From: (b)(3):50 USC 3024(i); (b)(6)

Sent: Saturday, October 3, 2020 7:25 PM

To: (b)(3):10 USC 424; (b)(6)

Cc:

Subject: CDC COVID-19 Update 02Oct2020 (For Internal USG only)

Attachments: Final CDC COVID-19 SITREP 176 10-02-2020.pdf; (FOUO) CDC COVID-19 RESPONSE UPDATE 20201002.pdf; covidview-10-02-2020.pdf

Good evening,

Please see attached CDC Report.

Cases/deaths as of 02 Oct 2020:
- 7,260,465 confirmed and probable U.S. cases, +47,046 since yesterday
- 207,302 U.S. deaths reported to CDC, +900 since yesterday
- 34,161,721 confirmed cases worldwide (WHO dashboard data)

Highlights:
- **Case Counts and Deaths:** 7-day case average is unchanged from the previous 7-days. 7-day death average is down 5% from the previous 7-days. 1,566 counties within the US (50%) are currently experiencing a rebound of COVID-19 cases compared to 37% in mid-Sept. Case trajectory data: 29 (52%) states/jurisdictions in an upward/worsening trajectory; 8 (14%) in a plateau; and 19 (34%) in a downward/improving trajectory.
- **RT-PCR Test Positivity:** National percent positivity = 4.4%. 7 states/territories with a 7-day RT-PCD percent positivity >10%: GU, UT, SD, MT, ID, NE, OK; 11 worsening states/territories, and only 3 improving: OK, VA, TX.
- **Travel Health Notices (THNs):** https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html, no changes since 28 Aug.
- **CDC COVID -19 SITREP:** now published three times a week Monday/Wednesday/Friday.

New MMWR Pubs:
- **COVID-19 Trends Among School-Aged Children — United States, March 1–September 19, 2020:** https://www.cdc.gov/mmwr/volumes/69/wr/mm6939e2.htm?s_cid=mm6939e2_x, COVID-19

incidence among adolescents aged 12–17 years was approximately twice that in children aged 5–11 years. As with adults, comorbid conditions corelated with increased disease severity.

- Recent Increase in COVID-19 Cases Reported Among Adults Aged 18–22 Years — United States, May 31–September 5, 2020: https://www.cdc.gov/mmwr/volumes/69/wr/mm6939e4.htm?s_cid=mm6939e4_w, Weekly COVID-19 cases among persons aged 18–22 years increased 55% nationally between August 2nd and September 5th. Increases were greatest in the Northeast (144%) and Midwest (123%), and not solely attributable to increased testing.

- Multiple COVID-19 Clusters on a University Campus — North Carolina, August 2020: https://www.cdc.gov/mmwr/volumes/69/wr/mm6939e3.htm?s_cid=mm6939e3_w, A North Carolina university (might rhyme with Apple Chill) experienced a rapid increase in COVID-19 cases and clusters within 2 weeks of opening the campus to students.

MMWR Early Release:

- Case Series of Multisystem Inflammatory Syndrome in Adults Associated with SARS-CoV-2 Infection — United Kingdom and United States, March–August 2020: https://www.cdc.gov/mmwr/volumes/69/wr/mm6940e1.htm?s_cid=mm6940e1_w, Clinical suspicion and testing, including antibody testing, might be needed to recognize and treat adults with MIS-A. Further research is needed to understand the pathogenesis and long-term effects of this condition.

Please regularly refer to CDC's COVID-19 webpage; information and guidance is updated daily: https://covid.cdc.gov/covid-data-tracker/

VR/

(b)(6)

Dept of Defense Liaison to the Centers for Disease Control and Prevention, Atlanta, GA

(b)(6)

(b)(3) 50 USC 3024(i); (b)(6)

Department of Health and Human Services
Centers for Disease Control and Prevention
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CDC Coronavirus Disease-2019 (COVID-19) Situation Report #176

Sensitive but Unclassified (SBU). This document may contain sensitive information that may be exempt from public release under the Freedom of Information Act (FOIA) (5 U.S.C. 552). This information is for internal government use only. Further distribution to authorized personnel with a "need to know" and for awareness is authorized by the Centers for Disease Control and Prevention.

CDC Response Status: Agency Level Activation
Date: 10/02/2020
Report Period: 10/01/2020 – 10/02/2020
IMS Activation: 01/21/2020
Location of Event: Global
Lead Agency: Centers for Disease Control and Prevention (CDC)
Lead CDC CIOs: National Center for Immunization and Respiratory Diseases (NCIRD)
Center for Preparedness and Response (CPR)
Description: CDC Coronavirus Disease-2019 (COVID-19) Response

Significant Activities (SIGACTs)/Information

- CDC COVID-19 website provides the latest resources for community and healthcare professionals on information regarding United States COVID-19 cases: https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Confirmed and probable U.S. cases of COVID-19: 7,260,465 (as of Oct 1); for complete domestic updates visit the CDC Data tracker - https://www.cdc.gov/covid-data-tracker/#cases.
- U.S. deaths reported to CDC: 207,302 (as of Oct 1).
- Worldwide confirmed cases of COVID-19 can be found at the WHO Coronavirus Disease Dashboard - https://covid19.who.int/.

Current Task Force Updates by Objectives:

Objective 1: Support of USG-wide Response – *Integrate CDC response activities with the USG response to inform and synchronize public health actions among all key stakeholders in support of the Federal Incident Strategic Plan.*

Laboratory and Testing Task Force

- Continue to support provisioning of data regarding kits shipped to Public Health Laboratories (PHLs) from International Reagent Resource (IRR).

Community Interventions & Critical Populations Task Force (CICP)

- One Health Working Group is collaborating on technical aspects of COVID-19 and the connection between human, animal, and environmental health through leading the One Health Federal Interagency COVID-19 Coordination Group.
  - CDC is chairing this group.
  - Participation from more than 60 representatives from 18 key federal agencies representing multiple departments (HHS, USDA, DOI, DOD, DHS, and others).

Global Migration Task Force (GMTF)

- The third extension to CDC's No Sail Order was signed by CDC Director.
- Effective Sep 30, 2020.
- Extends the no sail period until Oct 31.
- Updated No Sail Order regulatory website and cruise ship pages at: www.cdc.gov/quarantine/cruise.

Objective 2: Data/Surveillance – *Conduct timely and actionable data analytics, surveillance, lab reporting, and modeling activities to monitor and forecast epidemic progression and inform data-driven decision making.*

Data, Analytics, and Modeling Task Force

- Produced COVID-19 Forecast of New Hospitalizations
  - Updates publicly available on CDC website.
- Produced national and state-level ensemble forecasts of cumulative COVID-19 associated deaths
  - Updates publicly available on CDC website.

Innovation, Technology and Analytics

- Section leadership presented data and findings from a manuscript "Risk of clinical severity by age and race/ethnicity among adults hospitalized for COVID-19 — United States, March–July 2020" at the Incident Management meeting.

