COVIDView
A Weekly Surveillance Summary of U.S. COVID-19 Activity

Key Updates for Week 32, ending August 8, 2020

Nationally, levels of influenza-like illness (ILI) are below baseline but higher than typically seen at this time of year. Indicators that track ILI and COVID-19-like illness (CLI) and the percentage of laboratory tests positive for SARS-CoV-2 have continued to decrease nationally since mid-July. Regionally, from week 31 to week 32, indicators that track ILI and COVID-19-like illness (CLI) were decreasing or stable (change of ≤ 0.1%) in all regions of the country, and the percentage of laboratory tests positive for SARS-CoV-2 decreased or remained the same in nine of ten HHS regions. Weekly hospitalization rates and mortality attributed to COVID-19 declined during week 32 but may change as more data for admissions and deaths occurring during recent weeks are received. Mortality attributed to COVID-19 remains above the epidemic threshold.

Virus

Public Health, Commercial and Clinical Laboratories

Nationally, the percentage of respiratory specimens testing positive for SARS-CoV-2 decreased from 7.7% during week 31 to 7.0% during week 32 and decreased or remained the same in nine of ten HHS regions. National percentages of specimens testing positive for SARS-CoV-2 by type of laboratory are listed as follows:

- Public health laboratories – decreased from 7.9% during week 31 to 7.0% during week 32;
- Clinical laboratories – decreased from 6.3% during week 31 to 5.8% during week 32;
- Commercial laboratories – decreased from 7.9% during week 31 to 7.1% during week 32.

Outpatient and Emergency Department Visits

Outpatient Influenza-Like Illness Network (ILINet) and National Syndromic Surveillance Program (NSSP)

Two surveillance networks are being used to track outpatient or emergency department (ED) visits for illness with symptoms compatible with COVID-19.

- Nationally, ILI activity remains below baseline for the seventeenth week but is higher than typically seen at this time of year.
- Nationally, during week 32, the percentage of visits reported by ILINet participants for ILI was 1.1% and has declined for three consecutive week; the percentage of visits for CLI reported to NSSP was 2.6% and has declined for four consecutive weeks.
- Recent changes in health care seeking behavior, including increasing use of telemedicine, recommendations to limit emergency department (ED) visits to severe illnesses, and increased social distancing, are likely affecting data reported from both networks, making it difficult to draw conclusions at this time. Tracking these systems moving forward will give additional insight into illness related to COVID-19.

Severe Disease

Hospitalizations

Cumulative COVID-19-associated hospitalization rates since March 1, 2020, are updated weekly. The overall cumulative COVID-19 hospitalization rate is 144.1 per 100,000, with the highest rates in people aged 65 years and older (394.2 per 100,000) and 50-64 years (217.0 per 100,000).

Mortality

Based on death certificate data, the percentage of deaths attributed to pneumonia, influenza or COVID-19 (PIC) increased from week 26 – week 30 (June 27 – July 25) for the first time since mid-April. The percentage for week 32 is 8.1% and currently lower than the percentage during week 31 (12.5%); however, the percentage remains above the epidemic threshold. Percentages for recent weeks will likely increase as more death certificates are processed.

All data are preliminary and may change as more reports are received. A description of the surveillance systems summarized in COVIDView, including methodology and detailed descriptions of each data component, is available on the surveillance methods page.

Key Points

o Nationally, the percentage of specimens testing positive for SARS-CoV-2 and the percentages of visits for ILI and CLI have continued to decrease since mid-July.

o Using combined data from the three laboratory types, the national percentage of respiratory specimens testing positive for SARS-CoV-2 with a molecular assay decreased from 7.7% during week 31 to 7.0% during week 32.
  - o Regionally, the percentage of respiratory specimens testing positive for SARS-CoV-2 also declined or remained the same in nine of ten HHS regions. A small increase of 0.2% was seen in Region 2 (NY/NJ/Puerto Rico).
  - o The highest percentages of specimens testing positive for SARS-CoV-2 were seen in Regions 4 (South East, 11.5%) and 6 (South Central, 12.6%). The percentage is declining in both regions following peaks seen in week 28 and 27, respectively.

o The percentage of outpatient and ED visits for ILI are below baseline nationally and in all regions of the country; however, ILI activity is above what is typical for this time of year. The percentage of visits to EDs for CLI decreased nationally for the fourth consecutive week and, compared to the previous week, decreased in all ten HHS regions.
  - o Systems monitoring ILI and CLI may be influenced by recent changes in health care seeking behavior, including increasing use of telemedicine, recommendations to limit emergency department (ED) visits to severe illnesses, and increased social distancing.

o The overall cumulative COVID-19-associated hospitalization rate was 144.1 per 100,000; rates were highest in people 65 years of age and older (394.2 per 100,000) followed by people 50-64 years (217.0 per 100,000). Cumulative hospitalization rates will increase as the pandemic continues.
  - o From week 25 – week 29 (weeks ending June 20 – July 18), overall weekly hospitalization rates increased for four consecutive weeks. Weekly rates have declined during the most recent three weeks but may increase as more data are received.
  - o Non-Hispanic American Indian or Alaska Native persons had an age-adjusted hospitalization rate approximately 5 times that of non-Hispanic White persons. Rates among non-Hispanic Black persons and Hispanic or Latino persons were both approximately 4.7 times the rate among non-Hispanic White persons.

o Based on death certificate data, the percentage of deaths attributed to pneumonia, influenza or COVID-19 (PIC) increased from week 26 – week 30 (weeks ending June 27 – July 25) after declining for 11 weeks since mid-April. The percentage of deaths due to PIC for week 32 is 8.1%, lower than the percentage during week 31 (12.5%), but above the epidemic threshold. These percentages will likely increase as more death certificates are processed.

o All surveillance systems aim to provide the most complete data available. Estimates from previous weeks are subject to change as data are updated with the most complete data available.

