



CDC Newsroom

Transcript: PHE Briefing

Press Briefing Transcript

Friday, May 5, 2023

- Audio recording  [MP3 – 6 MB]

Please Note: This transcript is not edited and may contain errors.

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Hello and thank you all for standing by. At this time, I would like to inform all participants that your lines are on a listen only mode until the question and answer portion of today's conference. Today's conference is also being recorded. If you have any objections you may disconnect at this time. I will now turn the call over to Mr. Benjamin Haynes. Sir, you may begin.

00:22

Thank you, Christy and thank you all for joining us today. We are joined by CDC Principal Deputy Director, Dr. Nirav Shah and Dr. Brendan Jackson, the head of CDC is COVID-19 response, who will talk about how to end the COVID-19 php or sorry on how the end of the COVID-19 php will affect CDC. This information will also be detailed into MWR as we are leasing tomorrow, Dr. Scholl's and Texan will provide remarks and then take your questions. I would also like to note that this briefing is embargoed until Friday, May 5 at 11am. Eastern when the report goes live on the CDC website. I'll now turn the call over to Dr. Shah.

01:05

Great. Thank you, Ben. And good afternoon, everyone. Thank you all for joining today. I'm speaking with you from Atlanta, where our CDC family suffered a terrible loss and yesterday's shooting. Our hearts are with our colleagues, friends, families, and co workers. I will start today by highlighting four aspects of our changing approach to COVID-19. And then turn things over to Dr. Jackson. First. Although next week marks the end of the public health emergency, it is not the end of COVID-19 COVID-19 remains a risk. And CDC remains committed to preventing severe illness and death associated with COVID-19. Particularly for those who are at higher risk. This includes older Americans, people who are immune compromised, and those who are living with disabilities. We have the right data for this phase of COVID-19. Though our data going forward will be different. They will continue to provide timely insights for CDC, for local health officials, as well as for the public to understand COVID-19 dynamics at the community level. There are two important points about these metrics. First, we will continue to keep our eye on the COVID-19 ball. And we will do so through a multitude of metrics. Indeed, our epidemiological understanding of COVID-19 after the end of the public health emergency will be deeper than what we have for other viruses like RSV, and influenza. Second, the specifics of some metrics are changing, but the key insights remain intact. For example, our COVID-19 community levels rely in part on aggregate case rates. And those case

rates may not be reported to CDC by jurisdictions after the end of the public health emergency. However, the replacement based solely on hospital admission data will be a strong indicator of COVID-19 status at the local level. CDC scientists have back tested this and as noted in the forthcoming MWR. Since February of 2022. There has been a 99% Concordance between the CCL the community levels, which are being retired and the new hospital admission driven metrics. In short, we will still be able to tell that it's snowing, even though we're no longer counting every snowflake. Third, the changes that we're discussing today are happening because the end of the public health emergency means that CDC will have less authority to collect certain types of public health data. That means less data will be available to us. That said, we will have good sightlines into COVID-19. And that's because at this stage, there is not one single metric of the moment. Instead, we will continue to use a multitude of metrics to understand how COVID-19 is unfolding. And those exist on a continuum. Some metrics rise earlier and are more sensitive. Some rise later and are more specific. But the broad the broad panoply of metrics that we will use will continue. That includes wastewater testing, emergency department diagnoses, laboratory testing for positivity rates, as well as hospital admission data. All told these will continue to give us a full view in as timely a manner as possible and forth. As I've mentioned, our data at this juncture are fit for the purpose ahead. But that does not mean the work to modernize our data architecture is done, far from it. Simply put, our ability to detect and monitor disease threats should be better in the future than it has been in the past. And that ability to detect and monitor should be built into our baseline, not contingent upon emergency declarations. For example, in the next pandemic, we shouldn't wait six months to have complete hospitalization data. We shouldn't need dozens of data use agreements to understand the demographics of who's getting vaccinated, we should have access to robust data before a pandemic. We should be ready, so we don't have to get ready. That is the work ahead of us and the work we are committed to doing. Now I'd like to turn things over to Dr. Jackson.