Objective 3: Global – *Assess global data as a guide for domestic response, provide guidance on international travel to reduce travel-associated infections, and provide support to mitigate the pandemic in other countries.*

International Task Force (ITF)

- Updated analysis code for ITF mitigation database and school mitigation measures on ITF dashboard.
- Presentation regarding Mitigation in Humanitarian Settings cleared for external audiences.
- Conducted Interactive Mitigation Session concerning contact tracing.
- Completed mapping of global and CDC domestic-oriented schools' guidance.
- Joint United Nations Programme on HIV/AIDS (UNAIDS) showed CDC Interfaith Stigma video at the United Nations General Assembly (UNGA) Interfaith HIV Conference
  - Audience of 900 global faith leaders.
- Conducted technical assistance calls concerning tailored emergency response capacity support with Malawi, South Africa, and Guatemala CDC Country offices.
- Supported Zambia Ministry of Health and National Public Health Institute's Inter-Action Review Process.
- Instigated new COVID-19 technical exchange opportunity with G7 countries, plus Mexico, through the Global Health Security Initiative (GHSI) platform.
- Briefed interagency counterparts regarding the International Health Regulations and CDC's role.
- Distributed FAQ document to Posts to clarify CDC testing and minimum standards for the safe return of CDC staff to U.S. missions abroad.

Objective 4: Lab/Epi – *Conduct and provide support for epidemiologic and laboratory studies to examine dynamics of disease spread and control, including expanding testing and analyzing serologic studies to assess spread of infection across America.*

Laboratory and Testing Task Force

- IRR shipped 2,330 reagents to 17 laboratories on Oct 1.

Epidemiology Task Force (Epi TF)

- Paired swabbing began in Oshkosh, WI for the Wisconsin pediatric study.
  - Approximately 130 students have been tested.

Objective 5: Community/Health Systems – *Provide community mitigation strategies and tools in support of domestic plans for phased approaches to COVID-19 and provide healthcare systems strengthening and guidance to support patient treatment and infection prevention and control (IPC).*

Health Systems and Worker Safety Task Force (HSWS)

- The Clinical Team presented updates on SARS-CoV-2 reinfection to the ACIP COVID-19 vaccine working group.
- The Worker Safety and Health Team (HSHT) participated in a webinar titled "Outcomes and Recommendations from Plant Inspections 2020" at the National Meeting on Poultry Health, Processing, and Live Production.

- The Worker Safety and Health Team published the infographic "COVID-19 Case Investigation and Contact Tracing in Non-Healthcare Workplaces".
- The Worker Safety and Health Team participated in weekly call with the American Nurses Association (ANA).
  - Discussed CDC's respirator decontamination and reuse guidelines along with ANA's recently published survey regarding nurses' perceptions of respirator reuse and decontamination.
- The Healthcare Systems Coordination Team (HSCT) met with Health Pulse representatives to discuss collaboration concerning the availability of data for personnel protective equipment usage and misuse in facilities.
- The HSCT's Federally Qualified Health Center (FQHC) Unit provide support to Community Health Worker web resources and tools.
- The FQHC Unit sponsored a call with the National Association of Community Health Centers (NACHC) to discuss communication strategies and collaborations with the National Syndromic Surveillance Program (NSSP) and the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE).
- The FQHC Unit provided status update to CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS) task force regarding CSTLTS Cooperative Agreement with NACHC- Building Capacity of Community Health Centers to Respond to COVID-19.

Global Migration Task Force (GMTF)

- GMTF United States Mexico Unit: Assisted the CDC Latino Hispanic Health Work Group with CDC's upcoming National Hispanic Heritage Month virtual event for October 8th, "Addressing Urgent Hispanic/Latino Challenges during the Era of the COVID-19 Pandemic".

Objective 6: State, Tribal, Local and Territorial Support (STLT) – *Provide support for outbreak response, needs assessments, contact tracing, and monitoring impact, as well as support the development and implementation of CDC COVID Corps activities.*

State, Tribal, Local & Territorial (STLT) Support Section

- Deployed 44 field teams to provide multi-disciplinary technical assistance at request of health departments.
  - Teams provide support for outbreak response, epidemiologic, surveillance and data analysis, community mitigation, infection prevention and control, laboratory support and technical assistance as needed.

Community Interventions & Critical Populations Task Force (CICP)

- The One Health Working Group deployed a field team to support state and local public health, animal health, wildlife, USDA, and other partners investigating SARS-CoV-2 in people and animals on multiple mink farms in Utah.

Objective 7: Communication and Outreach – *Ensure active, timely, effective public health and safety messaging around response priorities with key federal, state/local partners, policy-makers, media, and the public.*

Joint Information Center (JIC)

- New web content:
  - Interim Guidance for Case Investigation and Contact Tracing in Institutions of Higher Education (IHEs)
    - Shared guidance with EPIC partners
- Updated web content:
  - CDC COVID Data Tracker
  - Previous COVID-19 Forecasts: Hospitalizations
  - Considerations for Outdoor Learning Gardens and Community Gardens
  - Testing, Screening, and Outbreak Response for Institutions of Higher Education (IHEs)
  - Considerations for Outdoor Farmers Markets
- Posted COVID-19 content on OADC social media channels:
  - Differences in COVID-19 and Seasonal Flu
  - How to Wash Your Mask
  - COVID-19 Partner Update Call
  - 7-Day Case Counts

  - MMWR on CDC partnerships with state, local, and territorial health agencies
  - COVID-19 Monitoring and Evaluation for School Administrators
  - Guidance for Parents
- Posted COVID-19 content on Spanish language OADC social media channels:
  - Health Equity and COVID-19
  - Differences in COVID-19 and Seasonal Flu
  - Choosing Your Facemask
  - COVID-19 and Pregnancy
  - Cautions for Alcohol-Based Hand Sanitizers

Community Interventions & Critical Populations Task Force (CICP)

- Completed eight engagements of Technical Assistance (TA) supporting IHEs, CRAFT missions, health departments, and interagency partners.
  - Provided guidance clarification regarding defining close contacts, safely playing youth sports, trainings for mask observation protocols at IHEs, along with advocating for CDC communications inclusion with vaccine distribution planning to co-message vital strategies.
- Published the How Right Now National Domestic Violence Awareness Month newsletter.
- Sewage Surveillance: Presented NWSS implementation update during a webinar convened by the California Water Environment Association and the California Association of Sanitation Agencies.
  - Webinar presented the results of the Water Environment Federation Blue Ribbon Panel recommendations for wastewater worker safety.
  - Unit lead for the National Wastewater Surveillance System in WASH represented CDC.
- One Health webpages and guidance have over 6.6 million views as of October 1.

State, Tribal, Local & Territorial (STLT) Support Section

- Fielded inquiries from states and territories:
- Provided guidance on Rapid Antigen Testing.

Policy

- Briefed Rep. Van Taylor (TX) regarding contact tracing
  - Briefing focused on metrics for success, best practices, and data collection.

Objective 8: Vaccine – *Develop and support access to vaccines to prevent COVID-19, influenza, and childhood vaccine-preventable diseases.*

Vaccine Task Force - Nothing significant to report

General Staff Activities

Operations

- Received/triaged 50 COVID-19 related calls during the reporting period.
- Processed eight International Health Regulations (IHR) request and six Do Not Board (DNB) actions.