U.S. Virologic Surveillance

The number of specimens tested for SARS-CoV-2 using a molecular assay and reported to CDC by public health laboratories and a subset of clinical and commercial laboratories in the United States are summarized below. All laboratories are performing primary diagnostic functions; therefore, the percentage of specimens testing positive across laboratory types can be used to monitor overall trends in COVID-19 activity. As the outbreak progresses, it is possible that different types of laboratories will take on different roles, and the data interpretation may need to change.

Summary of Laboratory Testing Results Reported to CDC*	Week 32 (August 2 – August 8, 2020)	Cumulative since March 1, 2020
No. of specimens tested	2,020,771	38,026,858
Public Health Laboratories	256,042	4,286,454
Clinical Laboratories	147,862	3,868,206
Commercial Laboratories	1,616,867	29,872,198
No. of positive specimens (%)	141,923 (7.0%)	3,522,138 (9.3%)
Public Health Laboratories	18,010 (7.0%)	352,735 (8.2%)
Clinical Laboratories	8,609 (5.8%)	244,094 (6.3%)
Commercial Laboratories	115,304 (7.1%)	2,925,309 (9.8%)

* Commercial and clinical laboratory data represent select laboratories and do not capture all tests performed in the United States.
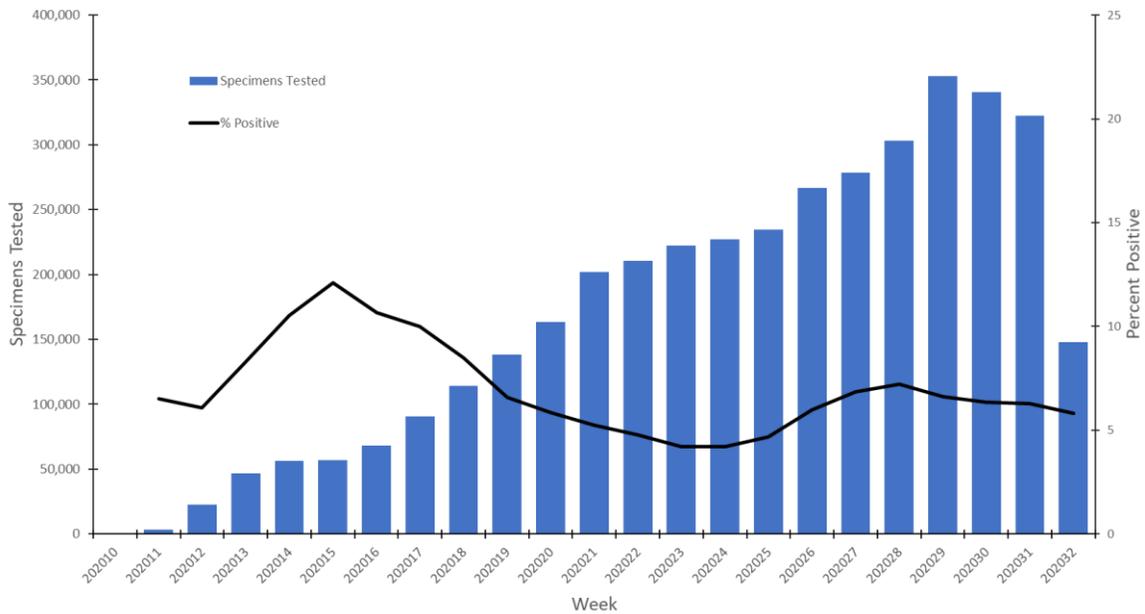
Public Health Laboratories

U.S. State and Local Public Health Laboratories Reporting to CDC:
Number of Specimens Tested and Percent Positive for SARS-CoV-2
March 1, 2020 – August 8, 2020
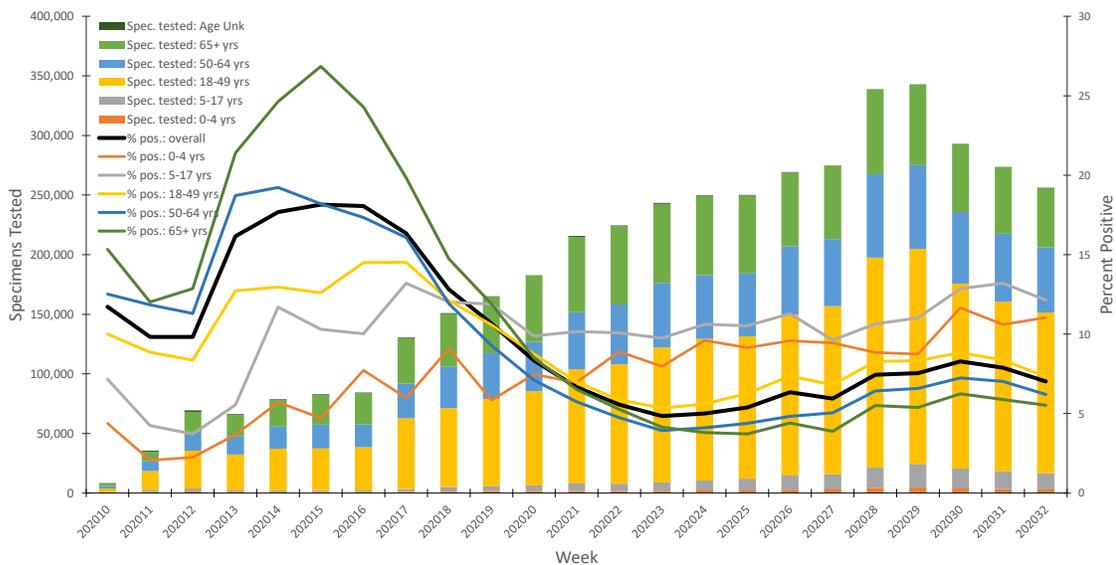
Clinical Laboratories

U.S. Clinical Laboratories Reporting to the National Respiratory and Enteric Virus Surveillance System: Number of Specimens Tested and Percent Positive for SARS-CoV-2
March 8, 2020 – August 8, 2020

