COVID-19 Case Reporting System User Guide

The Electronic COVID-19 Case Reporting System allows reporters to enter positive case information online to replace paper CD-1 reporting to DHSS.

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 disease surveillance system to enter data. Case information submitted to the electronic COVID-19 Case Reporting system will be imported into EpiTrax for follow up.

Anyone required to report positive COVID-19 case information to DHSS can use the Electronic COVID-19 Case Reporting System.

Tips and Tricks:

- Don’t use browser navigation buttons to move between pages, the “previous” and “next” buttons at the bottom of each screen will help you navigate the pages.
- The Electronic COVID-19 Case Reporting System works optimally in the Google Chrome browser. Microsoft Edge and Firefox are acceptable, however Internet Explorer will not work. (If you are unable to use the Electronic COVID-19 Case Reporting due to your browser or other issues, please continue to report utilizing the paper CD-1 form.)

Use the guide below to understand whether a particular field is required.

<table>
<thead>
<tr>
<th>Indicates a required field</th>
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<tr>
<td>* Indicates a required field with an ‘Unknown’ option</td>
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<tr>
<td>Indicates a field that is NOT required.</td>
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<tr>
<td>Indicates a field that becomes required if you answer the preceding skip logic question</td>
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<tr>
<td>Indicates a skip logic field that is NOT required.</td>
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Do you have feedback about the system?

Please email questions and suggestions to COVID19ReportingSystem@health.mo.gov
Reporter Information

Date of Report  Enter the current date and time

Reporter Name  Enter the first and last name of the contact for this case report. This should be the individual appropriate for follow up contact by the Department and/or the local public health agency.

Reporter Entity Type: Choose one of the following options. Choose ‘Other’ if you do not see your entity type listed.

Note: If you are a higher education institution, please select ‘Higher Education Dormitory’. The system will be enhanced for this option to state ‘Higher Education Institution’.

- DMH Developmental Disabilities (DD) Community Residential Setting
- DMH Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- DMH DD Community State Operated Community Residential Setting
- DMH Recovery Support Provider (non-housing)
- DMH Recovery Support Provider (housing)
- DMH Behavioral Health Treatment Provider (outpatient setting):  
  Enter Administrator Name and Phone Number
- DMH Behavioral Health Treatment Provider (residential/detox/inpatient setting)
- Skilled Nursing Facility
- Assisted Living Facility
- Residential Care Facility
- Intermediate Care Facility
- Department of Corrections Facility
- County or City Jail
- Higher Education Dormitory
- K-12 School
- Child Care
- Adult day Care
- Residential Summer Camp
- Clinic
- Federally Qualified Health Center
- Hospital
- Laboratory
- Health Department
- State agency
- Physician (not affiliated with entity type above)
- Physician Assistant (not affiliated with entity type above)
- Nurse (not affiliated with entity type above)
- Other please specify:  
  - Enter Other Entity Description
Entity Organization Name

- Facility Name drop down list may be available for some of the Entity Types. If so, please select one of the options. Note: If you have selected your entity type and you do not see your facility name listed, please contact user support at COVID19ReportingSystem@health.mo.gov

Reporter Entity Address (Address Line 1, City, State, Zip)

Reporter Phone Number Enter the reporter’s best phone contact in the following format: xxx-xxx-xxxx

Entity NPI Format: 10 digit numerical

Reporter email address Enter a valid email address that is the best contact for the reporter.

Patient Information

Patient Name Enter the patient’s first and last name.

Patient Date of Birth Enter the patient’s date of birth in the following format: (MM/DD/YYYY)

Patient Address Enter the address of the patient’s current residence.

Note: If they reside in a congregate care facility such as a correctional facility, enter this address, rather than the home address.

Patient Home Phone Enter the patient’s home phone number in the following format: (123-1234)

Patient Work Phone Enter the patient’s work phone number in the following format: (123-123-1234)

*Race Check the box to identify the patient’s race. When choosing ‘Other’, specify in the free text field. If race is not known, choose ‘Unknown’.

*Ethnicity: Check the box to identify the patient’s ethnicity. If ethnicity is not known, choose ‘Unknown’.

*Sex: Check the box to identify the patient’s gender. If gender is not known, choose ‘Unknown’.

If ‘Female’ is chosen, indicate whether the patient is currently pregnant. If pregnancy status is not known, choose ‘Unknown’.

County of Residence: Choose the county where the patient is residing.
Note: If the patient is residing out of state, please choose the county of the facility where the patient is working. The system is currently being enhanced to allow an out of state county selection.