Resource Support

- 124 CDC personnel deployed or pending deployment (118 deployed, six pending).

Situational Awareness (SA)

- Provided *Epi-X* support to state health departments in receiving, accessing, and posting:
  - 1,685 passenger Entry Screening Reports and contact lists for post-arrival monitoring for travelers arriving from a country with widespread transmission of COVID-19.
  - 251 state notification and contact lists for persons who may have been exposed to COVID-19 on a flight.
  - 323 interstate movement notifications to states receiving persons traveling to their jurisdiction who are under self-monitoring with public health supervision for COVID-19; PUI with recent travel reports; lab results sent to health department associated with the jurisdiction where the traveler was tested; or persons with a history of close contact to a confirmed case of COVID-19.

The Point of Contact for this report is the IMS Planning Section Chief (**eocplans@cdc.gov**).

CDC COVID-19 Response Update Friday, 02 Oct, 2020
INTERNAL - NOT FOR FURTHER DISTRIBUTION

Table of Contents

Domestic Updates

Case Counts

The CDC numbers have been reviewed and approved by states and are suitable for use in all official communications.

Counts by Jurisdiction (Cumulative and New Cases and Deaths)[1]

Data Through 01 Oct 2020 *Last Updated: 02 Oct 2020 11:30*

57 Jurisdictions Reporting COVID-19 Cases 50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands													
Reporting Area[2]	Cases	New Cases[3]		Cases Per 100K			Deaths	New Deaths[3]		Deaths per 100K			CFR[4]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
AK	7,948	124	116.6	1077.8	16.8	15.8	57	1	1.6	7.7	0.1	0.2	0.7%
AL	155,744	1,043	1,076.9	3186.3	21.3	22.0	2,548	8	9.7	52.1	0.2	0.2	1.6%
AR	84,821	1,124	824.6	2814.4	37.3	27.4	1,384	15	19.7	45.9	0.5	0.7	1.6%
AZ	219,212	705	480.0	3056.6	9.8	6.7	5,674	24	16.4	79.1	0.3	0.2	2.6%
CA	813,687	3,062	3,292.4	2057.0	7.7	8.3	15,888	96	82.0	40.2	0.2	0.2	2.0%
CO	71,218	682	571.6	1250.4	12.0	10.0	2,054	3	3.0	36.1	0.1	0.1	2.9%
CT	57,742	192	181.4	1616.2	5.4	5.1	4,511	3	1.7	126.3	0.1	0.0	7.8%
DE	20,937	324	141.4	2164.8	33.5	14.6	642	6	1.7	66.4	0.6	0.2	3.1%
FL	700,602	2,551	2,250.7	3289.3	12.0	10.6	14,444	127	92.7	67.8	0.6	0.4	2.1%
GA	319,334	1,308	1,184.0	3035.6	12.4	11.3	7,063	42	34.4	67.1	0.4	0.3	2.2%
HI	12,694	105	108.0	893.6	7.4	7.6	139	3	2.1	9.8	0.2	0.2	1.1%
IA	90,009	1,179	918.1	2851.9	37.4	29.1	1,360	14	8.3	43.1	0.4	0.3	1.5%
ID	42,561	513	475.3	2426.2	29.2	27.1	472	3	2.1	26.9	0.2	0.1	1.1%
IL	297,929	2,166	2,051.4	2338.3	17.0	16.1	8,940	24	23.7	70.2	0.2	0.2	3.0%
IN	121,176	1,157	991.4	1810.8	17.3	14.8	3,645	13	13.9	54.5	0.2	0.2	3.0%
KS[5]	59,749	-	646.1	2052.2	-	22.2	678	-	8.1	23.3	-	0.3	1.1%
KY	69,728	888	795.7	1560.5	19.9	17.8	1,191	17	7.7	26.7	0.4	0.2	1.7%
LA	168,009	551	509.0	3605.4	11.8	10.9	5,519	8	13.7	118.4	0.2	0.3	3.3%
MA	140,357	708	514.0	2033.5	10.3	7.4	9,473	23	16.4	137.2	0.3	0.2	6.7%
MD	126,222	712	551.9	2088.8	11.8	9.1	3,950	1	4.7	65.4	0.0	0.1	3.1%
ME	5,468	37	33.3	408.5	2.8	2.5	142	-	0.3	10.6	-	0.0	2.6%
MI	139,012	998	953.6	1390.7	10.0	9.5	7,102	19	11.9	71.0	0.2	0.1	5.1%
MN	100,200	1,066	858.7	1785.7	19.0	15.3	2,102	13	8.0	37.5	0.2	0.1	2.1%
MO	127,912	1,799	1,371.6	2087.9	29.4	22.4	2,128	10	25.1	34.7	0.2	0.4	1.7%
MS	99,558	672	503.7	3333.6	22.5	16.9	2,999	20	15.0	100.4	0.7	0.5	3.0%
MT	13,824	431	325.1	1301.3	40.6	30.6	183	2	2.3	17.2	0.2	0.2	1.3%
NC	212,909	2,277	2,102.9	2050.4	21.9	20.3	3,579	47	31.9	34.5	0.5	0.3	1.7%
ND	22,694	476	401.3	2985.8	62.6	52.8	264	8	6.4	34.7	1.1	0.8	1.2%
NE	46,185	621	493.4	2393.9	32.2	25.6	493	15	4.4	25.6	0.8	0.2	1.1%
NH	8,317	51	39.0	613.1	3.8	2.9	441	2	0.4	32.5	0.1	0.0	5.3%
NJ	205,889	614	619.6	2311.1	6.9	7.0	16,127	5	5.1	181.0	0.1	0.1	7.8%
NM	29,661	226	205.3	1415.5	10.8	9.8	882	5	3.3	42.1	0.2	0.2	3.0%
NV	80,515	430	449.0	2653.4	14.2	14.8	1,645	3	4.9	54.2	0.1	0.2	2.0%
NY City	246,069	607	483.4	2929.8	7.2	5.8	23,846	17	7.7	283.9	0.2	0.1	9.7%
NY State[6]	215,457	849	588.7	1933.5	7.6	5.3	9,046	5	4.1	81.2	0.0	0.0	4.2%
OH	155,314	1,327	1,081.4	1328.7	11.4	9.3	4,817	13	14.6	41.2	0.1	0.1	3.1%
OK	94,619	1,177	1,006.3	2399.6	29.8	25.5	1,041	4	7.0	26.4	0.1	0.2	1.1%
OR	33,862	353	285.3	808.0	8.4	6.8	560	1	3.0	13.4	0.0	0.1	1.7%
PA	160,123	1,156	960.9	1250.3	9.0	7.5	8,160	18	11.6	63.7	0.1	0.1	5.1%
RI	24,914	166	86.1	2356.3	15.7	8.1	1,117	3	1.6	105.6	0.3	0.1	4.5%
SC	148,323	381	802.3	2917.4	7.5	15.8	3,400	22	17.3	66.9	0.4	0.3	2.3%
SD	23,136	747	434.1	2622.4	84.7	49.2	236	13	3.7	26.8	1.5	0.4	1.0%

[1] Data are reported voluntarily by each jurisdiction's health department. Data are reported as provided by the health department and the number of confirmed and probable cases or deaths may sum to the total. Health departments may update case data over time when they receive more complete and accurate information. If the number of cases or deaths reported by CDC is different from the number reported by jurisdiction health departments, data reported by jurisdictions should be considered the most up to date. The differences may be due to the timing of the reporting and website updates. See Technical Information about this data on the CDC Webpage. Darker shading corresponds to higher values.