Commercial Laboratories

Select Commercial Laboratories Reporting to CDC:
Number of Specimens Tested and Percent Positive for SARS-CoV-2
March 29, 2020 – August 8, 2020
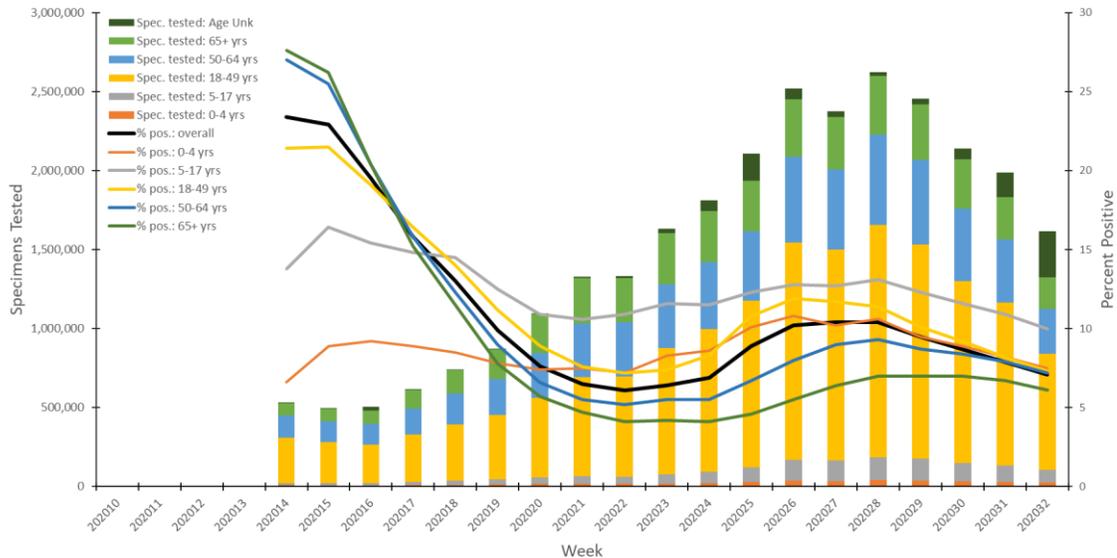
* Commercial laboratories began testing for SARS-CoV-2 in early March, but the number and geographic distribution of reporting commercial laboratories became stable enough to calculate a weekly percentage of specimens testing positive as of March 29, 2020.

Additional virologic surveillance information: Surveillance Methods
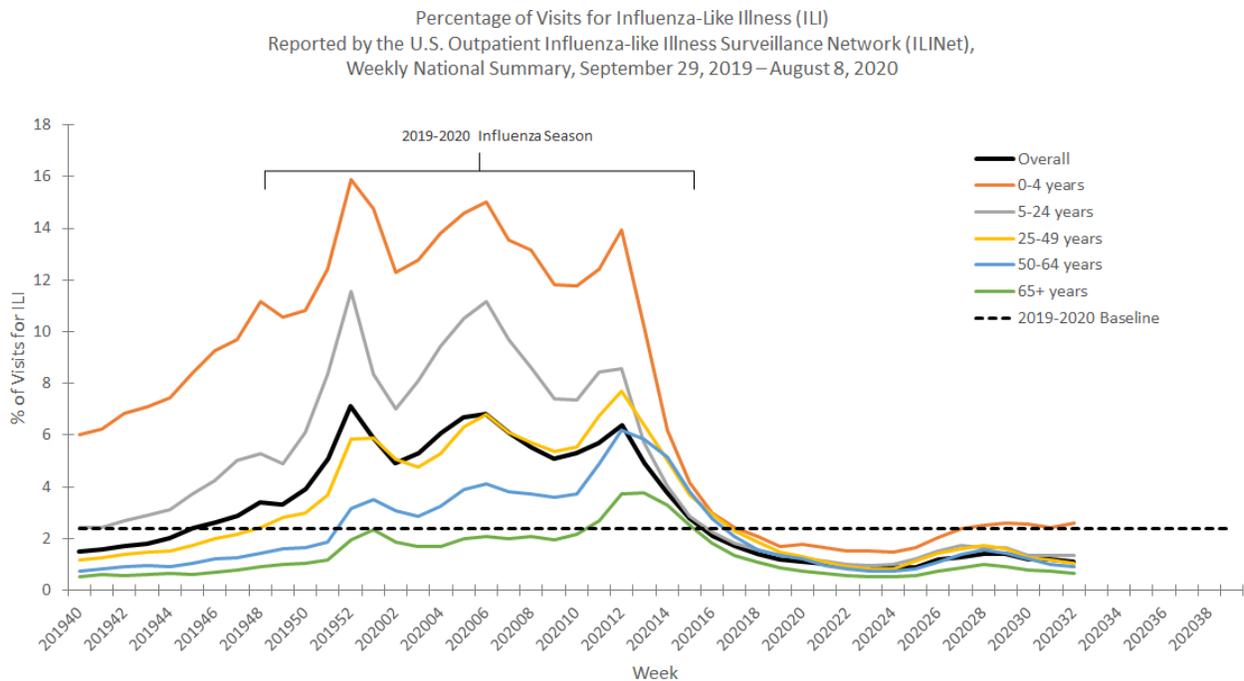
Outpatient/Emergency Department Illness

Two syndromic surveillance systems are being used to monitor trends in outpatient and emergency department (ED) visits that may be associated with COVID-19 illness. Each system monitors a slightly different syndrome, and together, these systems provide a more comprehensive picture of mild-to-moderate COVID-19 illness than either would individually. Both systems are currently being affected by changes in health care seeking behavior, including increased use of telemedicine, compliance with recommendations to limit ED visits to severe illnesses, and increased social distancing. These changes affect the numbers of people seeking care in the outpatient and ED settings and their reasons for doing so.

ILINet

The U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) provides data on visits for influenza-like illness (ILI) (fever [≥ 100°F] and cough and/or sore throat) to approximately 2,600 primary care providers, emergency departments, and urgent care centers in all 50 states, Puerto Rico, the District of Columbia, and the U.S. Virgin Islands. Mild COVID-19 illness presents with symptoms similar to ILI, so ILINet is being used to track trends of mild-to-moderate COVID-19 illness and allows for comparison with prior influenza seasons.

