DHSS Electronic COVID-19 Case Reporting System
Frequently Asked Questions
Updated August 11, 2020

1. **Should Local Public Health Agencies (LPHAs) enter positive COVID-19 cases into this system?**

   No, LPHAs should enter COVID-19 case data directly into EpiTrax. For more information on the EpiTrax disease surveillance system, visit [https://clphs.health.mo.gov/lphs/epitrax/](https://clphs.health.mo.gov/lphs/epitrax/).

2. **Does the electronic COVID-19 Case Reporting system send the positive case information to my local public health agency?**

   Positive cases will continue to be reported to the local jurisdiction from DHSS. Upon receipt of a report in the electronic COVID-19 Case Reporting System, the information will be in the EpiTrax system within 24 hours*. LPHAs will be able to access the case information in EpiTrax.

   We encourage LPHAs who are currently asking providers in their community to notify them separately to reach out and let them know this is no longer necessary because of the upgraded system.

   Note: The Department is currently working to integrate the Electronic COVID-19 Case Reporting System with EpiTrax. Once integration is complete (tentatively planned for early September), the information submitted will be immediately available in EpiTrax.

   *The 24 hour timeframe may be delayed slightly when technical issues arise or an extremely high volume of reports is received in a 24 hour timeframe.

3. **Will the COVID-19 cases submitted to the electronic COVID-19 Case Reporting system be assigned by jurisdiction?**

   Case data submitted through the system will flow into EpiTrax which will assign cases by jurisdiction according to the Patient County identified in the submission.

4. **As a long term care facility, where do I report a positive COVID-19 case? What about my testing spreadsheet?**

   All community providers, including long term care facilities, should enter positive case information into the electronic COVID-19 Case Reporting system.

   Testing spreadsheets should be uploaded to the designated link at [https://redcapdrltc.azurewebsites.net/redcap/surveys/?s=EEXEJPJJY4](https://redcapdrltc.azurewebsites.net/redcap/surveys/?s=EEXEJPJJY4). Do not report new positive COVID-19 case information in this location.
5. **What happened to the congregate facility reporting system?**

The congregate facility reporting system was removed and replaced by the electronic COVID-19 Case Reporting system. A congregate facility can fulfill both the requirement to submit a case report (CD-1 form) and the congregate facility reporting requirement by entering a positive COVID-19 case into the new system.

6. **I currently fax/email a copy of the CD-1 to my LPHA after sending it to DHSS. Will I now have to do both?**

LPHAs and Regional Epidemiologists will have access to the information submitted in EpiTrax (see question 1). Providers should contact their local LPHA to ensure this is sufficient to fulfill the local reporting requirement.

7. **What data elements are required to submit a case report in the electronic COVID-19 Case Reporting system?**

The following data elements are required to submit a complete COVID-19 case report:

<table>
<thead>
<tr>
<th>Reporter Information (Page 1):</th>
<th>Patient Information (Page 2):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Report</td>
<td>Patient Name</td>
</tr>
<tr>
<td>Reporter Name</td>
<td>Patient DOB</td>
</tr>
<tr>
<td>Reporter Entity Type</td>
<td>Patient Address</td>
</tr>
<tr>
<td>Organization Name</td>
<td>Patient Phone</td>
</tr>
<tr>
<td>Reporter Address</td>
<td>Patient Gender</td>
</tr>
<tr>
<td>Reporter Email</td>
<td>Patient Race</td>
</tr>
<tr>
<td>Reporter Phone</td>
<td>Patient Ethnicity</td>
</tr>
</tbody>
</table>

All other data elements are not required or allow an “unknown” option. If you miss any of the required data elements, the system will alert you to complete those fields before you can move on.

See Appendix 2 for a full listing of data elements.

8. **I am not the reporting laboratory, but I have the lab results. Should I enter these into the system?**

No. Do not complete this section. The Department is working to remove this section, as there is already a process in place for labs to submit results to the Department.

9. **Can I enter cases using the system if I only have Internet Explorer as a browser?**

No, the system requires Google Chrome, Microsoft Edge, or a similarly modern type of browser. Users who only have Internet Explorer should continue to report cases via the paper CD-1 form.
10. Is there a way to print or save what I have submitted?

This feature is not currently available. The Department is working to complete this upgrade.

11. Is there a user guide available for the system?

The Department is currently working to create a user guide. Once available, it will be posted below the reporting system button.

12. The patient is a resident of a congregate facility, but I am not the reporting facility. How do I complete the data elements in Section 7 (See Appendix 2)?

The Department is currently working to allow an option for users to indicate they do not have this information as they are not the reporting facility. In the meantime, please enter ‘1’ in the numerical sections and select ‘Unknown’ for all other questions in this section.

13. How do the COVID-19 data systems work together?

DHSS has a suite of software solutions designed to collect and manage COVID-19 case information, foster contact tracing activities, and ease the burden of reporting for LPHAs. See Appendix 1 for a comparison of the systems.

EpiTrax is a comprehensive disease surveillance system that houses case information and helps to manage cases.

