5

00:00:14,776 --> 00:00:15,926

or EPIC webinar.

6

00:00:15,926 --> 00:00:19,236

If this is your first webinar with us, welcome.

7

00:00:19,236 --> 00:00:24,416

We invite you to learn more about CDC's

emergency response communication activities,

8

00:00:24,566 --> 00:00:29,356

including past webinars and

newsletters, by visiting our EPIC webpage.

9

00:00:30,256 --> 00:00:35,626

Today's webinar will be recorded and

posted to our website in the coming days.

10

00:00:35,626 --> 00:00:40,396

If you do not wish for your participation

to be recorded, please exit at this time.

11

00:00:41,546 --> 00:00:44,206

Closed captions are available for this webinar.

12

00:00:44,536 --> 00:00:48,126

To view the closed captions,

please click the More option,

13

00:00:48,266 --> 00:00:50,866

the three dots, and select Show Subtitle.

14

00:00:51,566 --> 00:00:56,346

Be aware that this option may be

different depending on your device.

15

00:00:56,346 --> 00:01:01,466

We are also offering ASL interpretation

and live interpretation into Spanish.

16

00:01:01,856 --> 00:01:05,846

To get the Spanish interpretation,

select the language panel from the bottom

17

00:01:05,846 --> 00:01:09,356

of the Zoom screen, and the

audio will switch to Spanish.

18

00:01:12,676 --> 00:01:19,636

Today's webinar is all about how CDC uses

many different data sources to communicate

19

00:01:19,636 --> 00:01:25,836

about COVID-19 public health recommendations,

including the recent COVID-19 community levels.

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00:01:25,836 --> 00:01:29,696

We know that there are a lot of questions

about not only the communications

21

00:01:29,786 --> 00:01:32,516

but also the recommendations and guidance.

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00:01:32,516 --> 00:01:36,646

We have some experts here today

to discuss all of these topics.

23

00:01:36,826 --> 00:01:39,996

Please note that we'll put links

in the chat for your reference.

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00:01:39,996 --> 00:01:44,136

If you have a question, please

use the Q&A button.

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00:01:44,136 --> 00:01:47,436

I'd like to apologize in advance

that we may not get to all questions,

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00:01:47,436 --> 00:01:50,186

but we will do our best to

answer as many as possible.

27

00:01:52,146 --> 00:01:53,356

Next slide, please.

28

00:02:10,196 --> 00:02:15,996

And next slide.

29

00:02:16,106 --> 00:02:18,296

We'll hear from four speakers today.

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00:02:18,416 --> 00:02:22,406

First, Dr. John Brooks will

discuss following the science

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00:02:22,406 --> 00:02:24,526

and making public health recommendations.

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00:02:25,086 --> 00:02:31,196

Dr. Brooks is an internist and clinical

infectious diseases expert who normally serves

33

00:02:31,196 --> 00:02:36,116

as the Chief Medical Officer, the

CDC's Division of HIV AIDS Prevention,

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00:02:36,306 --> 00:02:39,386

where he coordinates the

division's activities related

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00:02:39,386 --> 00:02:42,516

to the national Ending the

HIV Epidemic Initiative.

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00:02:42,986 --> 00:02:48,256

He currently serves as a Senior Science

Advisor for CDC's COVID-19 response.

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00:02:48,256 --> 00:02:54,486

Second, Dr. Brian King will address how

CDC monitors data and where we are now,

38

00:02:54,486 --> 00:02:57,176

including the COVID-19 community levels.

39

00:02:57,566 --> 00:03:03,926

Dr. King is the executive editor of CDC's

Morbidity and Mortality Weekly Report,

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00:03:04,446 --> 00:03:07,716

also known as the MMWR, and is currently serving

41

00:03:07,716 --> 00:03:12,236

as Chief Science Officer of

the CDC COVID-19 response.

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00:03:12,236 --> 00:03:15,796

He has worked for nearly two decades

to provide the scientific evidence

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00:03:15,796 --> 00:03:18,806

that informs public health policy and practice

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00:03:18,806 --> 00:03:22,716

and to effectively communicate this

information to a variety of audiences.

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00:03:22,716 --> 00:03:29,466

Third, Captain Matt Ritchey will discuss

the numbers, the quantitative data,

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00:03:29,466 --> 00:03:31,906

what people usually refer to when they say data.

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00:03:32,976 --> 00:03:38,626

Captain Ritchey is the Chief of the Partnerships

and Evaluation Branch in CDC's Center

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00:03:38,626 --> 00:03:44,616

For Epidemiology, Surveillance and Laboratory

Services, where he oversees the CDC Data Hub,

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00:03:45,036 --> 00:03:51,236

the Electronic Case Recording Program, and

the CDC WONDER online data sharing platform.

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00:03:52,046 --> 00:03:57,576

He has served the COVID-19 response in numerous

positions and is currently the lead of the Data,

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00:03:57,576 --> 00:04:00,566

Analytics, and Visualization Task Force.

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00:04:00,566 --> 00:04:06,586

And, fourth, Miss Anisha Verma will talk about

going beyond the numbers with qualitative data

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00:04:06,586 --> 00:04:08,956

and one of the most important ways CDC tunes

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00:04:08,956 --> 00:04:12,176

in to people's opinions,

The Vaccine Insights Report.

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00:04:12,886 --> 00:04:18,266

Miss Verma has worked on the COVID-19 response

since February 2020 in many different roles.

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00:04:18,596 --> 00:04:24,096

She's currently a Senior Analyst on the

Insights team with the National Center

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00:04:24,096 --> 00:04:26,596

for Immunization and Respiratory Diseases.

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00:04:28,176 --> 00:04:28,986

Next slide.

59

00:04:33,776 --> 00:04:38,406

We have a lot of important information

to get through, so let's get started.

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00:04:38,406 --> 00:04:41,196

Again, to ask a question,

please use the Q&A button.

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00:04:41,196 --> 00:04:44,646

And we'll get to the questions

after the brief presentations.

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00:04:45,066 --> 00:04:46,536

Dr. Brooks, over to you.

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00:04:46,536 --> 00:04:48,956

>> Thank you so much, Haley.

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00:04:48,956 --> 00:04:49,976

I'm John Brooks.

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00:04:50,056 --> 00:04:55,266

As Haley introduced, I'm the Senior Science

Advisor, and I'm a White man who wears glasses.

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00:04:55,266 --> 00:04:58,466

And I'm in a brown check shirt today

on your screen if you see my image.

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00:04:58,466 --> 00:05:02,796

I really want to welcome you all to

this important webinar because we want

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00:05:02,796 --> 00:05:07,686

to make sure folks understand that CDC

is entirely a science-based organization.

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00:05:07,746 --> 00:05:12,336

You know, what we do, our bread and

butter, is based in the scientific method.

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00:05:12,336 --> 00:05:14,776

And, just briefly, what is

the scientific method?

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00:05:14,776 --> 00:05:19,326

People often ask, you know, what is it do

you mean when you say you follow the science

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00:05:19,326 --> 00:05:21,106

and you're using the scientific method?

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00:05:21,536 --> 00:05:27,706

Well, the scientific method differs from the

way that some people see the world insofar

74

00:05:27,706 --> 00:05:33,716

as we test an observation and

a question as a hypothesis.

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00:05:33,716 --> 00:05:37,726

So I might see a phenomenon,

have a question about it.

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00:05:37,726 --> 00:05:43,126

I develop a hypothesis about what's going

on, and then I do some kind of an experiment

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00:05:43,126 --> 00:05:46,556

or an analysis to test if

that hypothesis might be true.

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00:05:46,556 --> 00:05:49,136

And I, therefore, from that, draw a conclusion.

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00:05:49,306 --> 00:05:53,256

And that conclusion or result is

what we use to make recommendations.

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00:05:54,146 --> 00:05:58,756

So to give you a concrete

example, in the context of COVID,

81

00:05:59,036 --> 00:06:02,906

you might make the observation that,

gee, masks have been protective

82

00:06:02,906 --> 00:06:04,796

to people in the healthcare setting.

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00:06:04,796 --> 00:06:07,666

I wonder if they might help protect

people in the community setting.

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00:06:07,866 --> 00:06:11,846

And so you've observed in the

hospital setting masks are protective.

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00:06:11,846 --> 00:06:15,836

You question whether they might work in

the community, and we raise the hypothesis,

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00:06:16,406 --> 00:06:18,826

does a mask protect a person in the community?

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00:06:19,116 --> 00:06:21,946

Then you have to go about

designing an experiment or a method

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00:06:21,946 --> 00:06:26,816

to assess what was the potential benefit

or harm to somebody of wearing a mask,

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00:06:26,816 --> 00:06:29,326

and how can I say that with some

level of assurity [phonetic].

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00:06:29,326 --> 00:06:32,246

And that's what my colleagues may

talk about in greater detail later.

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00:06:32,296 --> 00:06:38,086

I conduct the analysis, I come to a finding, and

then I turn that finding into a recommendation

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00:06:38,086 --> 00:06:42,236

in the case of masks that, in general,

we find evidence that they are protective

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00:06:42,236 --> 00:06:46,916

against getting COVID-19 in the community;

and we recommend that persons wear them.

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00:06:47,026 --> 00:06:54,016

So the scientific method differs

from just random statements insofar

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00:06:54,016 --> 00:07:00,496

as we vigorously test ideas and generate

findings using established methods

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00:07:00,496 --> 00:07:02,936

that match what goes on in the real world.

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00:07:03,836 --> 00:07:09,496

One of the most difficult things we face as

an organization is taking this information

98

00:07:09,496 --> 00:07:13,416

and communicating it to the

public and doing so in real time.

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00:07:13,506 --> 00:07:16,676

First, it takes time to generate the data.

100

00:07:16,676 --> 00:07:20,286

And sometimes it can appear that we're

a little bit behind in what's going

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00:07:20,286 --> 00:07:23,766

on because it's not instantaneous

always to get the information.

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00:07:24,326 --> 00:07:26,626

Secondly, things change.

103

00:07:27,006 --> 00:07:32,216

So we might make a recommendation at one

time and then, as the pandemic evolves,

104

00:07:32,746 --> 00:07:36,376

this is something we've never encountered

before; we learn new information,

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00:07:36,596 --> 00:07:41,626

and some of that information sometimes change

a recommendation we've made in the past

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00:07:41,626 --> 00:07:44,666

that requires us to then come back and explain

107

00:07:44,666 --> 00:07:49,116

to people why we're changing a

recommendation based on a reanalysis

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00:07:49,116 --> 00:07:51,976

of a new question that led

us to a new conclusion.

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00:07:53,506 --> 00:07:57,896

Also, in talking about science-based

findings, there are a couple

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00:07:57,896 --> 00:08:00,486

of really important principles

I want to make sure you're aware

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00:08:00,486 --> 00:08:04,326

of because perhaps you are going

to be in the position one day

112

00:08:04,326 --> 00:08:09,676

of doing exactly what we do here at CDC,

which is trying to communicate to people,

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00:08:09,996 --> 00:08:13,996

sometimes things that are very difficult

or complex or keep changing over time.

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00:08:14,066 --> 00:08:20,776

Some of the best advice that I can give is that

you state it very simply and be very specific

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00:08:20,776 --> 00:08:25,416

and direct about what you did, how you --

that is, how you figured out what's going on

116

00:08:25,676 --> 00:08:27,426

and what you found, what it meant.

