Script COVID webinar transmission of information to local bodies

Slide 1: This webinar is about transmission of information of COVID testing and patients to local bodies.

Slide 2: Here, we will discuss why there is need for proper transmission of information of COVID-19. We will discuss, who all should be notified; how to report the cases of COVID-19; what to do if a COVID patient is detected; how to report a death; and finally how to use data for disease prevention.

Slide 3: Why proper information is required for COVID-19? COVID-19 is a new disease and clinical presentation is variable. Robust data are needed from every district and state in the country to measure the public health impact of COVID 19 and to plan for timely health interventions to protect communities.

Slide 4: We should know, who all be notified. All suspected and confirmed cases of COVID-19 should be notified. Similarly, all cases of ILI and SARI should be notified.

Slide 5: Next is, to whom to report. It is mandatory for all hospitals (Government and Private), Medical officers in Government health institutions and registered Private Medical Practitioners including AYUSH Practitioners, to notify such suspect or confirmed cases of COVID-19 to the concerned **District Surveillance Unit (DSU). DSU will report to SSU and SSU to CSU under IDSP** (Integrated Disease Surveillance Programme). It is on daily basis and via online portal system. The IDSP is now merged with **NCDC (National Centre for Disease Control**; formerly National Institute of Communicable Diseases), under the Ministry of Health and Family Welfare.

Slide 6: This is website of **National Centre for Disease Control.** It has data dashboard, various reporting formats and checklists, SOPS, training material, guidelines and many more.

Slide 7: Here is website of IDSP. TO READ ALL MATERIAL IN YELLOW BOX.

Slide 8: Initially, the reporting system was via phone and email. Now, it is via online portal system and it is need to updated on daily basis.

Slide 9: This is case report form. On left upper corner, there is EPID number to be filled at district. It is in format of Eg. COV-IND-ST-DIS-YR-Case number

e.g: First case of Patna Bihar in 2020 will be as: COV-IND-BI-PAT-20-0001. On left side, there is space for demographic details, case classification (confirmed or suspect), and clinical details. On right side, there is space for travel history, laboratory information, clinical course, and public health response.

Slide 10: When sending sample for COVID testing, this form need to be filled. It includes personal details, specimen information, exposure history, clinical features, underlying medical conditions, hospitalization, treatment and investigation, and finally details of health authority for sending the report.

Slide 11: All the laboratory are supposed to provide daily update (daily and cumulative) to District, State and Central Control Rooms on:

Numbers of

Samples received

Samples tested

Samples under testing

Positive samples

Slide 12: If a positive case is detected, first of all shift the patient dedicated COVID ward or COVID hospital for further management. Then, Inform to local Rapid Response Team and start contact tracing.

Slide 13: The central Rapid response teams is consist of epidemiologist, microbiologist and any other person deployed as per need. RRTs work in close coordination with state and district RRTs both at central and local levels; assist state to plan and implement containment

strategy, and Surveillance; assist in establishing system for sample transfer to nearest designated laboratory; and review implementation of Infection prevention and control practices in COVID- 19 designated health facilities.

Slide 14: **RRTs** will provide aggregate data on daily basis on the following (for the day and cumulative):

Total number of suspect cases

Total number of confirmed cases

Total number of critical cases on ventilator

Total number of deaths

Total number of contacts under surveillance

Slide 15: What to do in contact tracing? As soon as the single event (identification of suspect or confirmed case) is detected, contact tracing must be aggressively implemented (preferably to be completed within 48 hours).

Contacts of confirmed cases should be traced and monitored for at least 28 days after the last exposure to the case patient for evidence of CoV 19 symptoms as per case definition.

Information about contacts can be obtained from: Patient, his/her family members, persons at patient's workplace or school associates etc.

Maintain case wise Line-listing: as per format.

Slide 16: It is contact line listing form that contain detail of confirmed case and details of contacts including places visited: 2 days before and up to 14 days of symptom onset.

Slide 17: It is follow up form contact list for 28 days. Contact will be defined as HRC and LRC and put "X" if no symptoms and "✓" sign of one of "fever, cough or difficulty breathing".