05:54

Thank you, Dr. Shawn. I'm gonna go into a bit more detail about how we're shifting our COVID-19 data strategy as the PH D declaration comes to an end. Dr. Shaw mentioned data on hospitalizations will continue to be recorded from all hospitals nationwide, go on a different cadence moving from daily to weekly. This reporting will continue to provide a detailed, stable look at trends down to the county level. hospital admissions will serve as our primary surveillance metric for COVID-19. That will hospitalizations provide the best national level view of COVID trends. There are also metrics that provide earlier signals of change and COVID activity. First, CDC reports emergency department visits for COVID-19 on our COVID data tracker website down to the state level. This is a key EARLY INDICATOR OF evolving trends. Second, wastewater testing performed hundreds of sites nationwide and covering nearly 140 million people. It's also a good early indicator in areas where it is available. Third, later this month, we'll shift our source for test positivity data to a long standing system called the National respiratory and enteric virus surveillance system, which is based on voluntary reporting from over 450 laboratories nationwide. So that's early indicators. Moving on to death data, we're still going to be collecting data on deaths but with a change that improves data quality. We'll be switching our main method for tracking deaths to CDC national system based on death certificates, which has become much timelier over the course of the pandemic. Next, let's talk about vaccination data. Such as already mentioned, the data use agreements most jurisdictions have signed an extension for data use agreements with CDC and will continue to share COVID-19 vaccine data even after the end of the PHE will also track COVID vaccination data through vaccine coverage surveys like we do for other vaccines. vaccine effectiveness platforms such as IV and vision will continue to provide real world data on how well protection from vaccines is holding up. Now let's talk about case data. As the pandemic pandemic has progressed case data have become less reliable because of increases in home testing. As you all know, the results of which are often not reported an increase in mild and asymptomatic infection to further decreased testing rates. Also, once the PHA expires, some jurisdictions may lose the authority to collect COVID-19 case data at all. These factors coupled with a shift in focus towards tracking severe COVID-19 Rather than counted infections is leading us to remove case data as a primary metric and COVID data tracker beginning May 11. Finally, let's talk about two implications of these changes. One is Dr. Shawn mentioned COVID-19 community levels or CCS which are used to guide individual and community actions will be discontinued since they rely on those case data in part. That said this change again is not as big a deal as it might sound and will be replaced by the hospital admission levels, which were again the main driver of the community levels. Again with that 99% Concordance since they were established between the two. CDC will continue to use these levels to provide prevention recommendations that people especially those at higher risk of severe COVID-19 can use to determine how best to protect themselves. Now the second key implication of the data changes is that COVID-19 transmission levels which are different from which many levels, these transmission levels can no longer be calculated, and will also be discontinued since they're based on based on case and county level test positivity data. Use levels have mainly been used in healthcare settings to inform source control or masking, as well as to inform admission testing in nursing homes. Because of this change, CDC is updating its infection prevention and control recommendations to make sure that health

care facilities have appropriate information to inform their infection control processes. I want to reiterate that we're still monitoring COVID-19 intensively even as we work to integrate COVID into the broader fight against respiratory diseases. Turn it back to Ben so we can take questions. Thanks.

09:39

Thank you, Dr. Jackson. Christie, we're ready to open up for questions.

09:45

Thank you. At this time, if you would like to ask a question, please unmute your phone and press star one. Please state your name and affiliation when prompted. Again, please press star one, two Ask your question. If you need to withdraw yourself from the queue, please press star two. One moment while we wait for questions to come in.

10:15

Our first question comes from Brenda Goodman of CNN, you may ask your question. Hi,

10:24

thank you for taking my call. I have a question about cases and case reporting. So it's my understanding that COVID-19 is a nationally reportable nationally notifiable condition rather. So does that mean that that designation goes away? With the public health emergency? Or? Um, I did not understand why States wouldn't still have to report those numbers to the CDC.

10:52

Sure, and this is, Brendan, I'm happy to address that question. So it is a bit it's a bit challenging to sort of follow because it is it is not simple because of the fate, the set of state and federal process around all of this. So the national notifiable designation is not something determined solely by CDC that is done by the Council of State and Territorial Epidemiologists, that is a recommendation but it doesn't not carry sort of any authority. It's for required reporting. So what happens is, cases get reported to the state or other jurisdiction or other jurisdictions, and then that is notified then to CDC. So that recommendation is still in place. But there are you know, each individual state or other jurisdiction has its own rules or regulations that determines what is reportable. And some of those in some of the jurisdictions or some of the states, those authorities will go away with the end of the public health emergency. So it is a very much a state by state situation. Thanks. Next question, please. Thank you.

11:56

Our next question comes from Alice park of time your line is open. Thank you.

12:03

I just wanted to ask, you had mentioned wastewater surveillance as something that would help filling some of the gaps with some of the data that you're you might no longer be getting, can you specify whether there's any specific additional investments in that? I know that that program doesn't cover the entire country. So can you just detail what plans are to perhaps expand that or invest more heavily in that especially also, with respect to what you said that we want it to be better prepared for the next pandemic?