**Resident or Staff of a Congregate Facility:** Indicate if the patient is a resident, staff or contracted staff at one of the following types of congregate facilities.

Note: If the type of congregate facility is not listed (i.e. Division of Youth Services facility, Veteran’s facility, etc.), please choose ‘Other’ and list the type of facility in the free text field.

- DMH Developmental Disabilities (DD) Community Residential Setting
- DMH DD Intermediate Care Facility
- DMH DD Community State Operated Community Residential Setting
- DMH Recovery Support Provider (housing)
- DMH Behavioral Health Treatment Provider (residential/detox/inpatient setting)
- Skilled Nursing Facility
- Assisted Living Facility
- Residential Care Facility
- Intermediate Care Facility
- Department of Corrections Facility
- County or City Jail
- Higher Education Dormitory
- Residential Summer Camp
- Other

*Facility Name* If a prepopulated list appears, choose the appropriate facility. If there is not a drop down option, type the facility name.

*Total Number of Staff at Facility* Enter the number of residents at the facility. If this is information is not known, enter “1” in this field.

*Total Number of Residents at the Facility* Enter the number of staff at the facility. If this is information is not known, enter “1” in this field.

*Are you in need of infection control support?* Indicate whether infection control support is needed from the local epidemiologist. If the reporting entity does not know this information, choose ‘Unknown’.

*Has facility-wide testing been completed?* Indicate whether facility wide testing has been completed in the previous 14 days. If the reporting entity does not know this information, choose ‘Unknown’.

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If ‘No’ is selected, do you plan to conduct facility-wide testing? Indicate whether the facility has started the process to complete facility-wide testing. If this information is not known, select ‘Unknown’.

If ‘Yes’ is selected, do you need support to complete facility-wide testing? Indicate whether support is needed to complete facility-wide testing. If this information is not known, select ‘Unknown’.

If ‘Yes’ is selected, what kind of support? Indicate the type of support needed. (Ex: PPE, Testing Lab, critical staffing that would require immediate action, etc.)

**Treating Physician** Enter the first and last name of the treating physician.

**Affiliated Clinic/Practice Name** Enter the clinic or affiliated practice name.

**Physician Phone Number** Enter the treating physician’s phone number in the following format: (123-123-1234)

**Physician** Enter the treating physician’s address.

**Was the Patient Hospitalized?** Indicate whether the patient was hospitalized due to COVID-19. If this information is not known, select ‘Unknown’.

If ‘Yes’ is selected, enter the admission date if known and the discharge date if applicable and known.

**Was the patient admitted to the ICU?** Indicate whether the patient was admitted to ICU due to COVID-19. If this information is not known, select ‘Unknown’.

**Illness, Treatment, and Symptoms**

* **Is the patient deceased?** Indicate yes, no, or unknown. *If yes, enter date of death*

* **Is patient symptomatic?** Indicate yes, no, or unknown. *If yes, enter date of first symptom onset if known.*

If the patient is symptomatic, which of the following did the patient experience during their illness? Check all that apply. If the symptom(s) does not appear on this list, please describe the symptom(s) in the ‘other’ field.

- Fever >100.4F (38C)
- Cough (new onset or worsening of chronic cough)
- Subjective fever (felt feverish)
- Wheezing
- Chills
• Shortness of breath (dyspnea)
• Rigors
• Difficulty breathing
• Muscle aches (myalgia)
• Chest pain
• Runny nose (rhinorrhea)
• Nausea or vomiting
• Sore throat
• Abdominal pain
• New olfactory and taste disorder(s)
• Diarrhea (≥3 loose stools/24hr period)
• Headache
• Other, specify:
  ○ Enter Other Symptom Description

* Did the patient develop pneumonia? Choose one: yes, no, or unknown

* Did the patient have acute respiratory distress syndrome? Choose one: yes, no, or unknown

* Did the patient have an abnormal chest x-ray? Choose one: yes, no, unknown, or not applicable/no chest x-ray done

* Did the patient have an abnormal EKG? Choose one: yes, no, unknown, or not applicable/no EKG done

* Did the patient receive mechanical ECMO? Choose one: yes, no, unknown, not applicable/no ECMO

* Did the patient have another diagnosis/etiology for their illness? Choose one: yes, no, or unknown

* Did they have any underlying medical conditions and/or risk behaviors? Choose one: yes, no, or unknown.