Nationwide during week 32, 1.1% of patient visits reported through ILINet were due to ILI. This percentage is well below the national baseline of 2.4% but, while low overall, is higher than what is typical for this time of year compared to previous influenza seasons. Compared to week 31, the percentage of visits for ILI during week 32 was slightly lower overall. The percentage was slightly higher among those aged 0-4 years during week 32 compared to week 31, while the percentage in all other age groups was lower or the same.

Percentage of Visits for Influenza-Like Illness (ILI)
Reported by the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet),
Weekly National Summary, September 29, 2019 – August 8, 2020

* Age-group specific percentages should not be compared to the national baseline.

On a regional level, the percentage of outpatient visits for ILI ranged from 0.5% to 1.4% during week 32. In all ten regions, the percentage of outpatient visits for ILI is below the region-specific baseline and has either declined or remained stable (changes ≤ 0.1%) over the most recent three weeks.

Note: In response to the COVID-19 pandemic, new data sources will be incorporated into ILINet as we move into summer weeks, when lower levels of influenza and other respiratory virus circulation are typical. Starting in week 21, increases in the number of patient visits will be seen as new sites are enrolled and the percentage of visits for ILI may change in comparison to previous weeks. While all regions remain below baseline levels for ILI, these system changes should be considered when drawing conclusions from these data. Any changes in ILI due to changes in respiratory virus circulation will be highlighted here.
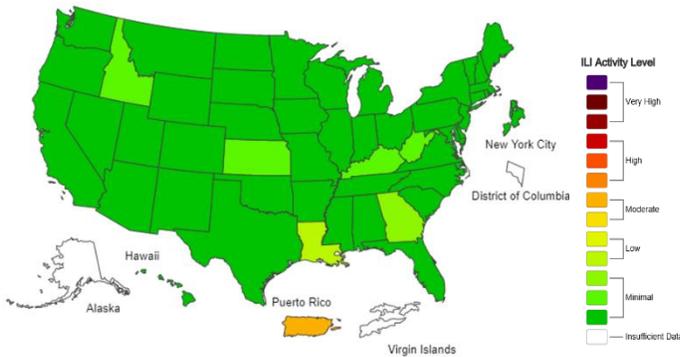
ILI Activity Levels
Data collected in ILINet are used to produce a measure of ILI activity for all 50 states, Puerto Rico, the District of Columbia, and New York City. The mean reported percentage of visits due to ILI for the current week is compared to the mean reported during non-influenza weeks, and the activity levels correspond to the number of standard deviations below, at, or above the mean.

The number of jurisdictions at each activity level during week 32 and changes compared to the previous week are summarized in the table below and shown in the following maps.

Activity Level	Number of Jurisdictions	
	Week 32 (Week ending August 8, 2020)	Compared to Previous Week
Very High	0	No change
High	0	No change
Moderate	1	No change
Low	0	-1
Minimal	50	+1
Insufficient Data	3	No change

ILI Activity Level Map, Week 31 Ending August 1, 2020

**ILI Activity Level Map, Week 32 Ending August 8, 2020**
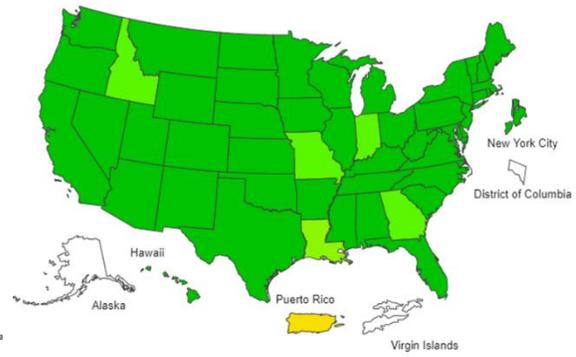
*Data collected in ILINet may disproportionally represent certain populations within a state and may not accurately depict the full picture of influenza activity for the whole state. Differences in the data presented here by CDC and independently by some state health departments likely represent differing levels of data completeness with data presented by the state likely being the more complete.

National Syndromic Surveillance Program (NSSP): Emergency Department (ED) Visits

NSSP is a collaboration among CDC, federal partners, local, and state health departments and academic and private sector partners to collect, analyze, and share electronic patient encounter data received from multiple health care settings. To track trends of potential COVID-19 visits, visits for COVID-19-like illness (CLI) (fever and cough or shortness of breath or difficulty breathing or presence of a coronavirus diagnosis code) and ILI to a subset of emergency departments in 47 states are being monitored.

Nationwide during week 32, 2.6% of emergency department visits captured in NSSP were due to CLI and 0.7% were due to ILI. Compared to week 31, this week there was a decrease in both percentages of visits for CLI and ILI. This was the fourth consecutive week the percentages of visits for CLI and ILI decreased. For the past three weeks, the percentages of visits for CLI and ILI decreased or remained stable (changes of ≤ 0.1%) in all ten HHS regions.