12:36

Thanks, Alex, this is near. I appreciate that question. We will get back to you with some additional numbers around where we are with respect to wastewater. But in broad strokes, wastewater surveillance testing is a part of our proposed and our current architecture for infectious disease monitoring and surveillance. As Dr. Jackson noted right now, wastewater testing covers about 138, close to 140 million Americans, which is about 40%. From a surveillance perspective, that is a robust sample of the United States that allows us to get insight not just into COVID-19, but other infectious diseases, indeed, increasingly, in some jurisdictions, non infectious diseases as well. So wastewater is one of those early Sentinel markers that we do use to understand where things go, and we intend to continue the investments that the CDC has made, particularly in partnership with state and local health departments. As to the exact numbers we will get through those and where we intend to go. Thank you. Next question, please.

13:40

Thank you. Our next question comes from Helen Branchville. Of sta T, your line is open.

13:49

Hi, thanks for taking my question. At the beginning of your March, Dr. Show, you talked about the fact that even with the data sources that are going away, CDC will still have sort of a better picture of what is going on or more detail on what is going on with COVID than it currently has with RSV. And who could you give us the more granularity? What are you getting for COVID that you don't know about fluid? RC?

14:21

Sure. I think Helen, I thank you for that question. And I'm, it's great to great to chat the I'll sort of go through it access by axis or category by category. So with respect to COVID, let's start with a lab testing. On the lab testing front, we are adding COVID into the nervous system, which currently right now gives us insight into other respiratory as well as Enteric Diseases. So on that axis COVID will join the ranks of some other diseases that we have monitoring from from nerves. But there are other areas where we have more insight into COVID than we would to those other diseases hospitalization. tins are a good example of that. We only receive we receive, sorry, going forward, we will continue to receive a significant amount of data around COVID hospitalizations as compared to what we were getting before. For example, one of the categories of things that's going away with respect to COVID hospitalizations are around suspect cases. At this juncture in the pandemic, with testing so widely available, there really isn't a suspect case anymore. That core data around COVID will continue to come in to CDC in a manner that it does not come in for RSV and influenza. That's that's one concrete example. I can take you a couple more if you'd like. But that's one example of how we will have better insight into the dynamics of COVID as compared to RSV and influenza. Thank you. Next question, please.

15:52

Thank you. Our next question comes from Robert Stein of NPR. Your line is open.

15:59

Yeah. Hi, thanks. Thanks for taking my question. Yeah. Just another question about hospital data. What? What data are you going to be? Can you give us a little bit more specifics about data you're giving up, for example, you're gonna still be able to be collecting data on race and ethnicity, for example. And then I was also wondering about, do you still think you'd be getting enough data to do genomic surveillance, adequate genomic surveillance?

16:28

I'd probably happy to take that question. This is Brendan Jackson, on the first question about hospitalization data. So there's two key sources that we're using for hospitalization, the one is what we get through our National Healthcare Safety Network, or NHSN. Those are really aggregate like total counts that we're getting from hospitals currently on a daily basis, then moving to a weekly basis that does not include sort of detailed demographic data on each of the patients that are hospitalized. But what we'd have secondarily to that is a sentinel surveillance system called COVID. Net, which includes 14 sites across the country, to about 10% of the US population. And that will continue to collect detailed granular data on this patient, including race ethnicity, but I mean, going very deep into underlying medical conditions, the level of care that they're receiving, et cetera. The the on the genomic piece of that is absolutely going to continue, there's certainly been a decline in the number of tests, amount of testing that's going on, and specimens that are able to be submitted for genomic sequencing. So we may need to scale back on the frequency of how often we're reporting on those. But we absolutely are going to be continuing to monitor that very closely. And I'll say, not only do we have sort of national genomic sequencing picture that's going on, but we also have, you know, this ongoing genomic sequencing of incoming travelers from international destinations coming to the United States. And so we're getting a look at what variants are coming to the US, it's been a very helpful early indicator of what might be seen in other countries, especially when those countries don't have as much sequencing. And we also have a small amount of sequencing that's happening in wastewater, that's still more in pilot phase, but it's at least helpful to get us some sense of how well that's working. And another another way to sort of triangulate what variants are out there. Rob, this

18:05

is near about I wanted to connect your question with Helens question previously, because those are additional examples of ways in which we will have good insight into COVID in a manner that would that superior will we have for flu and RSV, so genomic sequencing, although there is some that occurs with flu and RSV, there will be significantly more with COVID. Similarly, around hospitalization data will have far better insights. And the same with waste. I'm sorry, same with wastewater and genomic as well over.