[2] AS = American Samoa; DC = District of Columbia; FSM = Federated States of Micronesia; GU = Guam; CNMI = Commonwealth of the Northern Mariana Islands; PW = Palau; PR = Puerto Rico; RMI = Republic of the Marshall Islands; USVI = US Virgin Islands.

[3] These data represent new cases and deaths detected and tested in the US since the last update. Number of new cases and new deaths were included in total case numbers. Counts may have decreased from previous report due to case reclassification of cases to other jurisdictions or categories (e.g., probable to confirmed) by states.

[4] Percent change in cases, deaths and case fatality rates (CFR) are not calculated when the total number (denominator) was less than five.

[5] Jurisdiction did not provide an update.

[6] New York State excludes New York City.

57 Jurisdictions Reporting COVID-19 Cases 50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands													
Reporting Area[2]	Cases	New Cases[3]		Cases Per 100K			Deaths	New Deaths[3]		Deaths per 100K			CFR[4]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
TN	197,432	1,293	1,412.6	2916.3	19.1	20.9	2,501	47	27.3	36.9	0.7	0.4	1.3%
TX	752,501	3,534	4,083.1	2621.8	12.3	14.2	15,823	112	79.4	55.1	0.4	0.3	2.1%
UT	74,050	1,008	990.1	2342.5	31.9	31.3	459	-	2.1	14.5	-	0.1	0.6%
VA	149,687	966	750.6	1757.4	11.3	8.8	3,250	22	16.3	38.2	0.3	0.2	2.2%
VT[5]	1,755	-	3.4	280.2	-	0.5	58	-	-	9.3	-	-	3.3%
WA	88,116	594	554.0	1169.3	7.9	7.4	2,132	6	7.4	28.3	0.1	0.1	2.4%
WI	132,123	3,000	2,489.0	2272.7	51.6	42.8	1,358	21	11.9	23.4	0.4	0.2	1.0%
WV	16,024	176	188.3	887.3	9.7	10.4	354	4	4.1	19.6	0.2	0.2	2.2%
WY	6,083	135	111.1	1052.9	23.4	19.2	53	3	0.4	9.2	0.5	0.1	0.9%
AS	-	-	-	-	-	-	-	-	-	-	-	-	-
CNMI	73	3	-	128.3	5.3	-	2	-	-	3.5	-	-	-
DC	15,358	32	36.0	2186.3	4.6	5.1	628	1	1.0	89.4	0.1	0.1	4.1%
FSM	-	-	-	-	-	-	-	-	-	-	-	-	-
GU	2,550	62	37.7	1538.3	37.4	22.8	49	-	1.4	29.6	-	0.9	1.9%
PR	49,747	680	691.7	1557.0	21.3	21.6	673	8	5.4	21.1	0.3	0.2	1.4%
PW	-	-	-	-	-	-	-	-	-	-	-	-	-
RMI	-	-	-	-	-	-	-	-	-	-	-	-	-
USVI	1,326	8	-	1266.7	7.6	-	20	-	-	19.1	-	-	1.5%
Total	**7,260,465**	**47,046**	**43,119.0**	**2194.0**	**14.2**	**13.0**	**207,302**	**900**	**710.4**	**62.6**	**0.3**	**0.2**	**2.9%**
Navajo[7]	10,369	20	22.4	2905.4	5.6	6.3	556	1	0.7	155.8	0.3	0.2	5.4%

Compilations of US Case Counts

Reporting Source[8]	Data as of (all times are ET)	Cases	New Cases	Deaths	New Deaths
Official Sources (see table above)	02 Oct, 11:30	7,260,465	47,046	207,302	900
1Point3Acres	02 Oct, 11:06	7,438,582	49,787	212,096	987
Johns Hopkins	02 Oct, 10:23	7,282,027	46,542	207,867	859
USAFACTS	01 Oct, NA	7,174,914	44,869	205,231	1,020
New York Times	02 Oct, 07:48	7,309,089	46,459	207,699	847
WorldoMeter	02 Oct, 11:27	7,505,074	50,217	212,869	1,020
COVID Tracking Project	01 Oct, 16:00	7,244,316	45,727	199,776	847

[7] Cases in the Navajo Nation are likely also reported by AZ, NM, and UT and were therefore already included in the grand total above. Counts reported separately here from Navajo Department of Health COVID-19 and Navajo Epidemiology Center Coronavirus Response Hub

[8] Data from other organizations are not reviewed or validated by CDC and may include data derived from open media sources not represented on official state public health department web pages.

Number of New COVID-19 Cases in the US Reported to the CDC by States/Territories

Data: 22 Jan 2020 – 01 Oct 2020 Last Updated: 02 Oct 2020, 11:30
Source: CDC DCIPHER