  If the patient had any underlying medical conditions and/or risk behaviors, please check all that apply. If you are unfamiliar with the patient’s complete medical history, please check those that are known to you.

  If you choose yes to ‘disability’, ‘other chronic diseases’, ‘other underlying condition or risk behavior’, or ‘psychological/psychiatric condition’, please enter/describe the condition in the text box provided.

  • Diabetes Mellitus
  • Immunosuppressive condition
  • Hypertension
  • Autoimmune condition
- Severe obesity (BMI ≥40)
- Current smoker
- Cardiovascular disease
- Former smoker
- Chronic Renal disease
- Substance abuse or misuse
- Chronic Liver disease
- Disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment) - If yes, specify:
  - Disability Description
- Chronic Lung disease (asthma/emphysema/COPD)
- Other chronic diseases - If yes, please specify
  - Other chronic disease description
- Other underlying condition or risk behavior - If yes, specify:
  - Other underlying conditions or risks description
- Psychological/psychiatric condition - If yes, specify:
  - Psychological/psychiatric description

Laboratory Reporting

Do not complete this section. Choose ‘No’ and click ‘Next’. Lab results should be reported directly from the testing laboratory to DHSS through their established process. The system is currently being enhanced to remove this section.

Disease Investigation

*Under what process was the case first identified?* Describe the identification of the positive case. (ex: facility-wide testing, symptomatic patient, etc.)

*Was the case reported to the CDC?* Select Yes, No, or Unknown

*What is the reported date? If Yes enter the date reported to the CDC or select the calendar icon to reveal a drop down calendar.*

*Was the case reported to the local county health department?* Select Yes, No, or Unknown

*What is the reported date? If Yes enter the date reported to the local public health agency or select the calendar icon to reveal a drop down calendar.*
**Is this case associated with a community testing event or known outbreak?** Select Yes, No, or Unknown

*Identify the community testing event or outbreak. If Yes identify the community testing event or outbreak.*

**Which would best describe where the patient was staying at the time of the illness?** Select the drop down arrow and choose the appropriate description from the drop box provided.

- House/single family home
- Apartment
- Hotel/Motel
- Outside/in a car
- Hospital
- Congregate Facility
- Homeless Shelter

**Is the patient a health care worker in the United States?** Select Yes, No, or Unknown

**Is the patient a food handler?** Select Yes, No, or Unknown

**Did the patient recently travel outside of immediate area?** Select Yes, No, or Unknown

**In the 14 days prior to illness onset, did the patient have any of the following exposures?** Check the box next to the appropriate answer to the above question.

- Domestic travel (outside state of normal residence). *Specify State(s): Please specify which states the patient traveled to in the 14 days prior to the beginning of symptoms.*

- International travel. *Specify Country(s): Please specify which country or countries the patient traveled to in the 14 days prior to the beginning of symptoms.*

- Cruise ship or vessel travel as passenger or crew member. *Specify name of ship: Please specify the name of ship the patient traveled on in the 14 days prior to the beginning of symptoms.*

- Workplace
  - Is the workplace critical infrastructure (e.g., healthcare setting, grocery store)? Select Yes, No, or Unknown

- Airport/airplane
Adult congregate living facility (nursing, assisted living, or long-term care facility)
School/university/childcare center
Correctional facility
Community event/mass gathering
Animal with confirmed or suspected COVID-19. Specify animal: Please specify the type of animal the patient was in contact with in the 14 days prior to the beginning of symptoms.
Other exposures, specify: Please specify any other exposures not covered in this section that were important in the 14 days prior to the beginning of symptoms.
Contact with a known COVID-19 case (probable or confirmed):
  What type of contact? (Household, Community-associated Healthcare-associated) Please specify the type of contact in the associated text box.
  Is this case part of an outbreak? Select Yes, No, or Unknown
    Specify outbreak name: Please specify the outbreak, using location information, important markers to help determine the outbreak location, or the name of the outbreak if known.

Members of the Patient's Household. If the names of household members are known select Add Household Member
  Name Enter the household member’s first and last name
  DOB Enter the date of birth (if known) of the household member or select the calendar icon to reveal a drop down calendar.
  Phone number Enter the phone number of the household member (if known) using the following format (123-123-1234)

Has the patient donated or received blood or tissue? Select Yes, No, or Unknown

Additional case information Enter additional case information as needed in the provided text box.

Once you have completed all known case information, select the Submit Button.
Future system enhancements include a confirmation of submission and print submission option.