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00:08:27,426 --> 00:08:32,376

And perhaps, most importantly,

people remember things

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00:08:32,376 --> 00:08:34,466

when they can integrate it into their life.

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00:08:34,726 --> 00:08:41,786

So always ask yourself, What can I tell people

about what they can do based on what I found?

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00:08:41,786 --> 00:08:46,656

What is the advice I want them to follow

because, in the end, that's public health.

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00:08:46,756 --> 00:08:50,886

We come up with a recommendation that we

hope is going to change people's behavior

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00:08:50,886 --> 00:08:54,466

for the betterment of themselves and

for the betterment of everyone else.

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00:08:54,896 --> 00:08:58,656

It's also important to be very

directive, not be wishy washy, but,

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00:08:58,656 --> 00:09:02,186

at the same time, be honest about limitations.

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00:09:02,366 --> 00:09:08,976

So you want to state clearly and directly what

your advice is, but you don't want to couch it

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00:09:08,976 --> 00:09:13,446

in so many qualifications that you end up

throwing out the baby with the bathwater.

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00:09:13,446 --> 00:09:15,906

Some of us are very precise people.

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00:09:16,196 --> 00:09:21,546

And we feel very strongly that we have a firm

conclusion, but we may feel over-obligated

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00:09:21,546 --> 00:09:24,206

to get into the details about

all of the limitations.

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00:09:24,206 --> 00:09:29,326

And, remember, people will ask you about those

limitations or challenge you if they have them.

131

00:09:29,396 --> 00:09:35,606

So as a good example with regard to masking,

we might say something like a large body

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00:09:35,606 --> 00:09:41,446

of evidence now supports the benefit of masking

and with little evidence of any risk to health.

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00:09:42,796 --> 00:09:47,456

How is it that we can make

statements like that recommendation

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00:09:47,456 --> 00:09:51,106

in another -- let me put it another way.

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00:09:51,106 --> 00:09:58,426

How do we come from just one experiment, many

experiments to know that this is something

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00:09:58,426 --> 00:09:59,816

that we want to make as a recommendation?

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00:10:00,066 --> 00:10:05,086

What I'm trying to get at is

establishing the possibility of causation.

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00:10:05,686 --> 00:10:06,166

All right.

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00:10:06,266 --> 00:10:13,446

For instance, cigarette smoking, I think people

early on as far back as the 1930s and '40s

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00:10:13,446 --> 00:10:18,126

of the last century recognize that

cigarette smoking was a harm to health.

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00:10:18,126 --> 00:10:24,656

And some of the early studies suggested

that people who smoked also got lung cancer.

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00:10:25,206 --> 00:10:27,776

But one study wasn't enough.

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00:10:27,776 --> 00:10:30,166

And people, there's a big --

there's a big cigarette industry.

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00:10:30,166 --> 00:10:34,196

They were very committed to selling

their product, and they really wanted --

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00:10:34,196 --> 00:10:35,986

Americans enjoyed smoking immensely.

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00:10:36,176 --> 00:10:39,616

So they really wanted to be confident

that this was a real finding.

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00:10:40,016 --> 00:10:44,206

Well, what builds my confidence

so I can make a broad statement

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00:10:44,206 --> 00:10:45,736

like the one I just made about masking?

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00:10:45,736 --> 00:10:49,216

A couple of things: first, multiple studies.

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00:10:49,816 --> 00:10:54,776

So the more evidence that you have,

the more studies that you can do,

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00:10:55,366 --> 00:10:58,496

the better because that gives you more evidence.

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00:10:58,496 --> 00:11:01,536

If you study many different

kinds of populations,

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00:11:01,726 --> 00:11:05,916

that means you can broaden the

finding to more and more people.

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00:11:06,116 --> 00:11:09,996

Maybe I just studied, you know,

educated White men in one group.

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00:11:09,996 --> 00:11:15,376

I studied low educated and Hispanic

persons, another population.

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00:11:15,476 --> 00:11:19,686

I come to the same conclusion; I can be

confident that finding is generalizable

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00:11:19,686 --> 00:11:22,286

to people of different backgrounds.

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00:11:22,766 --> 00:11:24,976

Also you use different methods and approaches.

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00:11:25,196 --> 00:11:32,886

So this is more of a technical issue, but the

kinds of scientific studies that we do vary.

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00:11:32,886 --> 00:11:36,646

They're cohort studies, case control

studies, randomized control studies.

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00:11:36,646 --> 00:11:39,196

You may have heard these in the

news or know them well yourself.

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00:11:39,196 --> 00:11:44,666

But the more that you can use different types

of studies to look at the same question, again,

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00:11:44,666 --> 00:11:47,936

this really strengthens whatever

conclusion you come to.

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00:11:47,936 --> 00:11:52,426

And then, finally, that you addressed the

question in different times and places.

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00:11:52,856 --> 00:11:55,966

So I might look at it during the

summer in one part of the country,

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00:11:55,966 --> 00:11:58,716

in the winter in a different

part of the country.

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00:11:58,716 --> 00:12:03,426

And in the case of cigarette smoking, it

became evident over a number of years that,

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00:12:03,426 --> 00:12:08,166

no matter how you looked at the question,

you kept coming to the same conclusion.

169

00:12:09,046 --> 00:12:13,536

Similarly, masking had this

-- had a same finding.

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00:12:13,536 --> 00:12:17,686

That no matter how we tried to look

at the question and analyze it,

171

00:12:17,686 --> 00:12:22,646

we kept coming to the same conclusion, that

places that had put masking into place or people

172

00:12:22,646 --> 00:12:25,206

that used masks had a lower risk of disease.

173

00:12:25,306 --> 00:12:27,606

This is sort of the phenomenon of what I saw --

174

00:12:27,606 --> 00:12:31,036

what I call all of the road signs

pointing in the same direction.

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00:12:31,036 --> 00:12:38,526

It's very hard to prove with causation,

right, that smoking causes cancer.

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00:12:38,526 --> 00:12:44,216

That didn't come until the 1960s and

'70s when we had laboratory research,

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00:12:44,266 --> 00:12:47,026

and we really understood the

mechanism by which it happened.

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00:12:47,566 --> 00:12:54,256

But the epidemiologic data that we had, what

I've just described, was immensely overwhelming

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00:12:54,256 --> 00:12:57,516

that it caused cancer and actually

led to public health recommendations,

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00:12:57,926 --> 00:13:02,606

just as some of this fundamental understanding

around what was actually going on became known.

181

00:13:02,786 --> 00:13:08,446

Similarly, with masking, we had this

important information available through lots

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00:13:08,446 --> 00:13:10,406

of different ways and felt confident

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00:13:10,406 --> 00:13:12,656

that all the road signs are

pointing in the same direction.

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00:13:12,656 --> 00:13:16,496

Lastly, I just want to point out

that context is important here.

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00:13:16,496 --> 00:13:19,976

Sometimes there'll be a new

way of looking something,

186

00:13:19,976 --> 00:13:21,686

and we may talk about this in a moment.

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00:13:21,686 --> 00:13:24,416

I'm going to as an example

use wastewater surveillance.

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00:13:24,656 --> 00:13:27,366

There may be a new way of talking

about something that comes along.

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00:13:27,616 --> 00:13:32,226

And when the numbers appear on your

computer screen or the figures are there,

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00:13:32,446 --> 00:13:34,236

you know, that looks pretty definitive.

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00:13:34,616 --> 00:13:36,946

I mean, it's black and white on your screen.

192

00:13:36,946 --> 00:13:38,806

This is the value that we're seeing.

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00:13:39,296 --> 00:13:44,946

And for as, depending on where you are, it's

important that people understand the context

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00:13:44,946 --> 00:13:48,706

of what you're seeing, you know, to

better interpret what those data mean.

195

00:13:48,706 --> 00:13:53,326

It may be black and white on your screen,

but everything has a little bit of nuance.

196

00:13:53,466 --> 00:13:58,516

And then, lastly, I really want to

emphasize the concept of health equity.

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00:13:58,856 --> 00:14:05,646

You know, we in the Public Health Service and

who serve the public, serve the entire country.

198

00:14:05,986 --> 00:14:10,536

And if we don't take care to ensure

that the findings that we are generating

199

00:14:10,536 --> 00:14:13,676

and the recommendations that

we're making apply to everyone,

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00:14:13,676 --> 00:14:15,426

that we're really not serving anyone.

201

00:14:15,846 --> 00:14:21,896

And so be assured that all the work we do

makes -- takes great care to ensure that,

202

00:14:21,896 --> 00:14:27,566

when we make a recommendation, we can apply

it with fidelity to everyone in this country.

203

00:14:27,906 --> 00:14:32,096

I think I'll stop there and turn it back

to the moderator, and we can move forward.

204

00:14:32,096 --> 00:14:32,816

Thanks very much.

205

00:14:34,776 --> 00:14:36,626

>> Thank you so much, Dr. Brooks.

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00:14:36,626 --> 00:14:40,626

That's great information, including the

strategies to building an evidence base

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00:14:40,626 --> 00:14:45,766

and contextualizing it to support communication

efforts and also the emphasis on health equity.

208

00:14:46,196 --> 00:14:49,616

Next, we'll hear from Dr. Brian King.

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00:14:50,586 --> 00:14:52,216

Dr. King, please begin.

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00:14:53,556 --> 00:14:55,216

>> Great. Thanks, Haley.

211

00:14:55,216 --> 00:14:57,596

So it's my pleasure to speak with you all today.

212

00:14:57,596 --> 00:15:00,146

And for those looking to

find me, I'm a White male.

213

00:15:00,226 --> 00:15:05,056

I'm wearing a button down shirt

and a navy sweater over it.

214

00:15:05,056 --> 00:15:07,156

So, if you could, advance

to the next slide, please.

215

00:15:07,156 --> 00:15:10,396

So, as was noted, I'm Brian King.

216

00:15:10,396 --> 00:15:13,556

I'm the Chief Science Officer

of CDC's COVID-19 response.

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00:15:13,556 --> 00:15:19,316

And today I'd like to give you an overview of

how CDC monitors data with a specific focus

218

00:15:19,316 --> 00:15:23,936

on the data we use to inform our recently

released COVID-19 community levels,

219

00:15:23,936 --> 00:15:26,826

which were announced a few months back.

220

00:15:26,826 --> 00:15:31,636

So, before I start, I did want to

reinforce that CDC is a data-driven agency,

221

00:15:31,636 --> 00:15:33,466

as you've already heard from Dr. Brooks.

222

00:15:33,466 --> 00:15:38,106

And so following the science is really essential

for us to informing our decision-making,

223

00:15:38,106 --> 00:15:41,566

including the recommendations that we make,

whether that be to the general public,

224

00:15:41,636 --> 00:15:46,036

healthcare providers, state and local

health departments, as well as others.

225

00:15:46,036 --> 00:15:51,896

That said, since the pandemic began in 2020,

we've used a variety of different data sources

226

00:15:51,896 --> 00:15:57,046

to inform our decision-making, from things

like self-reported surveys of youth and adults

227

00:15:57,046 --> 00:16:02,156

to electronic health records from hospitals to

even monitoring wastewater from sewage samples

228

00:16:02,156 --> 00:16:05,256

from all over the country that

you've already heard a bit about.

229

00:16:05,396 --> 00:16:09,926

But it is important to note that not all data

are created equally, depending on the purpose.

230

00:16:09,926 --> 00:16:11,466

And they do come in many forms.