Number of New COVID-19 Cases in the US reported to the CDC by States/Territories

22-Jan-20 | 01-Oct-20 | 02-Oct-20
DATA FROM* DATA THROUGH LAST UPDATED

7,260,465
Total Cases Reported

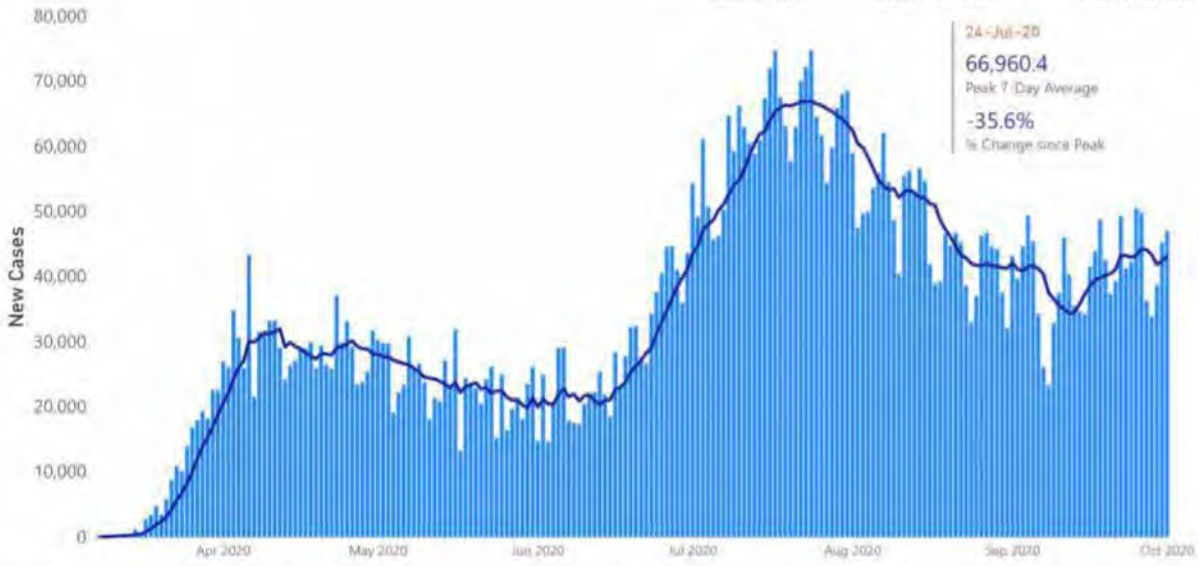
47,046
New Cases Reported

0.7%
24-Hour Change

43,119.0
Current 7-Day Average
25-Sep-20 to 01-Oct-20

43,014.7
Prior 7-Day Average
18-Sep-20 to 24-Sep-20

0.2%
1 Week Change



Data Sources, References & Notes: Total cases are based on aggregate counts of COVID-19 cases reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 22 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Numbers include confirmed and probable COVID-19 cases as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as cases/100,000 people. The 7-day moving average of new cases (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall case numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER, US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

Number of New COVID-19 Deaths in the US Reported to the CDC by States/Territories

Data: 22 Jan 2020 – 01 Oct 2020 Last Updated: 02 Oct 2020, 11:30
Source: CDC DCIPHER

Number of New COVID-19 Deaths in the US Reported to the CDC by States/Territories

22-Jan-20 | 01-Oct-20 | 02-Oct-20
DATA FROM* DATA THROUGH LAST UPDATED

207,302
Total Deaths Reported

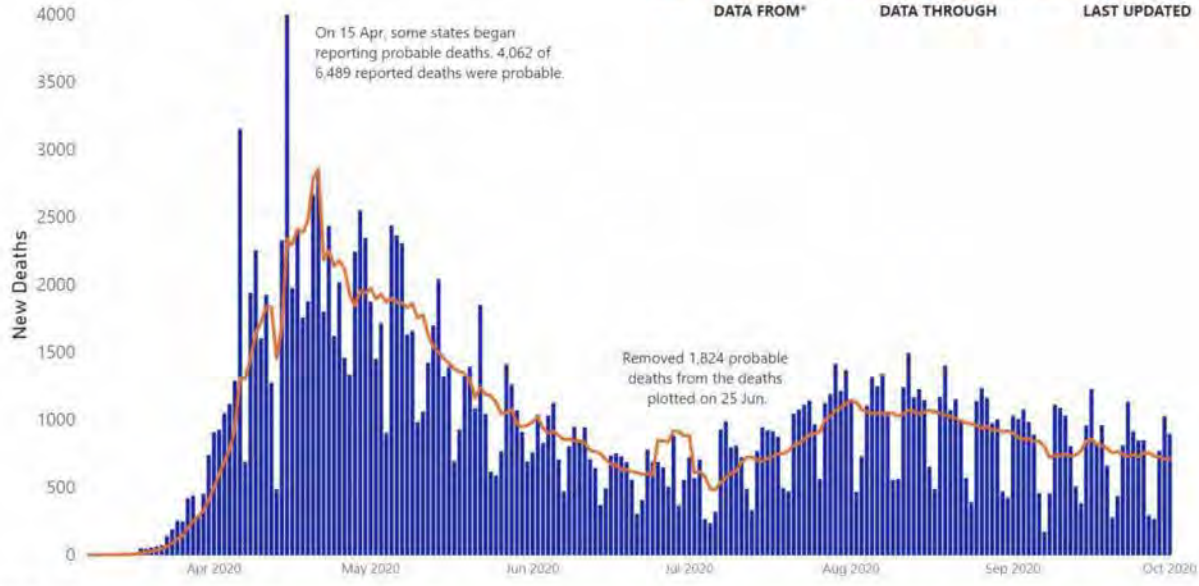
900
New Deaths Reported

0.4%
24-Hour Change

710.4
Current 7-Day Average
25-Sep-20 to 01-Oct-20

744.7
Prior 7-Day Average
18-Sep-20 to 24-Sep-20

-4.6%
1 Week Change in Average

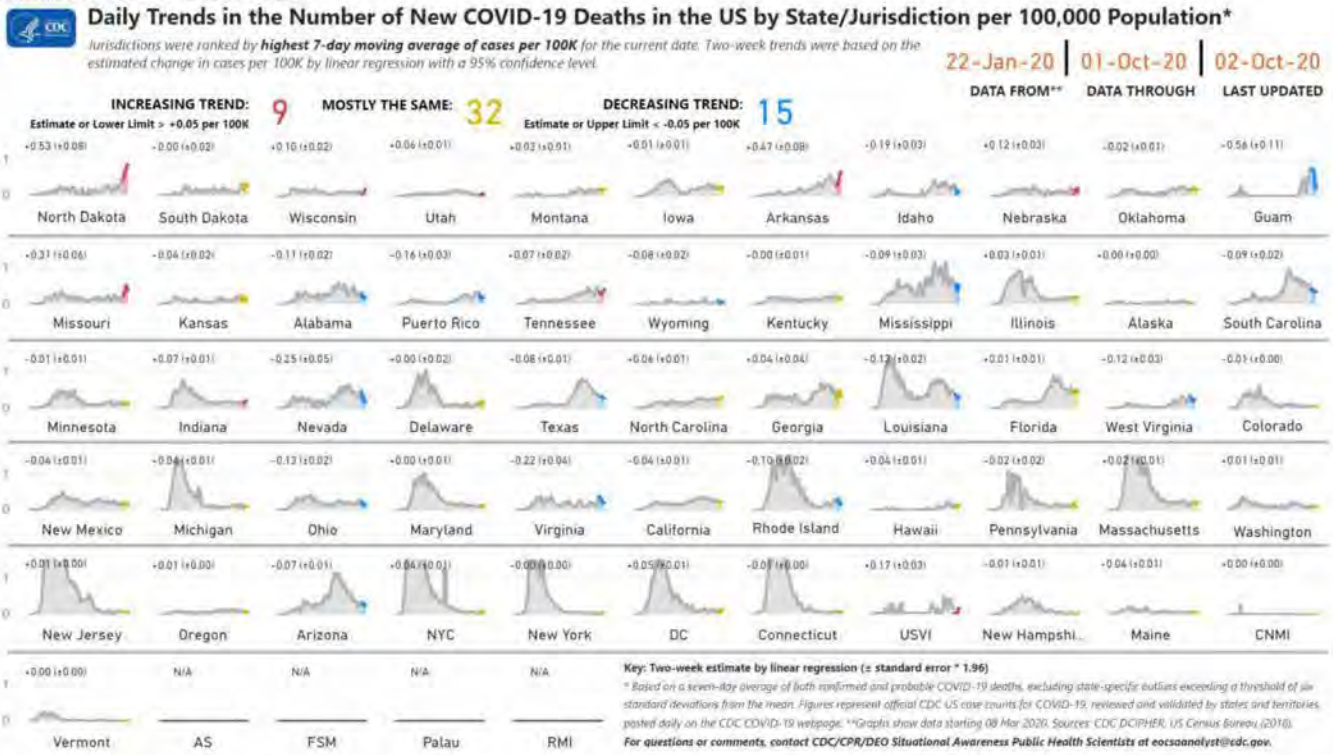


Data Sources, References & Notes: Total deaths are based on aggregate counts of COVID-19 deaths reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 21 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Number include confirmed and probable COVID-19 deaths as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as deaths/100,000 people. The 7-day moving average of new deaths (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall death numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER, US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