NSSP: Percentage of Visits for Influenza-Like Illness (ILI) and COVID-19-Like Illness (CLI) to Emergency Departments
Weekly National Summary, September 29, 2019 - August 8, 2020
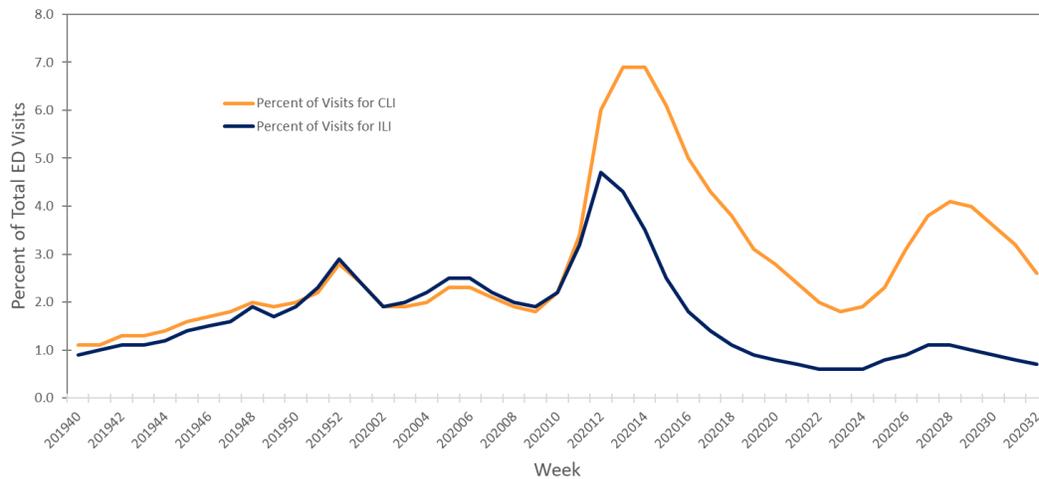
Additional information about medically attended outpatient and emergency department visits for ILI and CLI: Surveillance Methods

COVIDView Week 32, ending August 8, 2020

Hospitalizations

The COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) conducts population-based surveillance for laboratory-confirmed COVID-19-associated hospitalizations in select counties participating in the Emerging Infections Program (EIP) and the Influenza Hospitalization Surveillance Project (IHSP).

A total of 46,986 laboratory-confirmed COVID-19-associated hospitalizations were reported by sites between March 1, 2020, and August 8, 2020. The overall cumulative hospitalization rate was 144.1 per 100,000 population. Among the 0-4 year, 5-17 year, 18-49 year, 50-64 year, and ≥ 65 year age groups, the highest rate of hospitalization was among adults aged ≥ 65 years, followed by adults aged 50-64 years and adults aged 18-49 years.

Laboratory-Confirmed COVID-19-Associated Hospitalizations

Preliminary cumulative rates as of Aug 08, 2020
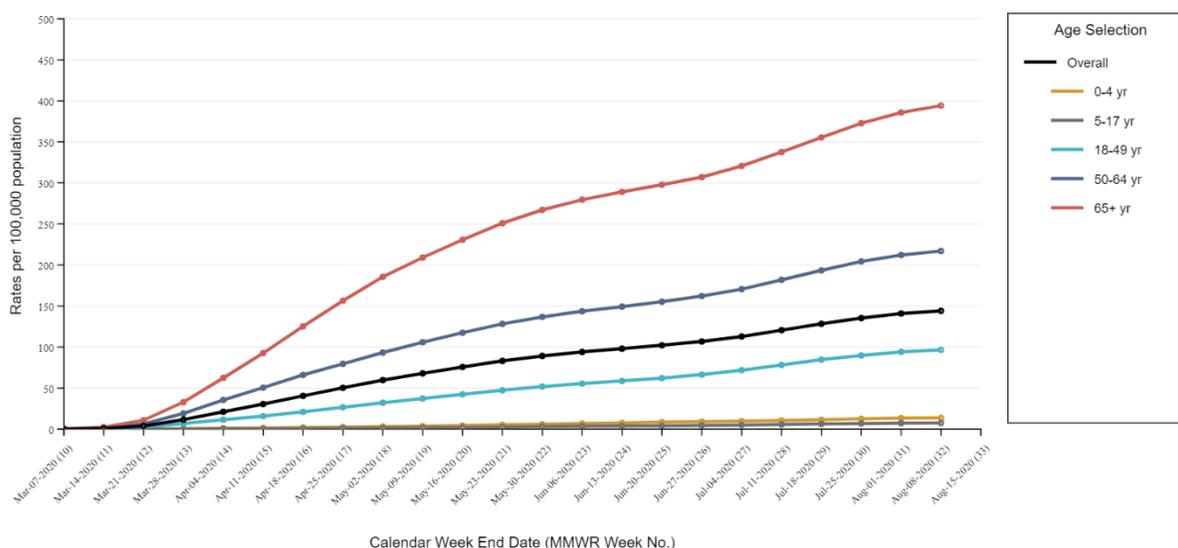
Age Group	Cumulative Rate per 100,000 Population
Overall	144.1
0-4 years	13.6
5-17 years	7.4
18-49 years	96.5
18-29 years	59.5
30-39 years	95.5
40-49 years	145.5
50-64 years	217.0
65+ years	394.2
65-74 years	294.0
75-84 years	467.9
85+ years	720.8

From June 20 (MMWR week 25)–July 18 (MMWR week 29), there was an increase in overall weekly hospitalization rates for four consecutive weeks. Data for the weeks ending July 25, August 1, and August 8 (MMWR weeks 30, 31, and 32) currently show a decline; however, this trend may change as more data for admissions occurring during those weeks are received.