231

00:16:11,466 --> 00:16:14,286

And so, for example, some data

are going to be quantitative,

232

00:16:14,286 --> 00:16:17,746

which means that it's numbers

based and countable or measurable.

233

00:16:17,746 --> 00:16:23,476

And data can also be qualitative, as well, which

means that it's more descriptive or conceptual.

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00:16:23,476 --> 00:16:30,596

And that helps us understand why or how or what

happened beyond and behind certain behaviors.

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00:16:30,596 --> 00:16:34,186

So you're going to hear some more examples

later today from some of our speakers

236

00:16:34,186 --> 00:16:39,396

on these different types of data for

qualitative versus quantitative methods.

237

00:16:39,396 --> 00:16:44,226

But before I move on, I did want to showcase

some of the typical quantitative measures

238

00:16:44,226 --> 00:16:48,046

that CDC has monitored since early 2020.

239

00:16:48,046 --> 00:16:51,936

And looking at these data over time on

the screen which we call surveillance,

240

00:16:51,936 --> 00:16:55,966

monitoring the same thing over time,

it helps us to get a pulse on the state

241

00:16:55,966 --> 00:17:00,986

of the COVID-19 pandemic and also to inform the

adoption or refinement of the recommendations

242

00:17:00,986 --> 00:17:04,386

that we do make come to various

individuals, including the general public.

243

00:17:04,386 --> 00:17:08,366

And so these data from COVID Data Tracker,

which you'll hear more about later today,

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00:17:08,366 --> 00:17:12,336

I'm showing the most recent monthly

changes in COVID-19 cases, in deaths,

245

00:17:12,336 --> 00:17:15,666

and hospitalizations, as well as vaccinations.

246

00:17:15,666 --> 00:17:19,016

And so you can see here that these data

really help us inform that progress continues

247

00:17:19,016 --> 00:17:23,606

to be made in these measures since the recent

peak during the Omicron surge earlier this year.

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00:17:23,606 --> 00:17:26,526

But you can also see that a slight

uptick in some measures occurred

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00:17:26,526 --> 00:17:29,636

within the most recent month, really

reinforcing the importance of continuing

250

00:17:29,636 --> 00:17:32,236

to monitor on these types of indicators.

251

00:17:32,236 --> 00:17:35,446

That said, the data also show us

that we're not out of the woods yet.

252

00:17:35,586 --> 00:17:40,076

And there remains opportunities in

improvement across all measures.

253

00:17:40,176 --> 00:17:41,506

So next slide, please.

254

00:17:42,886 --> 00:17:48,966

But scientific advances have helped us

move the COVID-19 pandemic to a new phase.

255

00:17:49,106 --> 00:17:52,936

And we do now have more tools than

ever before to prevent COVID-19.

256

00:17:52,936 --> 00:17:56,706

And three of those factors that have

really helped us move that needle to get

257

00:17:56,706 --> 00:17:59,606

to this point are noted on this slide.

258

00:17:59,606 --> 00:18:03,166

First, we now have widespread

availability of vaccines.

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00:18:03,306 --> 00:18:06,336

There's three COVID-19 vaccines

that are authorized or approved

260

00:18:06,336 --> 00:18:08,606

for use in the US to prevent COVID-19.

261

00:18:08,606 --> 00:18:12,256

Pfizer and Moderna are mRNA

vaccines, and their preferred.

262

00:18:12,346 --> 00:18:17,906

You can also get the Johnson & Johnson

Janssen COVID-19 vaccine in some situations.

263

00:18:17,906 --> 00:18:22,386

And these vaccines are available in the US,

and they're effective at protecting people

264

00:18:22,386 --> 00:18:26,256

from getting seriously ill but also

being hospitalized and even dying,

265

00:18:26,426 --> 00:18:28,716

especially those people who are boosted.

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00:18:28,716 --> 00:18:32,756

And as with other diseases, you're going to

be protected best from COVID-19 when you stay

267

00:18:32,756 --> 00:18:35,446

up to date with those recommended vaccines.

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00:18:35,446 --> 00:18:38,376

And, currently, CDC does recommend

that everyone ages five years

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00:18:38,376 --> 00:18:41,486

and older gets their primary

series of COVID-19 vaccine

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00:18:41,486 --> 00:18:44,316

and that everyone 12 years

and older receives a booster.

271

00:18:44,626 --> 00:18:47,046

And some people can receive two boosters.

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00:18:47,046 --> 00:18:51,346

In addition to vaccines, as you see on this

slide, we also have enhanced testing capacity,

273

00:18:51,346 --> 00:18:54,676

and that includes widespread

availability of at home tests.

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00:18:54,676 --> 00:18:58,636

Now the second factor on this slide is

widespread immunity from SARS-CoV-2,

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00:18:58,636 --> 00:19:02,596

the virus that causes COVID-19, which

is due to both increase vaccination

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00:19:02,596 --> 00:19:06,926

that we've already talked about and also

infection with the virus that causes COVID-19.

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00:19:06,926 --> 00:19:10,946

But, importantly, vaccination remains

the safest strategy to protect

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00:19:10,946 --> 00:19:14,226

against SARS-CoV-2 infections,

as well as hospitalizations,

279

00:19:14,226 --> 00:19:16,096

long-term health effects, and deaths.

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00:19:16,246 --> 00:19:19,716

Even among people who have previously

been infected, COVID-19 vaccination offers

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00:19:19,716 --> 00:19:24,456

that additional protection, with a booster

dose offering the highest level of protection.

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00:19:24,456 --> 00:19:27,426

Now, the third factor is that

we've seen significant advances

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00:19:27,426 --> 00:19:29,596

in proven evidence-based treatments.

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00:19:29,746 --> 00:19:34,246

So proven treatments can be used for a variety

of different reasons, depending on the severity

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00:19:34,246 --> 00:19:36,486

of the illness, in order to slow the virus,

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00:19:36,486 --> 00:19:40,466

reduce an overactive immune response,

or even to treat complications.

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00:19:40,466 --> 00:19:43,706

But, importantly, treatments used

for COVID-19 should be prescribed

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00:19:43,706 --> 00:19:45,346

by your healthcare provider.

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00:19:45,416 --> 00:19:48,296

So next slide, please.

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00:19:49,996 --> 00:19:54,606

So with the current high levels of vaccination

and the high levels of population immunity

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00:19:54,606 --> 00:19:58,586

from both vaccination and infections, the

risk of medically significant disease,

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00:19:58,586 --> 00:20:02,696

hospitalization, and death from COVID-19

has been greatly reduced for most people.

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00:20:02,696 --> 00:20:07,266

And at the same time, we know that some people

in communities such as our oldest citizens,

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00:20:07,266 --> 00:20:10,716

people who are immunocompromised, and people

with disabilities, they're going to be

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00:20:10,716 --> 00:20:12,376

at higher risk for serious illness.

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00:20:12,376 --> 00:20:16,326

And they're going to face challenging

decisions navigating a world with COVID-19.

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00:20:16,326 --> 00:20:18,876

And that's where the data

and the science comes in,

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00:20:18,876 --> 00:20:21,676

to help ensure that we can protect

them in the best way possible.

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00:20:21,676 --> 00:20:28,006

And so given that CDC recently updated the way

we monitor COVID-19's impact on our communities,

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00:20:28,006 --> 00:20:31,486

including focusing on three primary

factors, which are shown here,

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00:20:31,486 --> 00:20:34,996

and that's protecting the most

vulnerable, preventing severe illness,

302

00:20:34,996 --> 00:20:37,116

and minimizing burden on the healthcare system.

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00:20:37,116 --> 00:20:41,066

And, again, that's because we have evolved

into the next phase of the pandemic,

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00:20:41,066 --> 00:20:44,316

reinforcing the importance of

focusing on these key indicators

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00:20:44,316 --> 00:20:47,716

of severity to best protect public health.

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00:20:47,716 --> 00:20:51,916

And we know that, while we can't prevent all

cases of COVID-19, we can certainly continue

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00:20:51,916 --> 00:20:56,206

to limit the spread and protect those who are

going to be most at risk of severe illness

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00:20:56,206 --> 00:20:58,896

as we enter this phase of the pandemic.

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00:20:58,896 --> 00:21:02,906

Now, health officials and individuals should

consider these factors when making decisions

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00:21:02,906 --> 00:21:05,656

about community prevention

strategies and individual behaviors.

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00:21:05,656 --> 00:21:09,846

And that's important that we use the data

to inform the recommendations we make,

312

00:21:09,846 --> 00:21:13,106

both at the individual level

but also at the community level.

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00:21:13,106 --> 00:21:16,776

And so use of these COVID-19 community

levels ultimately helps communities

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00:21:16,776 --> 00:21:19,736

and individuals make those informed

decisions, and it's going to be based

315

00:21:19,736 --> 00:21:22,396

on their local context and their unique needs.

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00:21:22,396 --> 00:21:26,636

And so community vaccination coverage and

other local information like early alerts

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00:21:26,636 --> 00:21:30,736

from surveillance such as through wastewater

or the number of emergency department visits,

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00:21:30,736 --> 00:21:35,566

when available, can also inform decision-making

as well for health officials and individuals.

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00:21:35,566 --> 00:21:38,686

But these are the primary three

indicators that CDC is using

320

00:21:38,686 --> 00:21:43,326

to make those best informed decisions

around the prevention measures

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00:21:43,326 --> 00:21:45,676

that are being recommended

for a given community.

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00:21:45,676 --> 00:21:47,806

So next slide, please.

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00:21:49,716 --> 00:21:53,696

So given this new phase of the

pandemic, CDC launched a new tool

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00:21:53,696 --> 00:21:56,916

to monitor COVID-19 community

levels based on existing data.

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00:21:57,006 --> 00:22:00,736

And so, for this tool, CDC looks at

a combination of three data points

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00:22:00,806 --> 00:22:03,086

to determine the COVID-19 community level.

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00:22:03,086 --> 00:22:08,176

That's new COVID-19 admissions per

100,000 persons in the past week,

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00:22:08,176 --> 00:22:12,326

also the percent of staffed hospital beds

that are occupied by COVID-19 patients,

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00:22:12,326 --> 00:22:17,226

and also the total new COVID-19 cases

per 100,000 people in the past week.

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00:22:17,226 --> 00:22:19,496

And so the new COVID-19 admissions

and the percent

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00:22:19,496 --> 00:22:22,446

of staff inpatient beds occupied

represent the current potential

332

00:22:22,446 --> 00:22:24,216

for strain on the health system.

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00:22:24,216 --> 00:22:28,146

And then those data on new cases act as an

early warning sign for potential increases

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00:22:28,146 --> 00:22:33,556

in health system strain in the event of another

COVID-19 surge that could happen due to,

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00:22:33,556 --> 00:22:36,126

you know, potentially another

variant that could emerge.

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00:22:36,126 --> 00:22:40,676

And so using these data on the

COVID-19 community level for each county

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00:22:40,676 --> 00:22:43,946

across the US is classified

as low, medium, or high.

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00:22:43,946 --> 00:22:47,506

As you can see on this slide are

designated using a color-coded scheme

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00:22:47,506 --> 00:22:51,496

as green, yellow, and orange respectively.

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00:22:51,496 --> 00:22:55,446

And so, of note, the COVID-19 community level

is going to be based on the higher of the two

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00:22:55,446 --> 00:22:58,456

when it comes to the new admissions

and the hospital bed metrics.