18:33

Next question, please.

18:35

Thank you. Our next question comes from Mike Stobi of AP, your line is open.

18:42

Hi, thank you for taking my question. I wanted to if you could give me just a few more specifics about the data use agreements that are in place and not in place for vaccination data. And if I could also ask, could you say a little bit more regarding rough Stein's question about what might be lost in race and ethnicity data? And could you walk me and my readers to our readers through that, we talked about the community levels? I mean, how's it going to work in the future? Like, what if the pandemic takes a turn for the worst, either because of a new variant or something else? What? What is the CDC going to point to what data is it going to point to and say, Hey, things in Arkansas are getting worse? You need to mask you need to vaccinate, how is that type of thing going to play out in the future? Thank you.

19:31

Thanks, Mike. I'm going to turn to Brendan to discuss the D ways and the racial and ethnicity data. I'll pick it up on the backside. Absolutely, so

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I'm a data use agreements for the for the vaccine administration data. Right now. There's almost all of the jurisdictions in their 64 jurisdictions you know, 50 states plus additional ones have have signed these these data use agreements. There may be a couple that are not able to because their own individual state laws. So we have a pretty comprehend Have a look at what the administration data is like. I will say that there are challenges to those data because at the federal level, we cannot crosswalk those data between jurisdictions between states. And there's a number of other specific challenges with that, but it's still we still have that line of sight. The other piece is that we will have these vaccine coverage surveys like the National Immunization Survey that's going to collect. That's where we get most of our solid race, ethnicity information going forward, when it comes to vaccines and some other sources. broadening that out on race, ethnicity data, in general, there's still gonna be quite a number of data sources that are going to be collecting that. So we're not we don't anticipate any sizable loss in in inability to track those disparities or otherwise.

20:40

And then Mike, to answer your question of how we will know when a situation is getting more significant in any particular jurisdiction. And I sort of think about this on a continuum of data points, but, and those are the ones that we will continue to be putting on our website. So for example, if in a particular jurisdiction, we saw an increase in wastewater in a particular area, that's an early Sentinel indicator of potential increases, and things like cases. Now I'm going to dive into this for a quick second, Dr. Jackson can go deeper. But what we are not going to be receiving is aggregate case data, however, because many jurisdictions will still be reporting in because, as we noted earlier, it's still notifiable, we will still have line level data available on our website, and data.cdc.gov. So that'll be another indicator that we could use, to the extent that states are reporting it, then we'll have the constellation of laboratories from the nervous system that Dr. Jackson noted. This is over for about 450 laboratories across the country that gives us insight from a surveillance perspective of the volume of testing, as well as increases in positivity. Next, we've got the emergency department do this. This isn't just people who are visiting. This is people who are going to the emergency department and getting diagnosed with COVID in the IDI. And then finally, we will have an indicator around hospitalizations, who's getting hospitalized, whether they're ending up in the ICU, we also couple that with the improvements in the depth system, the depth reporting system, which is far more timely now than it was before, all of those factors when taken in Toto, give us an insight into what's happening at a local or jurisdictional level. Next question, please.

22:30

Thank you. Our next question comes from that Lina, son of the Washington Post, your line is open.

22:37

Hi, thank you for taking this question. Dr. Jackson, maybe you know, I was just curious on the voluntary data use agreements, how long does it typically take to work out what to do that work around with the state? And then secondly, a lot of this information is changing. There's been a lot of different information from the CDC and FDA on vaccine recommendations. At what point is CDC going to be updating its guidance across the board so that it's in sync with everything that's going on? Thanks.

23:13

You're absolutely so I'm a Data Use Agreement piece. It really is dependent on the state, right. I mean, there's sort of saying and we say you've seen once the health department, you've seen one, say health department it. There are, you know, legal processes that they've all got to go through. So I think the fact that we don't have a sort of a standing mechanism for this, and that we have to go through these individual DUAs. It definitely is a challenge. I would say this often can take in the range of weeks to months, depending on how things end up going in a way no,

23:37

sorry. I will mention a particular state health department in New England that was extremely efficient, and very easy

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to work with.