Laboratory-Confirmed COVID-19-Associated Hospitalizations

Preliminary weekly rates as of Aug 08, 2020
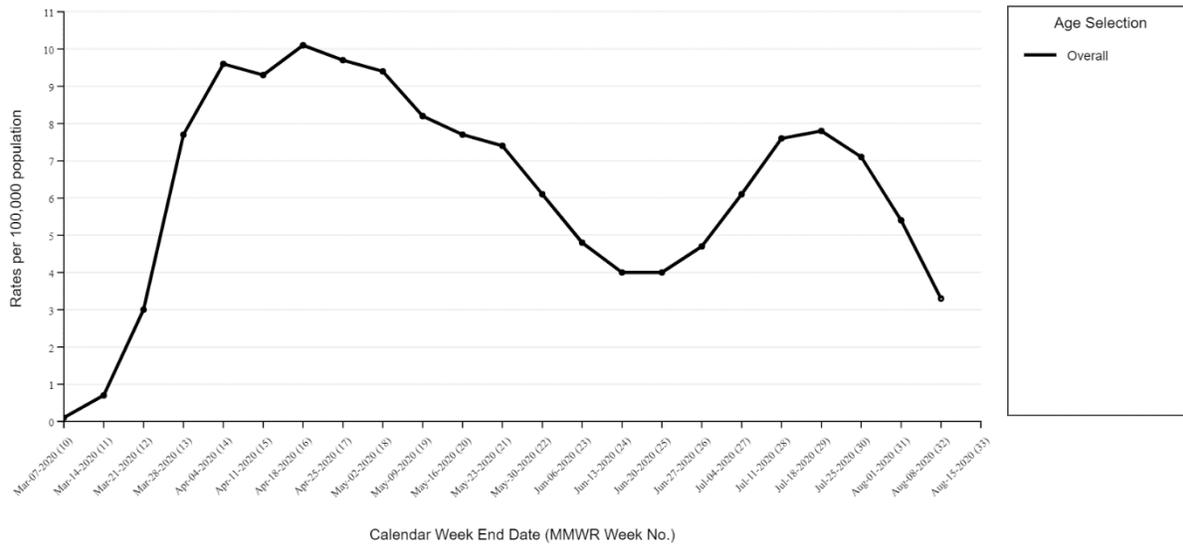
Among the 46,986 laboratory-confirmed COVID-19-associated hospitalized cases, 44,304 (94.3%) had information on race and ethnicity, while collection of race and ethnicity was still pending for 2,682 (5.7%) cases. When examining overall age-adjusted rates by race/ethnicity, non-Hispanic American Indian or Alaska Native persons had an age-adjusted hospitalization rate approximately 5 times that of non-Hispanic White persons. Rates for non-Hispanic Black persons and Hispanic or Latino persons were both approximately 4.7 times the rate among non-Hispanic White persons.

Age-adjusted COVID-19-associated hospitalization rates by race and ethnicity — COVID-NET, March 1–August 8, 2020
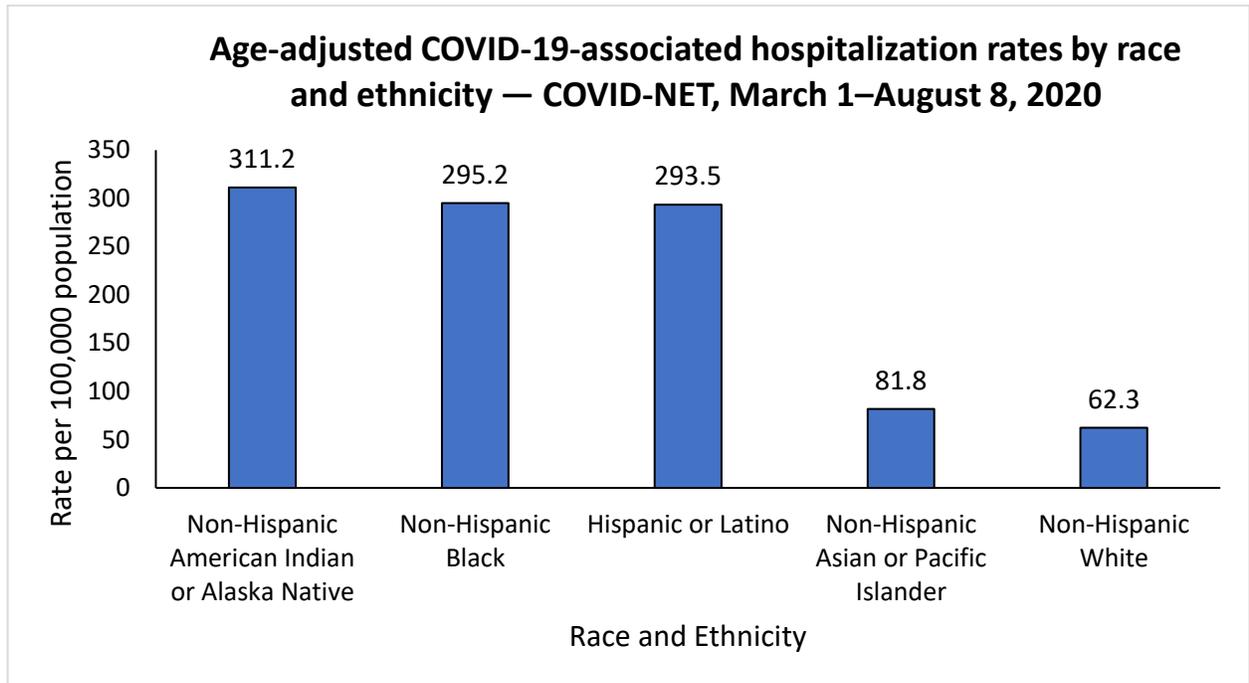
When examining age-stratified crude hospitalization rates by race and ethnicity, compared with non-Hispanic White persons in the same age group, crude hospitalization rates were 8.3 times higher among Hispanic or Latino persons aged 0-17 years; 9 times higher among both Hispanic or Latino and non-Hispanic American Indian or Alaska Native persons aged 18-49 years; 6.8 times higher among non-Hispanic American Indian or Alaska Native persons aged 50-64 years; and 3.8 times higher among non-Hispanic Black persons aged ≥ 65 years.

**Hospitalization rates per 100,000 population
by age and race and ethnicity — COVID-NET,
March 1, 2020–August 8, 2020**

Age Category	Non-Hispanic American Indian or Alaska Native		Non-Hispanic Black		Hispanic or Latino		Non-Hispanic Asian or Pacific Islander		Non-Hispanic White	
	Rate[1]	Rate Ratio[2,3]	Rate[1]	Rate Ratio[2,3]	Rate[1]	Rate Ratio[2,3]	Rate[1]	Rate Ratio[2,3]	Rate[1]	Rate Ratio[2,3]
0-17y	9.7	4.4	13.5	6.1	18.2	**8.3**	4.5	2.0	2.2	1
18-49y	231.2	**9.0**	154.5	6.0	229.2	**9.0**	44.7	1.7	25.6	1
50-64y	563.6	**6.8**	451.3	5.5	494.9	6.0	132.0	1.6	82.7	1
65+y	651.9	2.7	909.4	**3.8**	634.8	2.7	243.9	1.0	238.6	1
Overall rate[4] (age-adjusted)	311.2	**5.0**	295.2	4.7	293.5	4.7	81.8	1.3	62.3	1

[1] COVID-19-associated hospitalization rates by race/ethnicity are calculated using hospitalized COVID-NET cases with known race and ethnicity for the numerator and NCHS bridged-race population estimates for the denominator.
[2] For each age category, rate ratios are the ratios between crude hospitalization rates within each racial/ethnic group and the crude hospitalization rate among non-Hispanic white persons in the same age category.
[3] The highest rate ratio in each age category is presented in **bold**.
[4] Overall rates are adjusted to account for differences in age distributions within race/ethnicity strata in the COVID-NET catchment area; the age strata used for the adjustment include 0-17, 18-49, 50-64 and 65+ years.