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00:22:58,456 --> 00:23:00,766

But this really is a straightforward,

streamlined system

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00:23:00,766 --> 00:23:05,426

that helps us document what are those key levers

that are going to inform, and what are the data

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00:23:05,426 --> 00:23:09,066

that are going to influence those

recommendations when you need to go

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00:23:09,066 --> 00:23:12,476

from a different levels,

whether it be the low, medium,

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00:23:12,476 --> 00:23:16,906

or high as the COVID-19 pandemic

continues to evolve.

347

00:23:17,026 --> 00:23:18,746

Next slide, please.

348

00:23:18,746 --> 00:23:25,096

And so as I noted earlier, the COVID-19

community levels can help communities

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00:23:25,096 --> 00:23:27,126

and individuals in particular make decisions

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00:23:27,126 --> 00:23:30,476

about their local context

and also their unique needs.

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00:23:30,476 --> 00:23:34,816

And so to help with this, CDC has created

an interactive map on our website.

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00:23:34,816 --> 00:23:40,556

And you can get to this by

going to www.cdc.gov/covid19,

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00:23:40,556 --> 00:23:42,576

no hyphen needed between COVID and 19.

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00:23:42,576 --> 00:23:46,346

If you scroll to the bottom of the page,

it will give you a little input screen.

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00:23:46,346 --> 00:23:47,886

And you can put in information.

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00:23:47,886 --> 00:23:50,146

You just need to submit your

state and your county,

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00:23:50,146 --> 00:23:53,596

and it will show the current

community levels for your county based

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00:23:53,596 --> 00:23:55,996

on those three data points that I noted earlier.

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00:23:55,996 --> 00:24:01,616

And this COVID-19 community level map is updated

regularly with the newest data available.

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00:24:01,616 --> 00:24:04,526

And so we encourage you to check it

routinely to make sure that you make

361

00:24:04,526 --> 00:24:09,186

that fully informed choice about the best

way to protect yourself from COVID-19,

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00:24:09,186 --> 00:24:14,116

depending on those various data

points that are informing the level

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00:24:14,116 --> 00:24:16,986

that has been designated

for that respective county.

364

00:24:16,986 --> 00:24:18,816

So, with that, I'd like to thank

you all for your time today;

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00:24:18,816 --> 00:24:21,236

and we'll now turn it over to our next speaker.

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00:24:21,236 --> 00:24:21,756

Thank you.

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00:24:26,206 --> 00:24:28,516

>> Thank you so much, Dr. King.

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00:24:28,516 --> 00:24:33,146

Thank you for sharing the data that

informs the COVID-19 community levels.

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00:24:33,456 --> 00:24:36,696

I see that questions have begin to come in,

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00:24:36,696 --> 00:24:39,886

and I want to thank the participants

for being so engaged.

371

00:24:40,146 --> 00:24:41,726

We'll address those questions soon.

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00:24:42,146 --> 00:24:48,196

So please continue to use the Q&A button to

enter any additional ones that you may have.

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00:24:48,296 --> 00:24:52,526

Next up is Captain Matt Ritchey, who

will be talking about the numbers.

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00:24:52,926 --> 00:24:54,426

Captain Ritchey, over to you.

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00:24:55,826 --> 00:24:56,266

>> Wonderful.

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00:24:56,266 --> 00:24:56,936

Thank you, Haley.

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00:24:57,156 --> 00:24:58,076

Good afternoon, all.

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00:24:58,076 --> 00:25:02,266

To locate me on your screen, I'm a White

male wearing a blue US Public Health Service

379

00:25:02,266 --> 00:25:03,406

Commissioned Corps uniform.

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00:25:03,826 --> 00:25:05,646

As mentioned, my name is Matt Ritchey,

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00:25:05,646 --> 00:25:10,436

and I oversee the CDC COVID Response's Data

Analytics and Visualization Task Force.

382

00:25:10,436 --> 00:25:12,056

It's great to be talking with you today.

383

00:25:13,196 --> 00:25:16,776

As you may be aware, there's a wide array

of partners, many of which are reflected

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00:25:16,776 --> 00:25:21,076

on this slide, who are required to ensure

that vital public health data are collected,

385

00:25:21,296 --> 00:25:24,456

analyzed, and shared to inform

public health action.

386

00:25:24,456 --> 00:25:25,766

Next slide, please.

387

00:25:30,546 --> 00:25:34,616

This has been particularly true during the

COVID-19 pandemic, especially as the data

388

00:25:34,616 --> 00:25:36,416

and communication needs have evolved.

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00:25:36,416 --> 00:25:40,786

This figure provides a snapshot of

these evolving needs with a focus early

390

00:25:40,786 --> 00:25:46,976

on around case, testing data, and then evolving

to incorporate other data including hospital

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00:25:46,976 --> 00:25:52,396

and health outcome data, vaccine and genomic

data, and the interplay between vaccine

392

00:25:52,396 --> 00:25:57,346

and outcome data to assess for breakthrough

infections in vaccine effectiveness.

393

00:25:57,346 --> 00:25:58,226

Next slide, please.

394

00:26:04,246 --> 00:26:08,606

These data and analytic needs have led

to an unparalleled generation and release

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00:26:08,836 --> 00:26:11,956

of public health data that

are highlighted on this slide,

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00:26:12,406 --> 00:26:17,226

including around 866 million test

results being reported to CDC

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00:26:17,526 --> 00:26:21,806

and around 574 million vaccination

administration records

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00:26:21,926 --> 00:26:24,456

as well as a host of other robust data.

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00:26:26,366 --> 00:26:27,276

Next slide, please.

400

00:26:27,276 --> 00:26:34,976

For CDC, one of the main ways these data have

been shared is via the CDC COVID Data Tracker.

401

00:26:35,566 --> 00:26:39,416

The tracker is a huge leap forward

in terms of how much data is shared,

402

00:26:39,706 --> 00:26:45,026

the granularity of that data, its

timeliness, and how many people can use it.

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00:26:45,026 --> 00:26:49,906

Launched in April of 2020, the tracker

combines county, state, national,

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00:26:49,906 --> 00:26:54,966

and global data from across the response

into a series of interactive dashboards.

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00:26:55,476 --> 00:27:00,456

As of this past week, more than 292

million page views have occurred.

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00:27:00,456 --> 00:27:02,676

Next slide, please.

407

00:27:06,126 --> 00:27:09,136

CDC COVID Data Tracker has

evolved as we tried to make

408

00:27:09,136 --> 00:27:11,786

as much data available as quickly as possible.

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00:27:12,446 --> 00:27:16,006

As you can see in this slide, there's a

variety of data available on the site.

410

00:27:16,676 --> 00:27:19,546

We use these data to support the

development of recommendations

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00:27:19,546 --> 00:27:21,696

that have been referenced earlier into view --

412

00:27:21,696 --> 00:27:26,416

and view the transparency and displaying

critical data as a reflection of our leadership

413

00:27:26,416 --> 00:27:29,186

in this pandemic and service

to the American people.

414

00:27:29,256 --> 00:27:31,356

Next slide, please.

415

00:27:35,486 --> 00:27:39,146

One of the key ways we make the information

on the COVID Data Tracker available

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00:27:39,146 --> 00:27:42,506

to the public is through the

COVID Data Tracker Weekly Review,

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00:27:42,936 --> 00:27:45,366

which was launched in February of 2021.

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00:27:46,116 --> 00:27:49,476

The weekly review highlights

key data from the tracker along

419

00:27:49,476 --> 00:27:53,966

with high priority supplemental information,

narrative interpretations of the data,

420

00:27:53,966 --> 00:27:57,726

and visualizations from the

week in a centralized location.

421

00:27:58,836 --> 00:28:04,116

As of April 2022, this past week, the

weekly review has reviewed more --

422

00:28:04,476 --> 00:28:11,016

received more than 10.3 million views

and has over 98,000 weekly subscribers.

423

00:28:12,466 --> 00:28:13,426

Next slide, please.

424

00:28:16,526 --> 00:28:20,336

Further, much of the data presented on

the COVID Data Tracker and other COVID

425

00:28:20,336 --> 00:28:27,196

and non-COVID data are hosted on what we refer

to as data.cdc.gov, which provides timely data

426

00:28:27,196 --> 00:28:30,536

in multiple formats needed by

stakeholders and are available

427

00:28:30,536 --> 00:28:33,786

to the public anywhere on

any device and at any time.

428

00:28:34,816 --> 00:28:40,946

CDC programs have been published around 1200

datasets, charts, maps, and stories to date,

429

00:28:41,266 --> 00:28:44,346

including 107 COVID-19 datasets on the site.

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00:28:44,346 --> 00:28:50,476

In 2021 alone, the site was

visited by around 2.6 million users.

431

00:28:51,916 --> 00:28:55,826

Further, the information on the right in the

link that's provided provides an overview

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00:28:55,826 --> 00:29:00,926

of the rich array of other data made available

by CDC to monitor the impact of both COVID

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00:29:00,926 --> 00:29:04,136

as well as other public health threats.

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00:29:04,136 --> 00:29:05,086

Next slide, please.

435

00:29:07,706 --> 00:29:10,926

Now I'd like to walk through some

examples of frequently asked questions

436

00:29:10,926 --> 00:29:14,186

about the COVID data being

released by CDC and our partners.

437

00:29:14,186 --> 00:29:19,426

First, one topic that has come up frequently

is our ability or sometimes inability

438

00:29:19,426 --> 00:29:23,056

to effectively describe risk

by demographic characteristics,

439

00:29:23,056 --> 00:29:25,146

most notably, by race and ethnicity.

440

00:29:25,786 --> 00:29:29,916

Let me say this: One of the main reasons why

people get into public health, including me,

441

00:29:30,456 --> 00:29:33,726

is the opportunity to serve,

especially marginalized communities.

442

00:29:34,486 --> 00:29:39,636

Therefore, having access to complete and

accurate race ethnicity data is a high priority

443

00:29:39,916 --> 00:29:44,346

to better identify population groups most

at risk so that we can best support them.

444

00:29:45,346 --> 00:29:49,066

That being said there are inherent

and long-standing forces at hand

445

00:29:49,286 --> 00:29:52,696

that often limit our ability to

collect and provide this information.

446

00:29:54,136 --> 00:29:56,476

First is data completeness.

447

00:29:56,476 --> 00:30:00,556

Willingness to report this type of

information often differs across populations,

448

00:30:00,556 --> 00:30:03,396

which often these kinds of data

can be considered sensitive.

449

00:30:03,396 --> 00:30:08,376

Further, sometimes data systems are not

set up to collect demographic data at all,

450

00:30:08,556 --> 00:30:10,766

or in standardized ways,

which limits our ability

451

00:30:10,766 --> 00:30:13,216

to leverage the data when it comes to CDC.

452

00:30:14,276 --> 00:30:19,416

Also, there can be what we refer to as small

number issues, including stability of estimates

453

00:30:19,416 --> 00:30:22,696

over time where the values, because

they're based on such small numbers,

454

00:30:22,786 --> 00:30:26,966

appear to jump around a lot, as

well as policies for what we do

455

00:30:26,966 --> 00:30:29,526

for data suppression to protect confidentiality.

456

00:30:30,326 --> 00:30:35,056

We want these data to be helpful, but we need to

guard against unintended negative repercussions

457

00:30:35,176 --> 00:30:39,336

of releasing them when the findings can

be misleading because it data instability

458

00:30:39,736 --> 00:30:41,686

or people potentially being identifiable.