MO ACTS is Missouri’s Advanced Contact Tracing System and allows users to call, text, and email contacts of those with a COVID-19 case.

The electronic COVID-19 Case Reporting system is the best way to report a positive COVID-19 case if you do not have access to the EpiTrax system to enter data. Case information submitted to the electronic COVID-19 Case Reporting system will be imported into EpiTrax for follow up.

The REDCap Facility Survey is available for long term care facilities and congregate living facilities to upload their COVID-19 testing spreadsheets for reporting to DHSS.
<table>
<thead>
<tr>
<th>Who uses this system?</th>
<th>anyone required to report positive COVID-19 cases</th>
<th>Licensed long term care facilities and the Division of Regulation and Licensure</th>
<th>LPHAs and DHSS staff</th>
<th>LPHAs and DHSS staff</th>
</tr>
</thead>
</table>
| What does this system do? | 1. Replaces paper CD-1 reporting for COVID-19 cases  
2. Should be used by all entities required to report COVID-19 cases  
3. Should not be used by LPHAs to enter case information  
4. Case data flows into EpiTrax for case management and follow up | 1. Allows long term care facilities to upload their COVID-19 testing spreadsheets  
2. New COVID-19 cases should not be submitted to this system | 1. Comprehensive Disease Surveillance System that receives laboratory reports for COVID-19 tests  
2. EpiTrax is the authoritative record to trigger case management and investigations  
3. LPHAs enter COVID-19 case data directly into EpiTrax | 1. Integrated, exported contacts from EpiTrax  
2. Schedule, track, and visualize action taken  
3. Integrated phone system to centralize contact tracer’s work  
4. Text and email messaging within the system  
5. Call scripts to use during calls with contacts |
| How do I access this system? | Click to access | Click to access | Click to access | Click to access |
Appendix 2: COVID-19 Electronic Case Reporting (CD-1) Data Elements

1. Reporter Information: (all required unless specified)
   a. Date of Report
   b. Reporter Name
   c. Reporter Entity Type
      i. DMH Developmental Disabilities Community Residential Setting
      ii. DMH Intermediate Care Facility for Individuals with Intellectual Disabilities
      iii. DMH DD Community State Operated Community Residential Setting
      iv. DMH Recovery Support Provider
      v. DMH Recovery Support Provider
      vi. DMH Behavioral Health Treatment Provider
      vii. DMH Behavioral Health Treatment Provider
      viii. Skilled Nursing Facility
      ix. Assisted Living Facility
      x. Residential Care Facility
      xi. Intermediate Care Facility
      xii. Department of Corrections Facility
      xiii. County or City Jail
      xiv. Higher Education Institution
      xv. K-12 School
      xvi. Child Care
      xvii. Adult day Care
      xviii. Residential Summer Camp
      xix. Clinic
      xx. Federally Qualified Health Center
      xxi. Hospital
      xxi. Laboratory
      xxiii. Health Department
      xxiv. State agency
      xxv. Physician (not affiliated with entity type above)
      xxvi. Physician Assistant (not affiliated with entity type above)
      xxvii. Nurse (not affiliated with entity type above)
      xxviii. Other: please specify
   d. Entity Organization Name
   e. Reporter Entity Address
   f. Reporter Phone Number
   g. Entity NPI (not required)
   h. Reporter email address (not required)
   i. Administrator Name (not required)
   j. Administrator Phone Number (not required)

2. Patient Information: all required unless specified below
   a. Patient Name
   b. Patient DOB
   c. Patient Address
   d. Patient Home Phone (not required)
   e. Patient Work Phone (not required)
f. Patient Race

g. Patient Ethnicity

h. Patient Sex:
   i. If female, currently pregnant?

i. County of residence

j. Is the patient a resident, contracted staff, or a staff member of a congregate facility?
   i. Type of Facility:
      1. DMH Developmental Disabilities Community Residential Setting
      2. DMH DD Intermediate Care Facility
      3. DMH DD Community State Operated Community Residential Setting
      4. DMH Recovery Support Provider (housing)
      5. DMH Behavioral Health Treatment Provider (residential/detox/inpatient setting)
      6. Skilled Nursing Facility
      7. Assisted Living Facility
      8. Residential Care Facility
      9. Intermediate Care Facility
      10. Department of Corrections Facility
      11. County or City Jail
      12. Higher Education Dormitory
      13. Residential Summer Camp
      14. Other: Free Text
   ii. Facility Name

3. Treating Physician Information (all not required)
   a. Treating Physician Name
   b. Affiliated Clinic/Practice Name
   c. Physician Phone Number
   d. Physician Address