Daily Trends in the Number of New COVID-19 Cases in the United States by State/Jurisdiction per 100,000 Population

Data: 22 Jan 2020 – 01 Oct 2020 *Last Updated: 02 Oct 2020, 11:30*

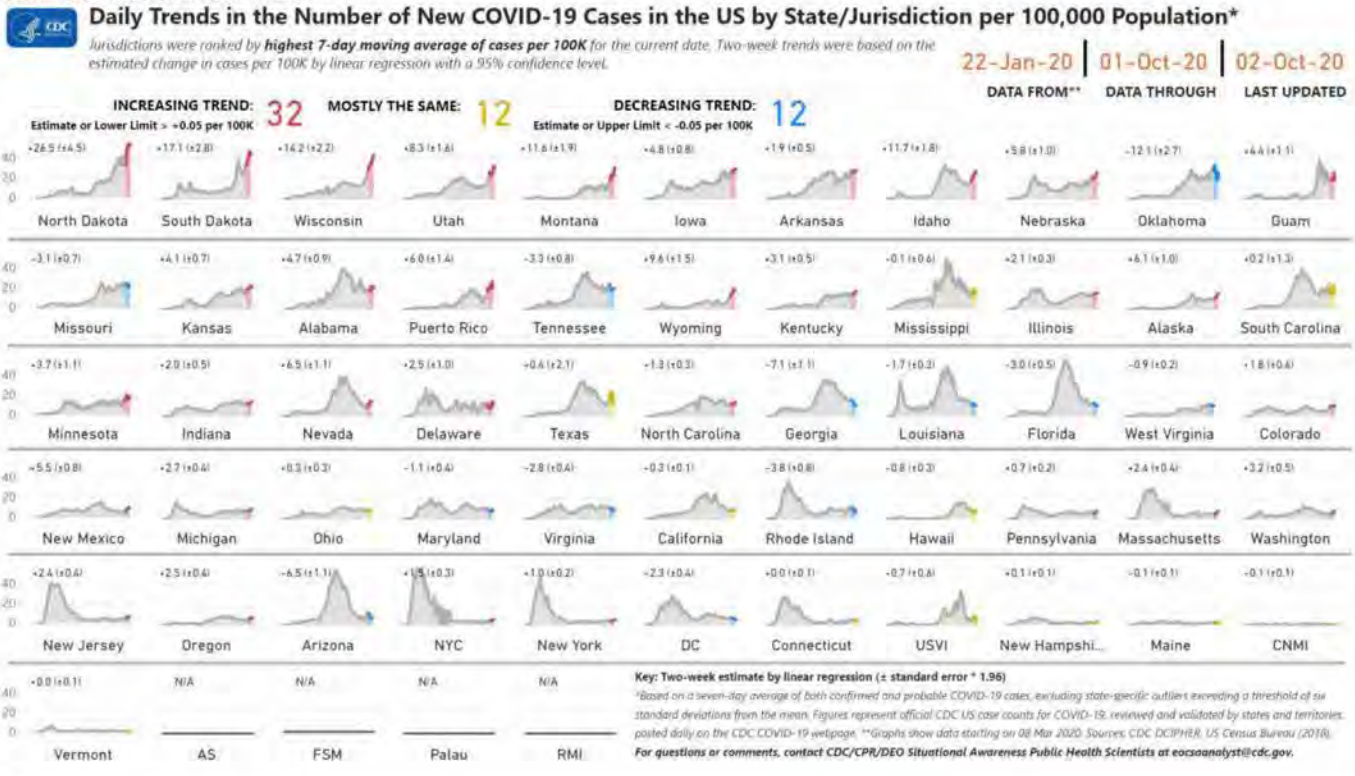
Source: CDC DCIPHER



Daily Trends in the Number of New COVID-19 Deaths in the United States by State/Jurisdiction per 100,000 Population

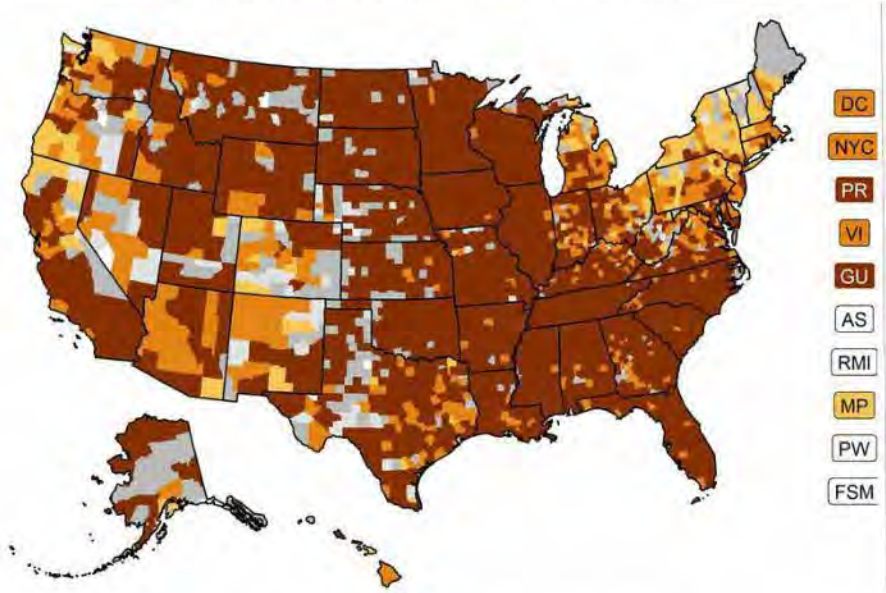
Data: 22 Jan 2020 – 01 Oct 2020 *Last Updated: 02 Oct 2020, 11:30*

Source: CDC DCIPHER



Cases by County9

Coronavirus Disease 2019 (COVID-19)
Number of New Cases per 100,000 in the past 2 weeks,
by U.S. County, 17 September–30 September, 2020