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You can imagine which one that would be but okay. And then on the vaccine recommendations piece, you know, there's been a lot to sort out and, as you know, there's been some additional updates to the emergency use authorizations related to immunocompromised children. So we have updated the interim clinical considerations for clinicians when it comes to vaccine recommendations. We've also updated our up to date page, and the other pages should be coming shortly, hopefully, as we speak, but you know, definitely in the next well, as soon as possible as this is the right answer. Thanks.

24:16

Next question, please. Thank you. Our next question comes from Hilary Burke, of the insider, your line is open. Hi, yeah, thanks

24:26

for doing this. My question is a little bit similar to what Helen asked earlier, but you talked about being ready for the next threat and the new tools you've developed during COVID outbreak. I'm curious, you know, what's different, if anything about the type of surveillance you're doing now, for things like influenza because of what you've implemented for COVID? And, you know, do you think that this would help you recognize a new threat faster than before? Can you talk a little bit about the future?

24:55

Yes, absolutely. I'm really glad you raised that. While Well, we are competent in the data that we have with respect to COVID. Going forward, as you heard me note and discuss with Helen, in many respects, those data are more insightful than what we currently have for RSV and influenza, that should not be taken to mean that we're good with RSV, and influenza, our entire public health data strategy, and our data Modernization Initiative are designed to lift up those other diseases to where we currently are with respect to COVID. So for example, I'll just give you 111 example of that, around around vaccination coverage, right, we still receive the weekly feeds from jurisdictions around ongoing COVID vaccination. But with respect to influenza, and RSV, with the flu, we receive that at best quarterly. In addition to some other surveys we do. And for RSV, of course, there's not a vaccine. But that's an example where we'd like to lift up, the Insight is in the surveillance approach to other infectious diseases, rather than less resting on our laurels with respect to COVID. And that's about that's what I meant about the work

26:03

ahead of us.

26:07

See, we have time for two more questions.

26:10

Thank you. Our next question comes from Spencer Kimball of CNBC. Your line is open.

26:17

Hi, thank you. Can you just walk me through what will be visible on the COVID? Data tracker, data tracker after May 11? I mean, my understanding from reading this and what you all it said is that weekly case data and weekly death data will not be visible. And it will primarily be hospitalization data. And with the death data with that transitioning to, you know, a new authority responsible for it, how often will def data be reported in the future? Thank you.

26:51

You're happy to take that to others, Brendan Jackson. So our two main indicators at the top are going to be hospitalizations and deaths, both are going to be continued to be available on a weekly update schedule. And I will note there'll be a slight change with the death data how that's reported. I think it's important to note the way we've been getting it in the aggregate that data in the same way a lot of new sources have been scraping it from state websites, we've been doing that but plus we have direct data feeds from the from the jurisdictions, those are generally based on date of report, not the actual date of death, what we're switching to now is actually a more stable form, where it's actually going to be reporting based on the date of death. So I think that you'll note that there's the date of the death data that we've had can be kind of spiky, right, there's gonna be batched reporting and those type of issues, moving to this death certificate based format should smooth that out, and we'll see it better. What that means, though, is in the past week, we had sort of a false sense of where things were, because it was based on data report, in the past week was now going to now it's gonna be based on date of death, we got a new metric that goes there, that is the percent of all deaths that have been reported for that week, that are caused by COVID. And what this does is this gets sort of addresses the problem

where you know, desk gigs can sort of come in and get reported at slightly different times. And that addresses for that, when you look backwards from there, you'll still get the total number of deaths as they fill in. But definitely, we're still going to have those data, it's just going to look a little bit different in terms of how those are displayed, you'll still be able to see the number of deaths that have been reported for the last we just understanding those are still going to be incomplete for a couple of weeks. While this is a to fill in. In addition to hospitalization and deaths, we're going to have emergency department visits, we're going to be displayed more prominently, wastewater data will still be there. And then in a couple of weeks, we're going to have that new nerves system for test positivity as the national test positive positive positivity system comes away number of other data sources that we're still going to have their genomic surveillance, all the traveler base genomic surveillance, wastewater, genomic surveillance, like there's a lot of other stuff that's still going to be there really the main changes are going to be the case data no longer displayed as prominently. Again, the line level case data that Dr. Shawn mentioned, will still be there in terms of the demographics, at least for a while until we move that to that to a different site. And then the national level test positivity in terms of the because of the COVID electronic lab reporting receiver CLR. A system is going to wait to be replaced by the by the nervous system. Anything you'd like to add Dr. Shaw? I think we're good. Thanks.

29:14

Our last question, please.

29:17

Thank you. Our last question comes from Alexander 10 of CBS News. Your line is open.