Non-Hispanic Black persons and non-Hispanic White persons represented the highest proportions of hospitalized cases reported to COVID-NET, followed by Hispanic or Latino, non-Hispanic Asian or Pacific Islander, and non-Hispanic American Indian or Alaska Native persons. However, some racial and ethnic groups are disproportionately represented among hospitalized cases as compared with the overall population of the catchment area. Prevalence ratios show a similar pattern to that of the age-adjusted hospitalization rates: non-Hispanic American Indian or Alaska Native persons have the highest prevalence ratio, followed by non-Hispanic Black, and Hispanic or Latino persons.

Comparison of proportions of COVID-19-Associated Hospitalizations, by race and ethnicity, COVID-NET, March 1–August 8, 2020
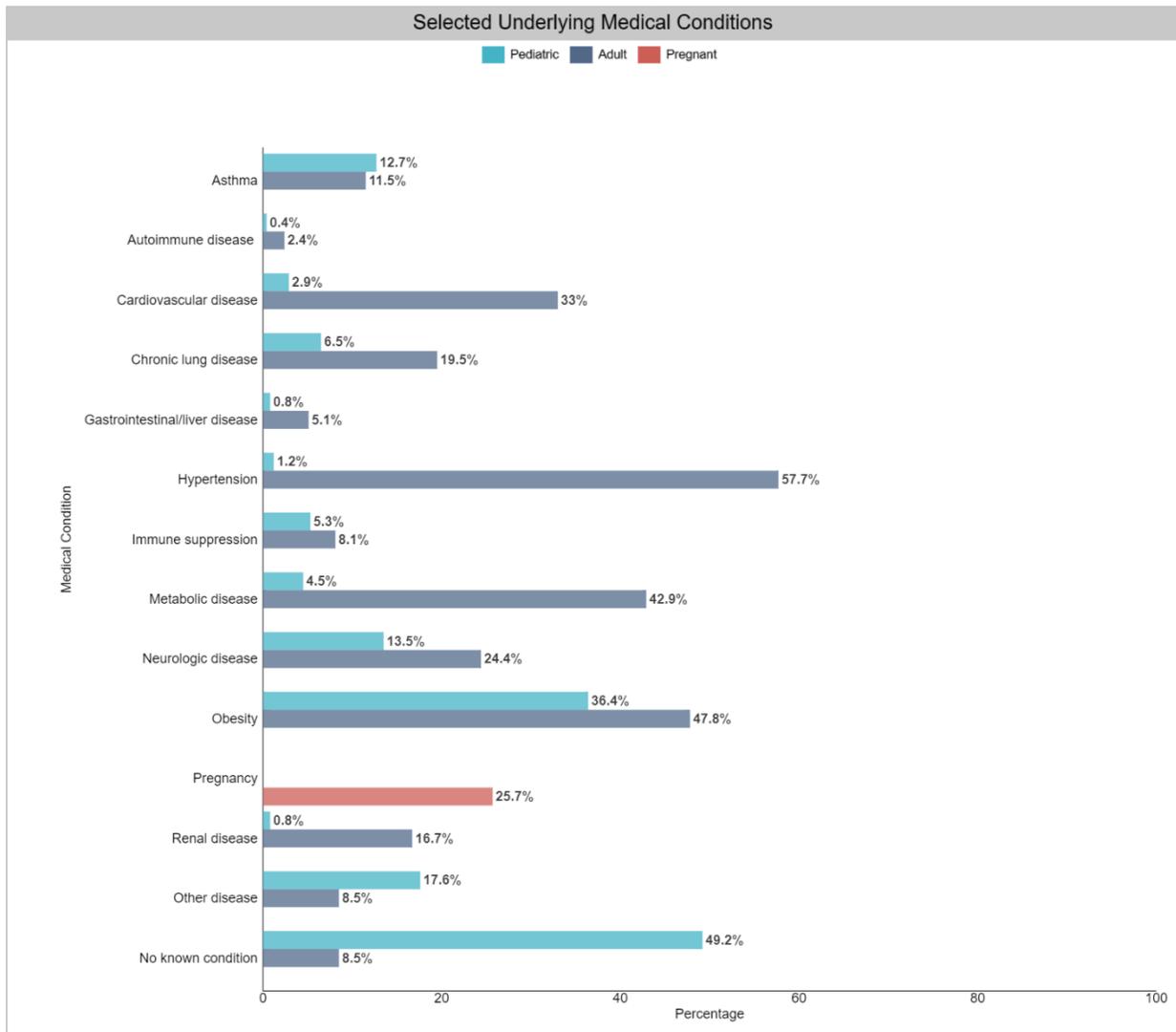
	Non-Hispanic American Indian or Alaska Native	Non-Hispanic Black	Hispanic or Latino	Non-Hispanic Asian or Pacific Islander	Non-Hispanic White
Proportion of hospitalized COVID-NET cases[1]	1.4%	33.2%	23.1%	4.9%	31.3%
Proportion of population in COVID-NET catchment area	0.7%	17.9%	14.1%	8.9%	58.5%
Prevalence ratios[2]	2.0	1.9	1.6	0.6	0.5

[1] Persons of multiple races (0.2%) or unknown race and ethnicity (6%) are not represented in the table but are included as part of the denominator.
[2] Prevalence ratio is calculated as the ratio of the proportion of hospitalized COVID-NET cases over the proportion of population in COVID-NET catchment area.