459

00:30:42,766 --> 00:30:46,426

And then, finally, data use agreements with

our partners, including our state colleagues,

460

00:30:46,666 --> 00:30:51,566

also sometimes limit what data we are

provided or able to release to the public.

461

00:30:53,056 --> 00:30:54,016

Next slide, please.

462

00:30:55,556 --> 00:30:58,646

Next few questions are around the

data systems we have at our disposal

463

00:30:58,646 --> 00:31:02,096

and the strategies we use to maximize their use.

464

00:31:02,096 --> 00:31:05,016

Here, I'd like to use hospital

data collection as an example.

465

00:31:05,016 --> 00:31:10,476

First, there are what we refer to

as the HHS Unified Hospital Data,

466

00:31:10,986 --> 00:31:13,546

which have been collected

since the summer of 2020.

467

00:31:14,316 --> 00:31:20,336

These data are reported by around 6000 hospitals

about the number of new COVID-19 admissions

468

00:31:20,336 --> 00:31:27,056

and the percentage of beds in use by COVID

patients, as referred to by Dr. King.

469

00:31:27,876 --> 00:31:31,826

These data are seen as being comprehensive

as long as all eligible hospitals

470

00:31:31,826 --> 00:31:34,846

in the US are reporting regularly

into the system.

471

00:31:35,826 --> 00:31:38,576

That being said, there are

also limitations to these data.

472

00:31:39,156 --> 00:31:42,646

One such limitation is that the data

are reported in what we call aggregate

473

00:31:42,646 --> 00:31:48,366

or big numbers, 10, 20, 30 hospitalizations,

and we don't have patient-specific information.

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00:31:48,366 --> 00:31:53,246

This is a common limitation of

more single-source data as you need

475

00:31:53,246 --> 00:31:57,406

to limit what is data is being collected

because so many groups are being asked to report

476

00:31:57,406 --> 00:32:00,706

into the system, and we want to be

respective of the burden that we're putting

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00:32:00,706 --> 00:32:05,306

on healthcare providers as

well as our hospital system.

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00:32:05,306 --> 00:32:08,676

Now, sentinel surveillance refers

to leveraging a collection of sites

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00:32:08,886 --> 00:32:13,646

that are strategically chosen, for example,

across unique geographies across states

480

00:32:14,016 --> 00:32:16,326

to gain an understanding

of the burden of disease.

481

00:32:17,156 --> 00:32:22,046

COVID Net is an example of this type of

strategy, one of the systems that CDC oversees.

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00:32:22,666 --> 00:32:25,936

COVID Net is a population-based

surveillance system that collects data

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00:32:25,936 --> 00:32:31,746

on laboratory confirmed COVID-19 associated

hospitalizations among children and adults

484

00:32:31,746 --> 00:32:37,256

through a network of over 250

acute care hospitals in 14 states.

485

00:32:37,256 --> 00:32:41,956

Based on information abstracted from medical

charts in these participating hospitals,

486

00:32:42,226 --> 00:32:47,636

COVID-related hospitalization rates can be

calculated overall and by age group, by sex,

487

00:32:47,636 --> 00:32:51,636

race/ethnicity, and also by underlying health

conditions, which adds a lot of information

488

00:32:51,636 --> 00:32:53,796

to us to help inform our decision-making.

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00:32:53,796 --> 00:33:00,076

And then finally is what we refer to as

data triangulation or taking information

490

00:33:00,076 --> 00:33:05,506

from multiple sources and interpreting

the findings in the context of other data.

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00:33:06,376 --> 00:33:10,696

These types of analyses are often more

difficult to perform and present to the public

492

00:33:10,696 --> 00:33:13,316

in a timely way but are extremely important.

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00:33:14,166 --> 00:33:18,316

One example of this type of work is using

a combination of the unified hospital data

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00:33:18,316 --> 00:33:23,336

that I mentioned earlier in concert with

some of our large healthcare data assets

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00:33:23,506 --> 00:33:28,736

that not only describe trends in overall

hospitalization use, the severity amongst those

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00:33:28,736 --> 00:33:31,976

who are hospitalized, including

their use of ICU care,

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00:33:32,376 --> 00:33:35,996

mechanical ventilation, and in-hospital death.

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00:33:36,306 --> 00:33:38,416

This information [inaudible] is also shown

499

00:33:38,416 --> 00:33:41,816

on COVID Data Tracker under

a healthcare setting tab.

500

00:33:41,816 --> 00:33:44,146

Next slide, please.

501

00:33:46,216 --> 00:33:48,286

Third is our ability to have linked data.

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00:33:48,976 --> 00:33:53,196

As shown earlier, we have enhanced or

established some incredible data pipelines

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00:33:53,196 --> 00:33:54,946

to bring in key public health data.

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00:33:55,596 --> 00:33:58,906

However, many of these pipelines are

still what we refer to as siloed,

505

00:33:59,296 --> 00:34:02,656

meaning they're not interconnected

with other relevant data streams.

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00:34:03,416 --> 00:34:07,376

One example of this limited linkage is

with vaccine data and its connection

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00:34:07,376 --> 00:34:11,826

with health outcome data like

cases, deaths, hospitalizations.

508

00:34:11,826 --> 00:34:15,756

State immunization information

system to provide a data

509

00:34:15,756 --> 00:34:20,796

on around 574 million vaccine

administrations for COVID.

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00:34:21,046 --> 00:34:22,706

However, the ability to link these data

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00:34:22,706 --> 00:34:26,916

with important case hospitalization death

data can be limited at the state level.

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00:34:26,916 --> 00:34:30,916

And if they are able to be linked at the

state, they often -- the state often has --

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00:34:30,916 --> 00:34:34,166

often has limitations in sharing

this linked data with CDC.

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00:34:34,166 --> 00:34:39,096

So CDC is unable to do this linkage on

our end because the information provided

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00:34:39,096 --> 00:34:42,016

to us is de-identified for privacy reasons.

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00:34:42,016 --> 00:34:44,656

So it has to happen before it gets to us.

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00:34:44,656 --> 00:34:50,076

So one way this limitation has been addressed,

and there's several couple of different ways,

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00:34:50,366 --> 00:34:55,796

include CDC working with 25 to 30 health

departments who regularly link case surveillance

519

00:34:56,106 --> 00:35:00,536

to immunization information system

data to regularly calculate estimates

520

00:35:00,536 --> 00:35:03,256

of vaccine effectiveness and breakthrough.

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00:35:03,966 --> 00:35:07,506

These findings are also provided on

COVID Data Tracker and updated regularly.

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00:35:07,506 --> 00:35:09,406

Next slide, please.

523

00:35:11,666 --> 00:35:15,866

And then finally are questions around differing

estimates being provided across sources,

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00:35:15,866 --> 00:35:19,646

including by the CDC, compared

to our state and local partners.

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00:35:19,766 --> 00:35:25,156

So one of our main aims at CDC is to establish

standardized methods for analyzing the data

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00:35:25,616 --> 00:35:29,526

that we receive and applying those

consistently across jurisdictions,

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00:35:29,526 --> 00:35:33,356

across states so the results are

comparable as you look across the country.

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00:35:34,336 --> 00:35:38,596

While we share our methods for performing these

calculations, differences still arise, though,

529

00:35:38,806 --> 00:35:40,606

when compared to what states are reporting.

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00:35:41,406 --> 00:35:43,506

These differences can arise

for a host of reasons,

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00:35:43,506 --> 00:35:45,086

and I'm going to walk through a couple of them.

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00:35:45,086 --> 00:35:49,936

So one of them, sometimes there are reporting

or processing errors, either the data coming in

533

00:35:49,936 --> 00:35:52,506

or how the data are being

packaged when they come to DC.

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00:35:53,166 --> 00:35:56,416

While we have processes for

identifying and addressing these errors,

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00:35:56,776 --> 00:36:00,676

in an effort to report the data as close

to real time as possible to get this data

536

00:36:00,676 --> 00:36:04,906

into your all's hands, they can sometimes

make their way into publicly released data.

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00:36:05,756 --> 00:36:06,406

That's one way.

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00:36:07,056 --> 00:36:11,236

Next, sometimes how the information

is summarized can differ how we do it

539

00:36:11,236 --> 00:36:12,436

versus how a state does it.

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00:36:12,436 --> 00:36:18,016

For example, the number of days included in a

measure may looking at seven weeks or seven days

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00:36:18,016 --> 00:36:23,866

versus 14 days or also how groups are collapsing

the information into meaningful categories.

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00:36:23,986 --> 00:36:25,556

Are we looking at just by race?

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00:36:25,556 --> 00:36:27,576

Are we looking at it by race and ethnicity?

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00:36:27,956 --> 00:36:30,166

All of these things can differ

across jurisdictions.

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00:36:30,166 --> 00:36:34,066

So when you see it on a COVID Data

Tracker or you see it on a state website,

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00:36:34,106 --> 00:36:35,926

the information seems to be conflicting.

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00:36:36,936 --> 00:36:41,406

And then, finally, sometimes jurisdictions have

additional data or more granular information

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00:36:41,406 --> 00:36:44,896

that they can use, and we at

CDC don't have access to it.

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00:36:44,896 --> 00:36:47,026

So those are just a couple of examples.

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00:36:47,126 --> 00:36:48,736

Next slide, please.

551

00:36:52,816 --> 00:36:56,486

So what does this look like moving forward

for CDC and for public health at large?

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00:36:56,636 --> 00:37:00,536

So we've taken all of our lessons

learned and formulated them into a set

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00:37:00,536 --> 00:37:04,836

of clear strategic priorities to advance

our ability to provide more timely

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00:37:04,836 --> 00:37:09,366

and accurate data now for the COVID

Response and as well as into the future.

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00:37:10,026 --> 00:37:12,646

This effort termed the Data Modernization Effort

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00:37:12,646 --> 00:37:16,396

For Public Health has been ongoing

throughout the pandemic and will continue.

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00:37:16,396 --> 00:37:18,516

Next slide, please.

558

00:37:21,266 --> 00:37:25,466

Here are just some examples of the progress

that we've made just over the last year or two.

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00:37:25,466 --> 00:37:29,236

For example, we've seen a massive

expansion of what is referred

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00:37:29,236 --> 00:37:34,646

to as electronic case reporting, with more

than 11,000 healthcare facilities nationwide

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00:37:34,646 --> 00:37:39,496

who are positioned to rapidly deliver COVID

case data from electronic health records.

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00:37:40,446 --> 00:37:43,626

Also, we build a new cloud-based

immunization data lake

563

00:37:43,916 --> 00:37:49,096

to solve the problem how CDC could take in,

analyze, and visualize the incredible volume

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00:37:49,096 --> 00:37:53,426

and velocity of data on vaccine

ordering, delivery, and administration;

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00:37:54,736 --> 00:38:00,006

as well as dramatically accelerating electronic

lab reporting, from thousands of reports a week

566

00:38:00,006 --> 00:38:03,426

for all conditions before

COVID to an average of one

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00:38:03,426 --> 00:38:07,196

and a half million reports per

day for COVID PCR tests alone.

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00:38:08,776 --> 00:38:10,326

Thank you again for your time.

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00:38:10,326 --> 00:38:13,776

I hope the information I shared was able to

demonstrate some of the progress we've made

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00:38:13,776 --> 00:38:17,786

and where we want to go in the future as we

work to advance our ability to leverage data

571

00:38:17,786 --> 00:38:20,426

and communicate key findings

to serve the American people.