Slide 18: Here is the updated definition of contact: A contact is a person that is involved in any of the following:

• Providing direct care without proper personal protective equipment (PPE) for COVID-19 patients

• Staying in the same close environment of a COVID-19 patient (including workplace, classroom, household, gatherings).

• Traveling together in close proximity (1 m) with a symptomatic person who later tested positive for COVID-19.

If symptoms of 2019-nCoV appear within the first 28 days following the contact, the individual should be considered a probable case and reported through IDSP network to NCDC.

Slide 19: **High-risk contact is who**:

Touched body fluids of the patient (respiratory tract secretions, blood, vomit, saliva, urine, faeces)

Had direct physical contact with the body of the patient including physical examination without PPE.

Touched or cleaned the linens, clothes, or dishes of the patient.

Lives in the same household as the patient.

Anyone in close proximity (within 1 meter) of the confirmed case without precautions.

Passenger in close proximity (within 1 meter) of a conveyance with a symptomatic person who later tested positive for COVID-19 for more than 6 hours.

Low-risk contact is who:

Shared the same space (same class for school/worked in same room/similar) and not having a high-risk exposure to confirmed case of COVID-19.

Travelled in same environment (bus/train/flight/any mode of transit) but not having a high-risk exposure.

Slide 20: Death reporting is another aspect of transmission of information related to COVID. For reporting death, Medical Certificate of Cause of Death (MCCD) should be filled and details are to be uploaded via ICMR-NCDIR e-Mortality (e-Mor) software at http://ncdirindia.org/e-mor/

Slide 21: It is typical MCCD containing part I (immediate cause and antecedent cause) and part II (other significant condition). Part I contain a, b, c and it should be filled as logical sequence from "c" to "a" mean "c" leading to "b" and "b" leading to "a". "a" is final immediate cause (not mode of death). Right column have time period between onset and death for a particular cause.

Slide 22: There are ICD 10 codes provided by WHO for COVID. U07.1 is for confirmed COVID-19 and U07.2 is for probable and suspected COVID-19.

Slide 23: Now we will discuss some examples, how to report COVID deaths as per MCCD format. First example is of 40 years old male diagnosed with COVID-19. Here, COVID-19 will be at "c". It leads to "b" that ARDS and it leads to "c" respiratory acidosis that was immediate cause. Code is written as U07.1 and duration is also mentioned as 7, 3, and 2 days.

Slide 24: This example is about 60 yrs male, father of a COVID-19 patient. He was diabetic, presented with ILI and died. The COVID test was not available. Here "C" is COVID-19 suspect with code U07.2. It leads to "b" ILI, and "b" leads to "a" ARDS that was immediate cause. Diabetes will be in part II, other significant condition.

Slide 25: One more example. 50 years female, received chemo for breast cancer. Admitted with breathlessness and developed shock and died. COVID was positive. Here c,b, a are COVID-19, pneumonia, DIC respectively, Breast cancer will be under part II, antecedent condition.

Slide 26: There is death investigation form also that include demographic details, clinical details, underlying condition, exposure history, and travel history.

Slide 27: The display of beds should be done as per instruction of local state. E.g. Delhi government has issued an order to display vacant beds in all Govt and Pvt. hospitals with bed capacity of 50 and above.

Slide 28: These data are used for disease prevention. Some data are available on dashboard of NCDC website.

Slide 29: E.g. here is data related to age and comorbidity of COVID patients.

Slide 30: Finally, we will discuss about zones based on these data. Districts are divided into red, orange and green zones, based on total number of active cases, doubling rate of confirmed cases, extend of testing and surveillance feedback. Red zone, also called as hot spot area is defined by presence of more than 15 cases. Green zone is the area with zero confirmed cases till date or no confirmed case in the last 21 days. Districts that are neither in the Red zone nor the Green zone are in the Orange zone. Containment area is defined by district officers by presence of number of cases within red area.

In the containment zones, only essential activities will be allowed and a strict perimeter control will be put in place to ensure there is no movement of people in or out of these zones, except medical emergencies and essential goods and services.

Activities in red zone (outside containment zone), orange zone, and green zone are decided by states.

Slide 31: To summarize,

Transmission of correct and complete information is an important step in managing an epidemic.

We should follow government guidelines for reporting disease and deaths.

The available information should be used for further preventive and therapeutic options.