4. Illness, Treatment, and Symptoms: all required unless specified below
   a. Is the patient deceased?
      i. If yes, Date of Death
   b. Is patient symptomatic?
      i. Date of first symptom onset
   c. Which of the following did the patient experience during their illness?
      i. Fever >100.4F (38C)
      ii. Cough (new onset or worsening of chronic cough)
      iii. Subjective fever (felt feverish)
      iv. Wheezing
      v. Chills
      vi. Shortness of breath (dyspnea)
      vii. Rigors
      viii. Difficulty breathing
      ix. Muscle aches (myalgia)
      x. Chest pain
      xi. Runny nose (rhinorrhea)
      xii. Nausea or vomiting
xiii. Sore throat
xiv. Abdominal pain
xv. New olfactory and taste disorder(s)
xvi. Diarrhea (≥3 loose stools/24hr period)
xvii. Headache
xviii. Other, please specify
d. Did the patient develop pneumonia?
e. Did the patient have acute respiratory distress syndrome?
f. Did the patient have an abnormal chest x-ray?
g. Did the patient have an abnormal EKG?
h. Did the patient receive mechanical ECMO?
i. Did the patient have another diagnosis/etiology for their illness?
j. Did they have any underlying medical conditions and/or risk behaviors?
   i. Diabetes Mellitus
   ii. Immunosuppressive condition
   iii. Hypertension
   iv. Autoimmune condition
   v. Severe obesity (BMI ≥40)
   vi. Current smoker
   vii. Cardiovascular disease
   viii. Former smoker
   ix. Chronic Renal disease
   x. Substance abuse or misuse
   xi. Chronic Liver disease
   xii. Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment)
   xiii. Chronic Lung disease (asthma/emphysema/COPD)
   xiv. Other chronic diseases If yes, specify
   xv. Other underlying condition or risk behavior
   xvi. Psychological/psychiatric condition

5. Laboratory Reporting: all required unless specified below.
   DO NOT COMPLETE THIS SECTION. Please select ‘No’ on 5.a. and select ‘Next’ to navigate to the next page.
   a. Do you have a laboratory results to report?
   b. Laboratory Name
   c. Laboratory address
   d. Laboratory CLIA (not required)
   e. Date received.
   f. Specimen type
      i. Aspirate
      ii. Bronchoalvelar lavage
      iii. Nasal aspirate
      iv. Nasopharyngeal aspirate
      v. Nasopharyngeal swab
      vi. Nasopharyngeal wash
      vii. Oropharyngeal aspirate
      viii. Oropharyngeal swab
ix. Oropharyngeal wash
x. Serum
xi. Sputum
xii. Tracheal aspirate
xiii. Other: please specify

g. Test type:
i. POLYMERASE CHAIN REACTION (PCR)
ii. COVID-19 ANTIGEN
iii. LAMP
iv. Culture
v. EIA / ELISA – IGG
vi. EIA / ELISA – IGM
vii. EIA / ELISA - TOTAL
viii. XRAY, CHEST
ix. CAT SCAN
x. OTHER

h. Test result
i. Has patient been notified of diagnosis/lab results? (not required)

6. Disease Investigation (all not required)
   a. Under what process was the case first identified?
   b. Was the case reported to the CDC?
      i. What is the reported date?
   c. Was the case reported to the local county health department?
      i. What is the reported date?
   d. Is this case associated with a community testing event or known outbreak?
      i. Identify the community testing event or outbreak
   e. Which would best describe where the patient was staying at the time of the illness?
      i. House/single family home
      ii. Apartment
      iii. Hotel/Motel
      iv. Outside/in a car
      v. Hospital
      vi. Congregate Facility
      vii. Homeless Shelter
   f. Is the patient a health care worker in the United States?
   g. Is the patient a food handler?
   h. Did the patient recently travel outside of immediate area?
   i. In the 14 days prior to illness onset, did the patient have any of the following exposures?
      i. Domestic travel (outside state of normal residence). Specify State(s)
      ii. International travel. Specify Country(ies)
      iii. Cruise ship or vessel travel as passenger or crew member. Specify name of ship:
      iv. Workplace
         1. Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)?
      v. Airport/airplane
      vi. Adult congregate living facility (nursing, assisted living, or long-term care facility)
vii. School/university/childcare center
viii. Correctional facility
ix. Community event/mass gathering
x. Animal with confirmed or suspected COVID-19. Specify animal
xi. Other exposures, specify
xii. Contact with a known COVID-19 case
   1. What type of contact? (Household, Community-associated Healthcare-associated)
   2. Is this case part of an outbreak?
      a. Specify outbreak name

j. Members of the Patient's Household
   i. Household Member’s Name
   ii. Household Member’s DOB
   iii. Household Member’s Phone number

k. Has the patient donated or received blood or tissue?

l. Additional case information

7. Congregate Facility Reporting (all required)
   a. Total Number of Staff at Facility
   b. Total Number of Residents at the Facility
   c. Are you in need of infection control support?
   d. Has facility-wide testing been completed?
      i. Do you plan to conduct facility-wide testing?
      ii. Do you need support to complete facility-wide testing?
      iii. What kind of support? (Ex: PPE, Testing Lab, critical staffing that would require immediate action, etc.)
   e. Additional information

8. Hospital Status: all required unless specified
   a. Was the patient hospitalized?
      i. Admission Date (not required)
      ii. Discharge Date (not required)
   b. Was the patient admitted to the ICU?