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00:38:20,426 --> 00:38:22,006

Thank you, Haley.

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00:38:23,196 --> 00:38:24,976

>> Thank you so much, Captain Ritchey.

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00:38:24,976 --> 00:38:27,036

This is a complex topic.

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00:38:27,036 --> 00:38:29,786

So thank you for sharing

the data considerations,

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00:38:29,786 --> 00:38:34,936

information about the COVID Data Tracker, and

other data resources that the public can access.

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00:38:35,576 --> 00:38:39,656

In addition, I'd like to remind participants

that there are a lot of good resources

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00:38:39,656 --> 00:38:42,866

in the chat regarding the evidence on masking

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00:38:42,866 --> 00:38:46,936

to reduce SARS-CoV-2 transmission,

so please review those.

580

00:38:49,116 --> 00:38:55,316

Transitioning on, CDC has several

ways we monitor how people all

581

00:38:55,366 --> 00:39:00,296

over the country are responding to

our guidance and communications.

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00:39:00,296 --> 00:39:05,276

Miss Anisha Verma is here to tell us more

about the kinds of qualitative data we monitor,

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00:39:05,396 --> 00:39:07,916

especially the Vaccine Insights Report,

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00:39:07,916 --> 00:39:12,156

which has helped us shift how CDC

has approached vaccination messages.

585

00:39:12,716 --> 00:39:15,366

Miss Verna -- Verma, excuse me, take it away.

586

00:39:16,626 --> 00:39:19,016

>> Thanks for the introduction, Haley.

587

00:39:19,016 --> 00:39:24,486

To locate me on the screen, I'm a South Asian

woman with black hair wearing a grey sweater.

588

00:39:24,486 --> 00:39:28,906

I'm Anisha Verma, and I'm currently a

Senior Analyst on CDC Insights Team.

589

00:39:28,906 --> 00:39:30,096

Next slide, please.

590

00:39:32,026 --> 00:39:35,716

CDC's monthly State of Vaccine Confidence

Insights Report looks at a variety

591

00:39:35,716 --> 00:39:40,316

of data sources to help us better understand the

public's perceptions, concerns, frustrations,

592

00:39:40,316 --> 00:39:43,986

and circulating misinformation

surrounding COVID-19 vaccines.

593

00:39:43,986 --> 00:39:47,296

As you can probably imagine, there's

a ton of information available.

594

00:39:47,296 --> 00:39:51,556

And it can be challenging to look at all the

amassed data and think, Where do I start, or,

595

00:39:51,556 --> 00:39:53,446

What are the right types of action to take?

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00:39:54,106 --> 00:39:58,686

This report is not meant to be an inventory of

issues impacting vaccine competence but, rather,

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00:39:58,686 --> 00:40:00,906

what the insights team believes

are the most prevalent

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00:40:00,906 --> 00:40:03,626

and pressing threats to vaccine confidence.

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00:40:03,626 --> 00:40:05,906

Next slide, please.

600

00:40:07,656 --> 00:40:12,156

The State of Vaccine Confidence Insights Report

assesses threats to vaccine confidence rapidly

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00:40:12,156 --> 00:40:16,806

and in near real time on a biweekly basis with

concurrent data collection from digital media,

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00:40:16,806 --> 00:40:18,876

polling data, and social listening platforms.

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00:40:18,876 --> 00:40:22,816

We of course pay attention to

reactions to our social media posts.

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00:40:22,816 --> 00:40:25,926

We notice what people are asking on

webinars and in regular communications

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00:40:25,926 --> 00:40:30,446

with our public health, governmental,

nongovernmental, and other community partners.

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00:40:30,446 --> 00:40:34,476

And we conduct survey and community

assessments and show others how to do the same.

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00:40:34,476 --> 00:40:38,596

Our wonderful Research and Evaluation team

also creates a regular thematic analysis

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00:40:38,596 --> 00:40:42,716

of what people are hearing and saying, asking

in news stories, social media conversations,

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00:40:42,716 --> 00:40:47,006

what they all call CDC to ask about,

and which web pages they're reviewing.

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00:40:47,006 --> 00:40:49,156

This helps us respond to emerging issues.

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00:40:49,566 --> 00:40:52,416

We then perform concurrent

analysis of these media sources.

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00:40:53,736 --> 00:40:56,726

In addition to detecting myths

and disinformation as it emerges,

613

00:40:56,826 --> 00:41:00,436

we analyze public perception and

opinions and identify information gaps

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00:41:00,436 --> 00:41:02,306

and voids and with other messaging issues.

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00:41:02,656 --> 00:41:08,216

To do this, we utilize a mixed deductive and

inductive approach, inductive in that we capture

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00:41:08,216 --> 00:41:12,456

and triangulate relevant themes around vaccines

that are rich -- that organically emerge;

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00:41:12,456 --> 00:41:17,996

deductive in that we make assessments about

the vaccines' themes relevance to and effect

618

00:41:18,106 --> 00:41:20,236

on vaccine confidence using the CDC's vaccinate

619

00:41:20,236 --> 00:41:23,036

with confidence strategy

and underlying framework.

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00:41:23,686 --> 00:41:27,766

This report also amplifies actionable next

steps focused on communications outreach

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00:41:27,766 --> 00:41:30,966

and engagement and research for

CDC, other federal agencies,

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00:41:30,966 --> 00:41:33,116

states and jurisdictions,

our partner organizations.

623

00:41:33,226 --> 00:41:34,586

Next slide, please.

624

00:41:37,766 --> 00:41:41,826

Additionally, all the reports are divided

into three sections: major themes, continuing

625

00:41:41,826 --> 00:41:43,596

and evolving themes, and emerging themes.

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00:41:43,696 --> 00:41:48,736

After collecting and analyzing each of these

input separately, our team comes to triangulate

627

00:41:48,736 --> 00:41:50,156

and synthesize what we are seeing.

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00:41:50,216 --> 00:41:54,066

This is especially important as it allows

us to wade through the noise and figure

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00:41:54,066 --> 00:41:58,796

out what major themes are rising to the

top of in the hectic digital landscape.

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00:41:58,796 --> 00:42:01,996

Our process has become more streamlined

with time, and we are now able

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00:42:01,996 --> 00:42:05,046

to better identify emerging issues

before they become major themes.

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00:42:05,046 --> 00:42:09,906

This work is part science and part art, as

there is no official quantitative process

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00:42:09,906 --> 00:42:14,306

to determine what necessitates a threshold

for a major theme or an emerging theme.

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00:42:14,306 --> 00:42:18,576

After we review all the potential themes,

the Insights team reviews all of the notes

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00:42:18,576 --> 00:42:22,206

and puts together an outline of

major emerging and continuing themes.

636

00:42:22,206 --> 00:42:23,916

Next slide, please.

637

00:42:23,916 --> 00:42:30,126

From there, our team determines the

threat level of each identified theme

638

00:42:30,126 --> 00:42:32,156

as it relates to vaccine confidence.

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00:42:32,156 --> 00:42:36,296

We developed a codebook in order to

make this a more formalized process.

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00:42:36,296 --> 00:42:39,626

We look at four levels: high

risk, moderate risk, low risk,

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00:42:39,626 --> 00:42:41,646

or whether the theme is a positive sentiment.

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00:42:41,646 --> 00:42:45,186

After this, our team considers

the directionality.

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00:42:45,186 --> 00:42:49,356

This is helpful for context to allow people to

see whether these conversations are on the rise

644

00:42:49,476 --> 00:42:53,186

or have remained stable over time or,

as other topics fall in prevalence,

645

00:42:53,186 --> 00:42:54,746

if a new theme is now standing out.

646

00:42:54,836 --> 00:42:56,136

Next slide, please.

647

00:42:57,786 --> 00:43:04,416

The COVID-19 State of Vaccine Confidence

Insights Report is not your average social

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00:43:04,416 --> 00:43:06,566

listening or media monitoring report.

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00:43:06,676 --> 00:43:10,636

What makes our work different than typical

social listening and media monitoring reports is

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00:43:10,636 --> 00:43:14,926

that alongside the narrative for each

identified theme we share ways to take action

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00:43:14,926 --> 00:43:18,356

and address the information gaps,

perceptions, and rumors that may have led

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00:43:18,356 --> 00:43:20,346

to the themes in the first place.

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00:43:20,346 --> 00:43:23,126

The ways to take action typically

fall into three categories.

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00:43:23,486 --> 00:43:27,736

The first is communication, which entails

what content or information is missing,

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00:43:27,956 --> 00:43:31,276

what messages do we need to disseminate

and amplify, and what messages --

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00:43:31,276 --> 00:43:34,456

what messengers we need to work with to do that.

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00:43:34,566 --> 00:43:38,826

The second is programmatic, which includes

what can we do to improve upon this issue

658

00:43:38,826 --> 00:43:42,046

and recommendations to create a

website, identify a new process

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00:43:42,046 --> 00:43:44,366

or system, or reduce a particular barrier.

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00:43:45,126 --> 00:43:46,376

The third is research.

661

00:43:46,376 --> 00:43:50,056

For example, what do we still not know

that we could learn from survey data,

662

00:43:50,056 --> 00:43:52,296

focus groups, or listening sessions?

663

00:43:52,296 --> 00:43:53,696

And what do we need to know in order

664

00:43:53,696 --> 00:43:56,526

to produce better communication

and programmatic opportunities?

665

00:43:57,826 --> 00:43:59,686

This is the most important part of the report.

666

00:44:00,066 --> 00:44:02,486

At the end of the day, we want this

report to find its way to people

667

00:44:02,486 --> 00:44:04,096

on the ground who can quickly take action.

668

00:44:04,096 --> 00:44:05,366

Next slide, please.

669

00:44:08,666 --> 00:44:11,076

Since the report began in February 2021,

670

00:44:11,196 --> 00:44:14,016

we have seen the conversations

shift and change drastically.

671

00:44:14,086 --> 00:44:18,826

Our first report in February heavily focused

on how frustrated customers were with state

672

00:44:18,826 --> 00:44:21,246

and jurisdictional eligibility and the lack

673

00:44:21,246 --> 00:44:23,416

of clear communication about

who was eligible and why.

674

00:44:23,416 --> 00:44:28,086

We saw the beginning of the conversation related

to the impact that virus variants would have,

675

00:44:28,086 --> 00:44:31,196

confusion about maintaining

mitigation measures after vaccination,

676

00:44:31,196 --> 00:44:34,066

and confusion about what we did

and did not know at that time

677

00:44:34,066 --> 00:44:37,196

about asymptomatic transmission of the virus.

678

00:44:37,196 --> 00:44:40,336

This was especially challenging as

it began to make many people think

679

00:44:40,336 --> 00:44:43,706

that vaccines were not a path out

of the pandemic and into normalcy

680

00:44:43,706 --> 00:44:45,436

and challenged the benefits of vaccination.

681

00:44:46,366 --> 00:44:48,816

Regular updates on the state of

vaccine confidence are important

682

00:44:48,816 --> 00:44:51,476

because the landscape changes as

one piece of information can work

683

00:44:51,476 --> 00:44:52,976

into something harmful to vaccine confidence.

684

00:44:53,066 --> 00:44:55,636

For example, we've seen how the misconception

685

00:44:55,636 --> 00:44:59,186

that the COVID-19 vaccines erode the

immune system can turn into VAIDS

686

00:44:59,186 --> 00:45:02,296

or Vaccine Acquired Immune Deficiency Syndrome.