Among 8,777 hospitalized adults with information on underlying medical conditions, 91.5% had at least one reported underlying medical condition. The most commonly reported were hypertension, obesity, metabolic disease, and cardiovascular disease. Among 246 hospitalized children with information on underlying conditions, 50.8% had at least one reported underlying medical condition. The most commonly reported were obesity, neurologic disease, and asthma.

COVID-19 Laboratory-Confirmed Hospitalizations
Preliminary data as of Aug 08, 2020

Selected Underlying Medical Conditions

Legend: ▬ Pediatric ▬ Adult ▬ Pregnant

Medical Condition	Pediatric	Adult	Pregnant
Asthma	12.7%	11.5%	
Autoimmune disease	0.4%	2.4%	
Cardiovascular disease	2.9%	33%	
Chronic lung disease	6.5%	19.5%	
Gastrointestinal/liver disease	0.8%	5.1%	
Hypertension	1.2%	57.7%	
Immune suppression	5.3%	8.1%	
Metabolic disease	4.5%	42.9%	
Neurologic disease	13.5%	24.4%	
Obesity	36.4%	47.8%	
Pregnancy			25.7%
Renal disease	0.8%	16.7%	
Other disease	17.6%	8.5%	
No known condition	49.2%	8.5%	

Percentage (x-axis: 0 to 100)

Additional data on demographics, signs and symptoms at admission, underlying conditions, interventions, outcomes and discharge diagnoses, stratified by age, sex and race and ethnicity, are available.
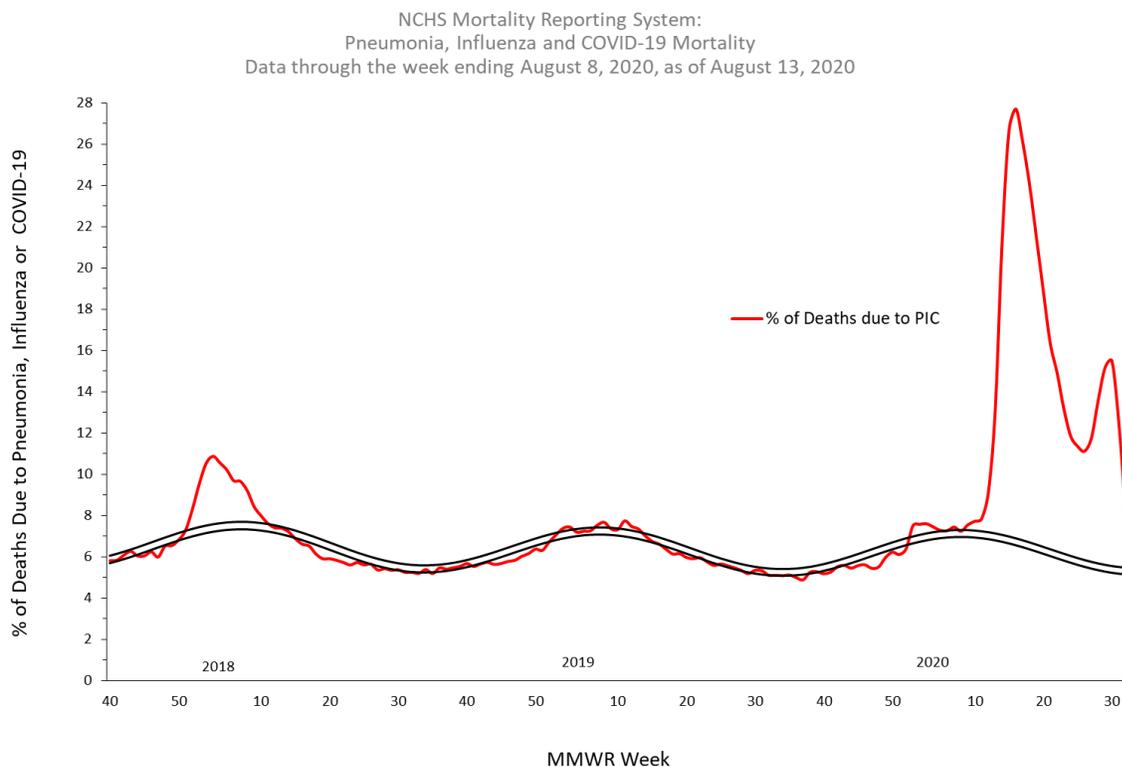
Additional hospitalization surveillance information:
Surveillance Methods | Additional rate data | Additional demographic and clinical data

CDC

Mortality Surveillance

The National Center for Health Statistics (NCHS) collects death certificate data from vital statistics offices for all deaths occurring in the United States. Based on death certificate data available on August 6, 2020, the percentage of deaths attributed to pneumonia, influenza, or COVID-19 (PIC) increased from week 26 – week 30 (June 27 – July 25) after declining for 11 weeks since mid-April. The percentage of deaths due to PIC for week 32 is 8.1% and, while lower than the percentage during week 31 (12.5%), remains above the epidemic threshold. Percentages for recent weeks will likely increase as more death certificates are processed.

Weekly mortality surveillance data include a combination of machine coded and manually coded causes of death collected from death certificates. Percentages of deaths due to PIC are higher among manually coded records than more rapidly available machine coded records. Due to the additional time needed for manual coding, the initially reported PIC percentages may be lower than percentages calculated from final data.

NCHS Mortality Reporting System:
Pneumonia, Influenza and COVID-19 Mortality
Data through the week ending August 8, 2020, as of August 13, 2020

*Data during recent weeks are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS and processed for reporting purposes.

Additional NCHS mortality surveillance information: Surveillance Methods | Provisional Death Counts for COVID-19

Report prepared: August 13, 2020

Detailed data tables are available on the COVIDView page