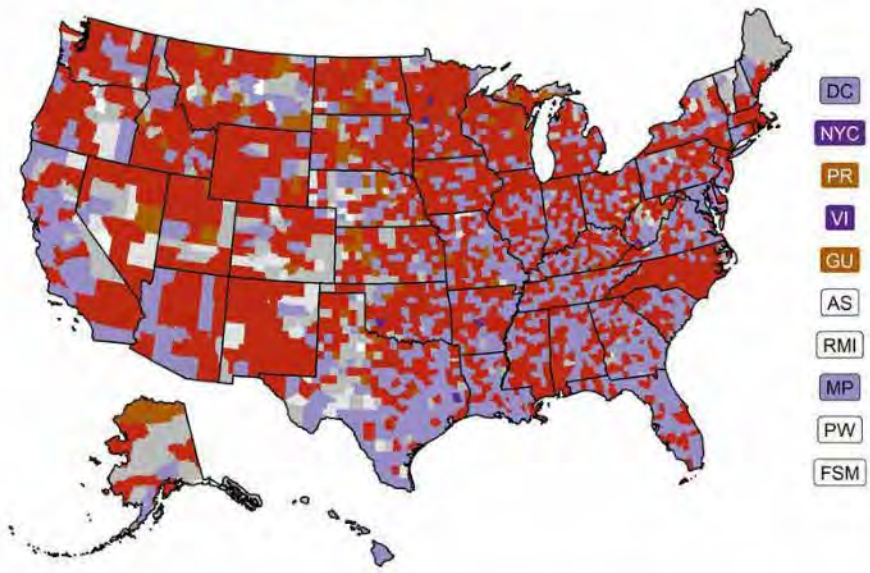
Incidence
- Low
- Moderate
- Moderately high
- High
- 1-5 cases in the past 2 weeks
- 0 cases in the past 2 weeks
- No reported cases

Purpose of this map
Describes recent incidence of COVID-19 infection to capture the potential burden of currently ill people who may be infectious and/or accessing healthcare.

Main Findings
- COVID-19 infection remains prevalent throughout the country.
- Elevated incidence of disease during the past 2 weeks remains widespread, including in the Southeast, the Midwest, and the West.

Notes: Defined using the number of new cases per 100,000 in the past 2 weeks. Low is >0 to 10, moderate is >10 to 50, moderately high is >50 to 100, and high is >100. Jurisdictions denoted as 0 cases in the past 2 weeks have had at least 1 case previously.
Sources: HHS Protect, US Census

Coronavirus Disease 2019 (COVID-19)
Current epidemic curve status*,
by U.S. County, September 30, 2020



Current status
- Low incidence growth
- Elevated incidence growth
- Elevated incidence plateau
- Sustained decline
- Low incidence plateau
- Rebound
- 1-5 cases in the past two weeks
- 0 cases in the past two weeks
- No reported cases

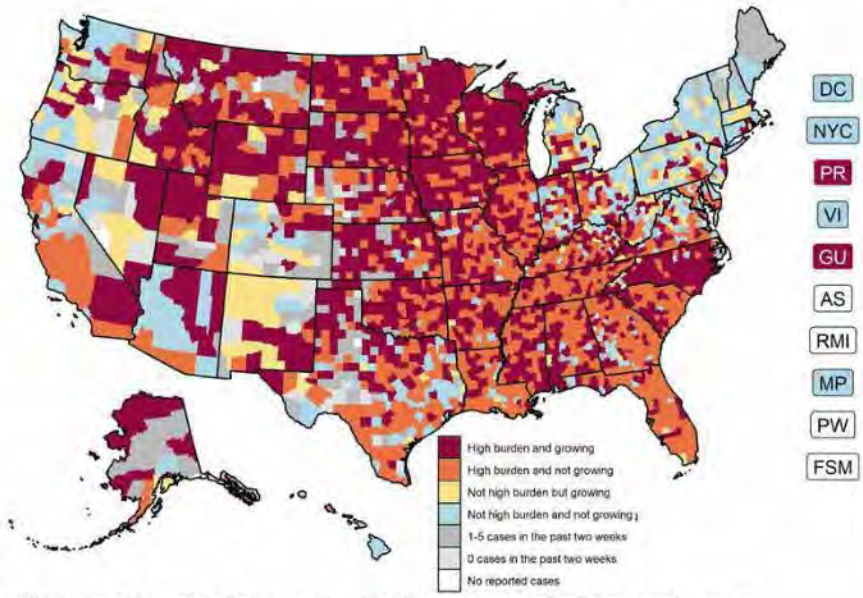
Purpose of this map
Provides the most detailed view into both the burden of illness and the trajectory of new illnesses.

Main Findings
- There are many counties throughout the States whose incidence are in rebound.
- Many counties in California, Texas, Louisiana, Georgia and Florida have burden in sustained decline.
- The goal is to have all communities be represented in the lighter colors, demonstrating little to no disease burden and no increase in trajectory.

*Categorized according to the slope of a spline fit to the 7-day moving average of daily incidence and the number of new cases (per 100,000) in the past 2 weeks. Elevated incidence is defined as >10 new cases per 100,000 in the past two weeks.
Sources: HHS Protect, US Census

[9] See CDC COVID-19 Data Tracker for the latest visualizations on cases and deaths trends by state and county.

Coronavirus Disease 2019 (COVID-19)
Burden and growing of new cases per 100,000 in the past 2 weeks, by U.S. county, 17 September–30 September, 2020



Notes: High burden and growing indicates counties with >100 new cases per 100,000 in the past two weeks and a slope of at least 0.1 per 100,000 per day.
Sources: HHS Protect, US Census

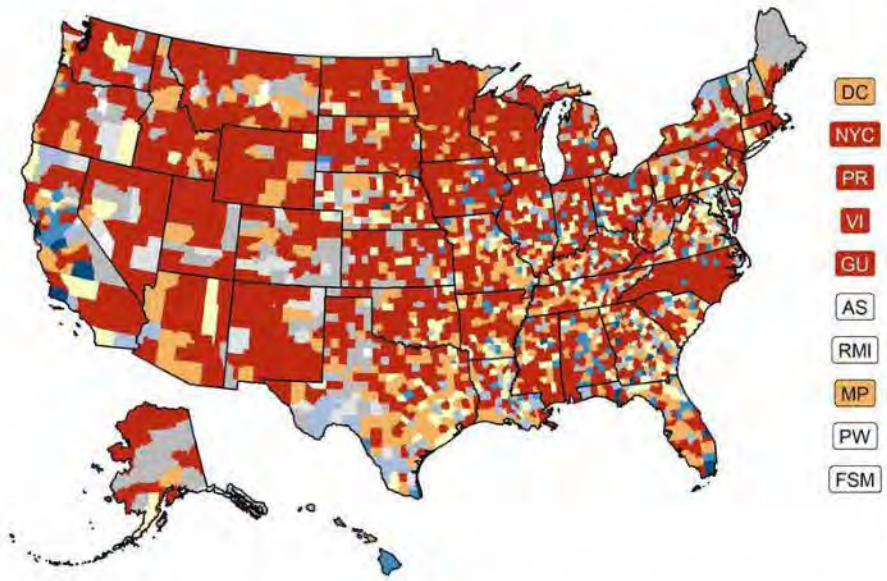
Purpose of this map
Identifies "areas of concern" where a county's disease burden is high and still growing.

Main Findings
- Counties with the greatest burden and which are still demonstrating growth are listed in the table below.