687

00:45:02,296 --> 00:45:07,046

This widely circulating slice of misinformation

bears varying significance to different people.

688

00:45:07,046 --> 00:45:11,676

Some people believe the vaccines cause immune

erosion, the vaccine will give them HIV,

689

00:45:11,786 --> 00:45:15,646

or that the vaccine will make

recipients more susceptible to HIV.

690

00:45:16,396 --> 00:45:19,216

And, with that, I'd like to thank

you so much for listening today.

691

00:45:19,636 --> 00:45:21,586

All of our past reports are

available to the public.

692

00:45:21,976 --> 00:45:24,796

In the follow-up emails of the webinar,

there will also be information about how

693

00:45:24,796 --> 00:45:26,246

to be added to the distribution list.

694

00:45:26,246 --> 00:45:26,876

Thank you.

695

00:45:30,296 --> 00:45:31,496

>> Thank you so much.

696

00:45:31,496 --> 00:45:36,586

This work is fascinating, how CDC uses this

info to address messaging and activities.

697

00:45:36,976 --> 00:45:40,906

I'd like to thank all of

our presenters for today.

698

00:45:40,906 --> 00:45:43,246

So now let's move on to questions and answers.

699

00:45:43,246 --> 00:45:48,116

And I'll apologize again in advance because we

will not be able to get to all the questions,

700

00:45:48,116 --> 00:45:50,506

but we will try to get through

as many as possible.

701

00:45:50,506 --> 00:45:56,686

So, starting off with our first question,

as a way to improve health equity,

702

00:45:57,606 --> 00:46:04,966

will CDC include disability prevalence as

a key demographic indicator in our reports?

703

00:46:04,966 --> 00:46:08,426

And I'll direct that to Dr. Brooks first.

704

00:46:08,986 --> 00:46:10,966

>> Right. Well, thanks for that question.

705

00:46:10,966 --> 00:46:14,566

You know, disability is a

prevalent issue in our country,

706

00:46:14,566 --> 00:46:17,336

and it's one that we take

very seriously at our agency.

707

00:46:17,336 --> 00:46:22,626

We have a large effort committed to

assisting people with disabilities

708

00:46:22,626 --> 00:46:28,506

and to navigate public health system

and our regulations and recommendations.

709

00:46:28,506 --> 00:46:36,016

I think one of the difficulties with putting a

figure on disability is knowing the actual --

710

00:46:36,016 --> 00:46:39,566

knowing the number of persons who are

disabled that we can track in real time.

711

00:46:39,566 --> 00:46:42,066

I'd be interested in what Matt

Ritchey thinks about this.

712

00:46:42,066 --> 00:46:47,886

But we're often asked about a variety of

different factors, why aren't you tracking them.

713

00:46:48,326 --> 00:46:54,066

And it's sometimes it's very hard to nail

down the data source that provides reliable,

714

00:46:54,106 --> 00:46:59,736

sufficiently reliable information to use that

in a way that could inform a recommendation.

715

00:46:59,916 --> 00:47:02,116

That doesn't mean that we

don't ignore the problem.

716

00:47:02,146 --> 00:47:03,236

On the contrary.

717

00:47:03,236 --> 00:47:07,856

Specifically with some forms of disability,

like immunocompromised, we go to great,

718

00:47:07,926 --> 00:47:13,806

great efforts to ensure that what we're

talking about and how it relates to persons

719

00:47:13,806 --> 00:47:15,426

with immunocompromised, which in the case

720

00:47:15,426 --> 00:47:19,726

of a respiratory infection is critical,

is directed at those audiences.

721

00:47:19,826 --> 00:47:24,116

And, likewise, when persons with other

disabilities have difficulties with other types

722

00:47:24,116 --> 00:47:30,076

of our recommendations, how to wear a

mask in a person who is unable to breathe

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00:47:30,286 --> 00:47:37,206

because of a respiratory tract issue as

another person would due to a respiratory issue

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00:47:37,316 --> 00:47:44,316

or who have difficulty managing other aspects

of our recommendations, we try to amend them.

725

00:47:44,586 --> 00:47:47,646

We also really rely on the feedback

for the disability community.

726

00:47:47,936 --> 00:47:51,866

We regularly speak both with members of the

community as well as groups that represent them

727

00:47:51,866 --> 00:47:56,166

and folks who care for them to ensure that

our recommendations are meeting their needs.

728

00:47:56,166 --> 00:47:59,526

And where we're not meeting their needs, we

want to hear about it so that we can do that.

729

00:48:03,766 --> 00:48:04,216

>> Thank you.

730

00:48:04,216 --> 00:48:07,796

Captain Ritchey, did you have anything to add?

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00:48:07,796 --> 00:48:09,016

>> Not too much to add.

732

00:48:09,136 --> 00:48:11,396

Dr. Brooks, I think, captured a lot of it.

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00:48:11,396 --> 00:48:14,826

It does go back to, as we think

about from a data perspective

734

00:48:15,126 --> 00:48:20,056

and of identifying the disability, the

population affected by disabilities.

735

00:48:20,256 --> 00:48:23,646

Difficult thing because there's a lot

of different definitions around that,

736

00:48:23,646 --> 00:48:27,936

that can be used, some that are administrative

based, others that are kind of more based

737

00:48:27,936 --> 00:48:30,246

on kind of certain context

and that sort of thing.

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00:48:30,536 --> 00:48:34,436

So within our data streams -- and I've been a

part of a lot of this work because it is central

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00:48:34,436 --> 00:48:38,056

to what we want to do as we talk

about health equity is to be able

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00:48:38,056 --> 00:48:41,366

to identify those populations and

seeing if they have an unequal burden

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00:48:41,666 --> 00:48:43,996

of COVID disease and poor health outcomes.

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00:48:43,996 --> 00:48:48,066

So definitely a high priority to us; there

is some difficulty that within our data

743

00:48:48,416 --> 00:48:50,516

about effectively identifying those populations.

744

00:48:50,946 --> 00:48:55,136

>> And I just want to also add to what

Matt just said, which we don't want

745

00:48:55,136 --> 00:48:57,216

to give the impression that this is impossible.

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00:48:57,326 --> 00:49:00,336

I think I look forward to a future

where we're able to capture this.

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00:49:00,336 --> 00:49:05,426

And I will offer as an example what now may

seem hard to imagine, but for a long time,

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00:49:05,426 --> 00:49:08,716

we didn't capture race and

ethnicity information around testing.

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00:49:08,906 --> 00:49:12,086

Well, it turns out that, you know, when

you turn in a lab slip for testing,

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00:49:12,086 --> 00:49:15,556

it doesn't routinely ask you to

record as a provider, let's say,

751

00:49:15,686 --> 00:49:20,626

what that person's race/ethnicity is or to --

or for the laboratory to record and report that.

752

00:49:20,796 --> 00:49:25,736

But through concerted efforts, we found ways

to help get those data streams and information

753

00:49:25,736 --> 00:49:27,426

into place to capture the information.

754

00:49:27,426 --> 00:49:30,906

And we might be able to look forward to

similar efforts like that the future.

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00:49:33,736 --> 00:49:35,376

>> Thank you both.

756

00:49:35,956 --> 00:49:37,236

Next question.

757

00:49:37,666 --> 00:49:40,986

The data used to populate

COVID-19 community levels is sent

758

00:49:40,986 --> 00:49:43,246

to CDC by local health departments.

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00:49:43,346 --> 00:49:44,676

That's the first question.

760

00:49:44,676 --> 00:49:49,066

If so, would it be fair to assume that the

differences in the surveillance systems of local

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00:49:49,066 --> 00:49:53,206

and state health departments can

influence the data, making it difficult

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00:49:53,206 --> 00:49:55,806

to compare levels between states?

763

00:49:55,806 --> 00:49:57,826

And I'll direct that to Captain Ritchey.

764

00:49:57,826 --> 00:50:01,966

>> As Dr. King mentioned,

there's three measures --

765

00:50:01,966 --> 00:50:02,326

>> Oh, sorry.

766

00:50:02,616 --> 00:50:07,336

>> I'm happy to take it or you, Matt, whatever.

767

00:50:07,336 --> 00:50:08,686

It doesn't matter.

768

00:50:08,686 --> 00:50:10,036

>> I can start and you can add on if you --

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00:50:10,226 --> 00:50:10,526

>> Okay.

770

00:50:10,936 --> 00:50:15,296

>> So, as Dr. King mentioned, there were

some three component measures that go

771

00:50:15,296 --> 00:50:18,066

into the COVID community level indicator.

772

00:50:18,466 --> 00:50:20,606

The first two are the hospitalization data.

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00:50:20,916 --> 00:50:25,016

So the hospitalization data

are overseen at the HHS level,

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00:50:25,016 --> 00:50:27,606

meaning coming from the federal

government as far as giving guidance

775

00:50:27,606 --> 00:50:29,266

to hospitals for reporting that data.

776

00:50:29,716 --> 00:50:34,286

How those data come to CDC sometimes passes

through the state health department first

777

00:50:34,286 --> 00:50:38,736

or comes directly to us through the

mechanisms that we've established.

778

00:50:39,026 --> 00:50:41,646

So there really isn't --

it's pretty clear guidance,

779

00:50:41,646 --> 00:50:45,786

and that guidance is consistently applied

across the country on the hospitalization side.

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00:50:45,856 --> 00:50:50,696

As far as it relates to the case surveillance

side, that third part of the COVID community,

781

00:50:50,886 --> 00:50:54,546

there could be a little bit of miteration

[phonetic] there between states and locals

782

00:50:54,546 --> 00:50:58,846

about how they're defining cases as

far as reporting confirmed cases only

783

00:50:59,146 --> 00:51:01,376

or some reporting also probable cases.

784

00:51:01,376 --> 00:51:03,076

So there's a little bit of variability there.

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00:51:03,386 --> 00:51:07,636

But there's strong consistency

on case definitions

786

00:51:07,636 --> 00:51:09,446

that are being applied across the country.

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00:51:09,446 --> 00:51:14,956

So, while there is a little bit of variability,

it's not overly likely impacting those measures

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00:51:14,956 --> 00:51:17,476

as we get down to the local

community to the county level.

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00:51:17,596 --> 00:51:20,426

Dr. King, if you want to add to that, please do.

790

00:51:20,426 --> 00:51:22,086

>> No. I completely agree with Captain Ritchey.

791

00:51:22,086 --> 00:51:25,416

And I think it ultimately comes down that the

requester is right, that there's going to be,

792

00:51:25,416 --> 00:51:29,156

you know, some variability but, ultimately, help

account for most of that with that definition.

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00:51:29,156 --> 00:51:33,746

And, as was noted, we do have standardized

definitions that are set by the Council of State

794

00:51:33,746 --> 00:51:37,086

and Territory Epidemiologists or CSTE.

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00:51:37,086 --> 00:51:41,386

And they have very clear

definitions around confirmed

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00:51:41,386 --> 00:51:43,796

and probable cases that we ultimately use.

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00:51:43,796 --> 00:51:47,816

And so although there is some extent of

bias, I would agree that it's limited.

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00:51:47,816 --> 00:51:50,556

And we help account for a lot

of that by making sure we use

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00:51:50,556 --> 00:51:53,696

that standardized definition

with the data that we do have.

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00:51:56,156 --> 00:51:56,586

>> Thank you.