29:24

I thanks for doing this. I said three things I was hoping maybe Dr. Jackson could clarify. So is the plan to have new specific thresholds from this metric on when the general population is recommended to take precautions like masking or will there no longer be those thresholds? Will source control and healthcare settings be tied to this new metric? And is both this new metric and the guidance ready to go tomorrow? Thanks so much.

29:55

You're absolutely happy Jake does

29:58

so essentially To the COVID community levels, which are again, targeted at, you know, the public and individuals, those are basically going to remain largely intact, just switching to the COVID hospital admission levels. I'll point out that right now 99 point plus percent of the population is in a low community level. And that would be basically the same for these new hospital admission levels. We understand that there's going to be a mix of uptake in this and the uptake may be low in some areas. But we feel it's important to put out there that when things get to a high level, and when hospitalizations if they do, we don't know if they will, in large part, but get to get to those high Community High was committee levels now the hospital admission levels, there will be a recommendation at least for people to wear masks your to the second question for the healthcare infection prevention and control guidance in the source control masking. At a minimum, the recommendation is for healthcare facilities to recommend facility wide masking when it's recommended in the community. So following those those those same levels that we just discussed for the public, there will be additional recommendations for when facilities may wish to also implement either sort of unit wide or facility wide masking recommendations based on the type of patients that they're caring for, you know, are they a higher risk patient group

versus a lower risk patient group, and also sort of the broader picture what's happening in their facility, whether they're having a facility based outbreak. And also this is sort of tying back to like, you know, pre existing pre pandemic infection control guidance that has already been in place, which is if you're seeing lots of respiratory disease in the community, whether it's COVID, or something else, like blue or RSV, that might be a time to also put in place masking recommendations for the facility. And in terms of the timing, I will defer to others on the exact timing about I don't believe it'll go ahead tomorrow. But it'll be it'll be coming quite soon within the next week. And I do I just wanted to add one point to the previous question about what's going to be uncovered data tracker, vaccine administration data will still be present on COVID data tracker, there will be a later pivot to focusing more on sort of the vaccine coverage data, but vaccine data will absolutely continue to be uncovered data tracker, thanks. Great.

32:07

Before we adjourn for the afternoon, I wanted to just offer two clarifying points based on the discussion that we've just had. The first is around the hospital reporting data, what we will continue to retain versus what may go by the wayside or what will go by the wayside, much of what will go by the wayside or when one example of that is around suspect cases, suspect cases were instituted to be reported early on in the process early on in the pandemic. This was in an era when testing was scarce. And we needed to have a sense of how many people were coming into the hospital, who likely had COVID. But we weren't sure, because of a lack of testing. Of course, now, testing is plentiful. And thus the concept of the suspect case, it's a difficult thing for a hospital to ascertain it requires someone to go around and figure out what's going on there. And it's not something that adds a lot of data or value to our understanding of COVID. That's an example of what's going away on the hospital front. Second clarifying question, there were some there's some discussion around our views around how we understand COVID relative to other respiratory infectious diseases. And for the for clarity around that, I wanted to go through just a couple of the axes. A couple of the examples of where with respect to COVID, we will have superior insight relative to RSV and influenza cases, we will continue to get some degree of case reporting and those will be on our website for COVID in a manner that we don't for RSV and influenza Death Reporting, we will continue to have improved Death Reporting data. As Dr. Jackson has noted, test positivity, we are on equal footing there. The hospitalizations are key. As we've discussed, we will continue to have national hospitalization reports for COVID. Whereas right now for RSV and flu, those only exist on a seasonal basis. We've already talked about wastewater, where we will have a robust wastewater covering about 40% of Americans. Whereas for RSV and flu, they are limited. Same with genomic surveillance, where we will have several fold more surveillance for for genomic variants for COVID than we do with respect to the other diseases. So those are just some clarifying examples for where we are right now to close again, our mission ahead of us is to lift all of those up to the same plateau that COVID is on right now. And that's the work we're committed to doing. Thank you. I'll turn it back to Ben.

34:26

Thank you, Dr. Sean Jackson, for joining us today. And to all the reporter thank you for your participation. I want to remind you that today's briefing is embargoed until tomorrow, May 5 at 11am. Eastern when the report goes live on the CDC website. If you have follow up questions, please call the main press office at 404-639-3286 or you can email media@cdc.gov Thank you This will conclude our call.

34:58

Thank you, that does conclude Today's conference you may disconnect at this time thank you and have a good day

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Last Reviewed: May 8, 2023