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00:51:56,586 --> 00:52:00,566

Related to the community

levels, the next question says,

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00:52:00,566 --> 00:52:05,416

It appears that the transmission data is

being buried in favor of a new community level

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00:52:05,416 --> 00:52:09,536

that really only indicates the community's

ability to withstand disease loads.

804

00:52:09,976 --> 00:52:12,726

Why are transmission levels being downplayed?

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00:52:16,046 --> 00:52:17,746

>> So I'm happy to take that.

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00:52:17,746 --> 00:52:22,346

And as we noted in the initial

points, that we really have evolved

807

00:52:22,346 --> 00:52:24,396

to a different phase of the pandemic.

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00:52:24,396 --> 00:52:29,716

And, as a result, it's really critical,

given the increase in vaccination rates

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00:52:29,716 --> 00:52:32,806

and the other progress that we've made

on a lot of variety of indicators,

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00:52:32,806 --> 00:52:36,056

to really shift in the way that we

look at the available data to ensure

811

00:52:36,056 --> 00:52:39,126

that we're really focusing on

the greatest burden on society

812

00:52:39,126 --> 00:52:41,186

and where there's going to be that stress.

813

00:52:41,186 --> 00:52:44,346

And so, ultimately, that's where

the COVID-19 community levels land.

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00:52:44,426 --> 00:52:49,926

In terms of focusing on those three

critical levers in terms of the impact

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00:52:49,926 --> 00:52:54,696

on not only the healthcare system

but also the COVID-19 case rates.

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00:52:54,826 --> 00:52:59,626

And so it really is consistent with the fact

that this is an incredibly dynamic pandemic.

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00:52:59,626 --> 00:53:04,846

But as we build more data, as we get new

information, so must we evolve with it

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00:53:04,846 --> 00:53:09,426

and ensure that we're really focusing our

efforts and using the data to really focus

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00:53:09,426 --> 00:53:13,316

on the greatest burden on society at

this phase, and that's really focused

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00:53:13,316 --> 00:53:18,436

on those three measures that we've ultimately

landed on in terms of the cases and the burden

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00:53:18,436 --> 00:53:24,836

in the hospitalization sector to really keep

our pulse on what the greatest burden is

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00:53:24,836 --> 00:53:28,936

and potential strain on those

various indicators.

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00:53:29,116 --> 00:53:30,906

So we'll continue to monitor moving forward.

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00:53:30,906 --> 00:53:33,716

But for right now at this stage in

the pandemic, we've really shifted

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00:53:33,716 --> 00:53:37,666

from those transmission rates, given

that we have those tools available

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00:53:37,806 --> 00:53:42,676

and that we really want to focus

on the greatest strains on society

827

00:53:42,676 --> 00:53:45,936

to help make those evidence-based

informed recommendations to the public.

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00:53:48,246 --> 00:53:48,826

>> Thank you.

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00:53:48,826 --> 00:53:55,746

Our next question is regarding

calculating statistics.

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00:53:55,746 --> 00:53:59,646

So how does CDC figure in numbers

that haven't been officially reported?

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00:53:59,646 --> 00:54:03,966

Related to this, there's a large

amount of home testing going on.

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00:54:03,966 --> 00:54:09,096

So how does that affect the testing

data and what CDC is able to report

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00:54:09,096 --> 00:54:11,576

on COVID Data Tracker, for example?

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00:54:12,616 --> 00:54:13,536

Captain Ritchey.

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00:54:17,046 --> 00:54:17,526

>> Sure. No.

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00:54:17,526 --> 00:54:18,136

Thank you, Haley.

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00:54:18,136 --> 00:54:19,356

So a really important question.

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00:54:19,356 --> 00:54:23,136

It's something that we've definitely been, you

know, exploring more and pushing into further.

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00:54:23,626 --> 00:54:29,976

So I guess first from a self-test data

perspective, self tests, really, I mean,

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00:54:29,976 --> 00:54:34,076

the main, main value of those

is for risk reduction tool,

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00:54:34,076 --> 00:54:38,146

as it can inform an individual's actions

to keep themselves and others safe.

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00:54:38,146 --> 00:54:41,726

So it's really, at the end of the day, am

I positive or negative based off self-test,

843

00:54:41,726 --> 00:54:43,906

and what should I do about

that to protect others?

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00:54:44,536 --> 00:54:50,016

And, really, we have no way of -- no

authority in mandating reporting of those data.

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00:54:50,016 --> 00:54:53,736

But we do know that they're out there, and

we want to make sure that we do, you know,

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00:54:53,736 --> 00:54:56,586

take them into account as

we thinking about, you know,

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00:54:56,586 --> 00:54:58,426

incidence of disease and that sort of thing.

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00:54:59,626 --> 00:55:03,816

One of the things that I think as we push into

this space and think more about it is that,

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00:55:03,936 --> 00:55:05,626

you know, we have a host of other data.

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00:55:05,626 --> 00:55:08,006

I walk through a lot of them,

other testing data.

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00:55:08,056 --> 00:55:10,856

And we're still getting millions

of test results, you know,

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00:55:10,976 --> 00:55:14,486

a day and a week for PCR tests

and things of that nature.

853

00:55:14,486 --> 00:55:19,406

And then we have robust other systems, whether

it's case reporting, wastewater surveillance,

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00:55:19,716 --> 00:55:23,126

hospitals surveillance to really

understand and monitor kind of the trends

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00:55:23,126 --> 00:55:24,646

that are going on across the country.

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00:55:24,856 --> 00:55:29,316

So while, yes, we may have a little bit less

visibility on some of the self-test results,

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00:55:29,466 --> 00:55:33,686

we have a host of other assets in

play that we can leverage to make sure

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00:55:33,686 --> 00:55:36,466

that we're having good situational

awareness of what's going on.

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00:55:37,186 --> 00:55:41,306

That being said, we've also been working with

our partners, both the federal government level

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00:55:41,306 --> 00:55:46,096

and also our state and also the manufacturers

of self-tests that kind of continue

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00:55:46,096 --> 00:55:50,196

to understand these self-test data

and how they potentially can be used

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00:55:50,196 --> 00:55:55,256

to augment our other surveillance that's already

going on for now, for the COVID responses

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00:55:55,256 --> 00:55:58,646

as well as into the future because, in

the future, as we've established some

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00:55:58,646 --> 00:56:01,556

of these pipelines to bring

in data on self-tests,

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00:56:01,776 --> 00:56:05,586

we see that there's really applicability

down the road as far as how to best leverages

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00:56:05,826 --> 00:56:08,396

that to help really inform what's

going on at the national level,

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00:56:08,396 --> 00:56:11,176

as well as it may be even more

importantly at a local level.

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00:56:11,176 --> 00:56:15,756

So, yes, we might not have all

the complete data on self-tests.

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00:56:15,756 --> 00:56:18,536

We feel like the amount of other

robust information that we're getting

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00:56:18,536 --> 00:56:20,806

in we're maintaining strong

situational awareness.

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00:56:22,926 --> 00:56:24,076

>> Thank you.

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00:56:24,076 --> 00:56:26,886

It looks like we have time

for maybe one more question.

873

00:56:26,886 --> 00:56:34,016

Any tips for public messaging when numbers

vary and fluctuate due to data scrubbing

874

00:56:34,196 --> 00:56:39,646

and also varying data metrics, for

example, CDC versus state versus county?

875

00:56:39,646 --> 00:56:44,006

Post-surge data scrubbing by different

jurisdictions can create public confusion

876

00:56:44,006 --> 00:56:45,156

and skepticism.

877

00:56:46,016 --> 00:56:51,966

So we can start off with maybe

Dr. King and then Captain Ritchey.

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00:56:52,816 --> 00:56:54,996

>> No. I'm happy to defer to you, Matt.

879

00:56:55,126 --> 00:56:56,896

I think that's in the data lane.

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00:56:57,086 --> 00:57:00,786

>> Sure. I tried to cover some

of this in the slides I walked

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00:57:00,786 --> 00:57:03,366

through because this is something

we come up frequently.

882

00:57:03,366 --> 00:57:06,436

And it gets at, you know, one, at a local level,

883

00:57:06,436 --> 00:57:09,836

sometimes there's other data

available that we don't have access to.

884

00:57:10,126 --> 00:57:12,996

And they're able to showcase that,

and we actually encourage that, right?

885

00:57:12,996 --> 00:57:16,946

We do it as best we can with the amount of

information we have in, which is robust.

886

00:57:16,946 --> 00:57:20,856

But we also know that there's other things in

play at the local context that they can leverage

887

00:57:21,086 --> 00:57:23,226

to kind of showcase what's

going on in their communities.

888

00:57:23,226 --> 00:57:24,506

So there's that one example.

889

00:57:25,176 --> 00:57:28,926

While we have tried to standardize how

we analyze those data and showcase them

890

00:57:28,926 --> 00:57:32,386

across the country, we also know that

at the individual -- at the low --

891

00:57:32,386 --> 00:57:35,426

at the lowest level, at the county

level or even at the state level,

892

00:57:35,696 --> 00:57:38,896

other decisions sometimes are made

that are meaningful to that community

893

00:57:39,196 --> 00:57:41,456

that showcase those data

in slightly different ways

894

00:57:41,456 --> 00:57:43,966

and totally understand how

that then can create confusion.

895

00:57:44,316 --> 00:57:48,576

You see one number one place and another

number in another place without really digging

896

00:57:48,576 --> 00:57:50,476

into what that number represents.

897

00:57:50,476 --> 00:57:52,036

So, yes. Totally realize that.

898

00:57:52,036 --> 00:57:54,886

So while we've tried to standardize

that, we realize sometimes that lack

899

00:57:54,886 --> 00:57:57,056

of standardization is going

on across the country.

900

00:57:57,336 --> 00:58:02,106

So I think those are two main ways that

sometimes that those discrepancies can arise.

901

00:58:04,976 --> 00:58:05,436

>> Thank you.

902

00:58:05,436 --> 00:58:07,866

We are out of time.

903

00:58:07,866 --> 00:58:12,296

But before we wrap up, we'd like

all the audience to take a moment

904

00:58:12,296 --> 00:58:15,806

to answer the second poll

question that we're putting up now.

905

00:58:51,756 --> 00:58:53,356

Thank you so much, everyone.

906

00:58:53,356 --> 00:58:57,536

I'd like to express thanks to the

participants for your interest and engagement.

907

00:58:57,536 --> 00:59:00,496

And I'd also like to thank the CDC

presenters for joining us today.

908

00:59:00,496 --> 00:59:04,946

If you have additional questions,

please email us at epic@cdc.gov.

909

00:59:05,256 --> 00:59:10,876

To learn more about CDC's Emergency Response

Communications, including past webinars

910

00:59:10,876 --> 00:59:13,636

and newsletters, please visit our EPIC webpage.

911

00:59:13,636 --> 00:59:17,436

For those interested in rewatching

and sharing today's event,

912

00:59:17,506 --> 00:59:20,886

you'll be able to access the

recording on Epic cdc.gov web page

913

00:59:20,886 --> 00:59:22,846

and YouTube in eight to ten days.

914

00:59:23,136 --> 00:59:30,246

To see previous CDC COVID-19 webinars, visit

the CDC COVID-19 Webinar and Partners Call page.

915

00:59:30,246 --> 00:59:33,676

Thank you so much for your time

and all the right questions.

916

00:59:33,846 --> 00:59:34,866

Have a wonderful day.