Counties in the high burden, growing category (Top 10 with the highest number of cases per 100,000 in the past 2 weeks)

County name, State	No. of new cases in past 2 weeks	2-week incidence (per 100,000)	Change in daily incidence (per 100,000 per day)
Emmons, ND	123	3,732.9	2.0
Roosevelt, MT	307	2,776.0	15.7
Logan, ND	49	2,574.9	12.1
Tripp, SD	116	2,117.6	4.6
Campbell, SD	29	2,106.0	13.9
Jerauld, SD	42	2,055.8	3.5
Renville, ND	46	1,937.7	6.9
Camas, ID	20	1,774.6	3.3
Stark, ND	535	1,726.0	2.5
Waseca, MN	322	1,722.8	4.9

Coronavirus Disease 2019 (COVID-19)
Current consecutive days of downward trajectory, by U.S. County, September 30, 2020



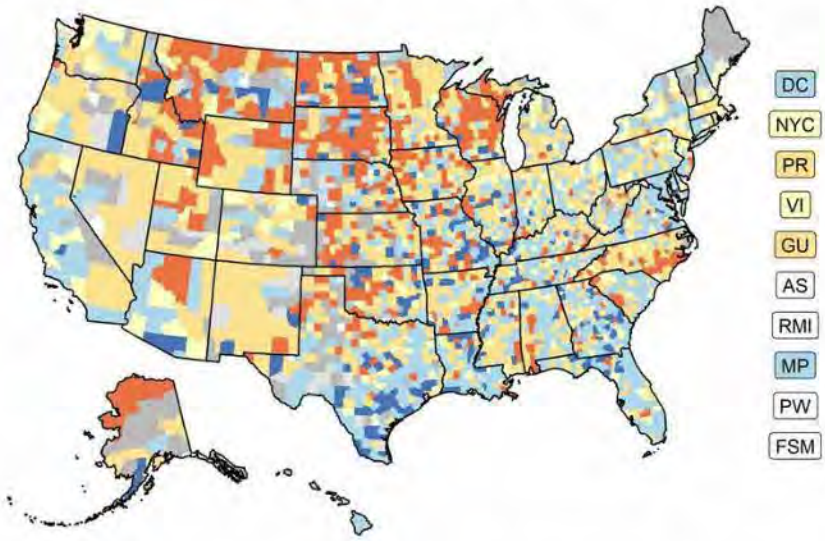
Days in downward trajectory*
- 1-6 days
- 7-13 days
- 14-20 days
- 21-41 days
- ≥42 days
- Not in downward trajectory
- 1-5 cases in the past 2 weeks
- 0 cases in the past 2 weeks
- No reported cases

Purpose of this map
Identifies progress in counties towards achieving a downward trajectory in case incidence over a 14-day period.

Main Findings
- 320 counties have been identified as having 14 or more consecutive days of improvement and are indicated in the blue colors (excludes counties with 0-5 cases in the past 2 weeks); median population size: 33,780 with a range of 776 – 2,761,581.
- This method is still being refined to best characterize progress towards achieving a downward trajectory in daily case incidence over a 14-day period, and the results provided should be interpreted with caution when determining mitigation strategies to use.

*The number of days in a downward trajectory represents the number of consecutive days for which the jurisdiction experienced either a negative slope or a low incidence plateau (two-week incidence ≤10 cases per 100,000 and slope >-0.1 and ≤0.1).
Sources: HHS Protect, US Census

Coronavirus Disease 2019 (COVID-19)
Change in Daily Incidence*,
by U.S. County, September 30, 2020



Change in incidence per 100,000 per day

- Greater decline
- Moderate decline
- Plateau
- Moderate increase
- Greater increase
- 1-5 cases in the past 2 weeks
- 0 cases in the past 2 weeks
- No reported cases

Purpose of this map
Describes the trajectory of new illnesses as recently increasing, being stable, or decreasing in number.

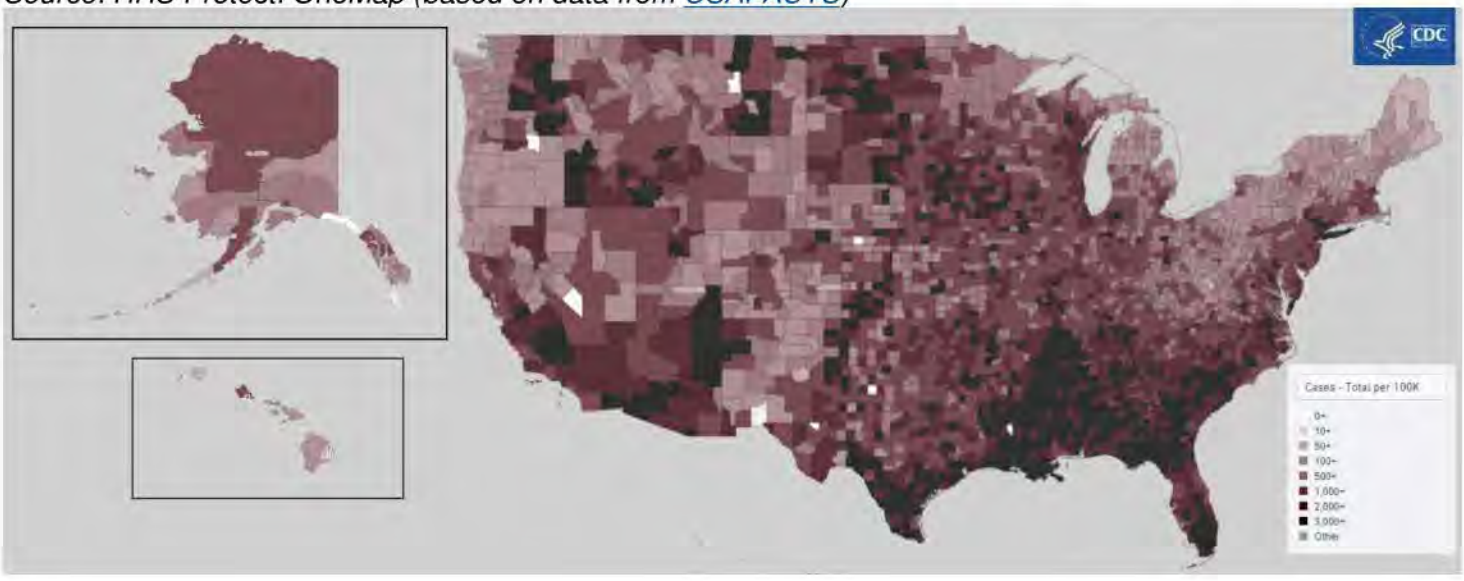
Main Findings

- Daily county-level incidence rates continue to decrease in much of the East Coast and the West Coast.
- However, county-level incidence is increasing throughout much of the Midwest and Great Plains, including Iowa, Minnesota, Wisconsin, North Dakota, South Dakota, Kansas, Wyoming, Montana, Idaho, Arizona, Oklahoma, North Carolina and Alaska.

*Measured as the change in slope of a spline fit to smoothed daily incidence. Incidence was smoothed using a 7-day moving average. These values therefore represent the change in 7-day average number of new cases per 100,000 per day. Greater declines are ≤-1, moderate declines are >-1 to -0.1, plateaus are >-0.1 to ≤0.1, moderate increases are >0.1 to 1, greater increases are >1. Counties denoted as 0 cases in the past 2 weeks have had at least 1 case previously.

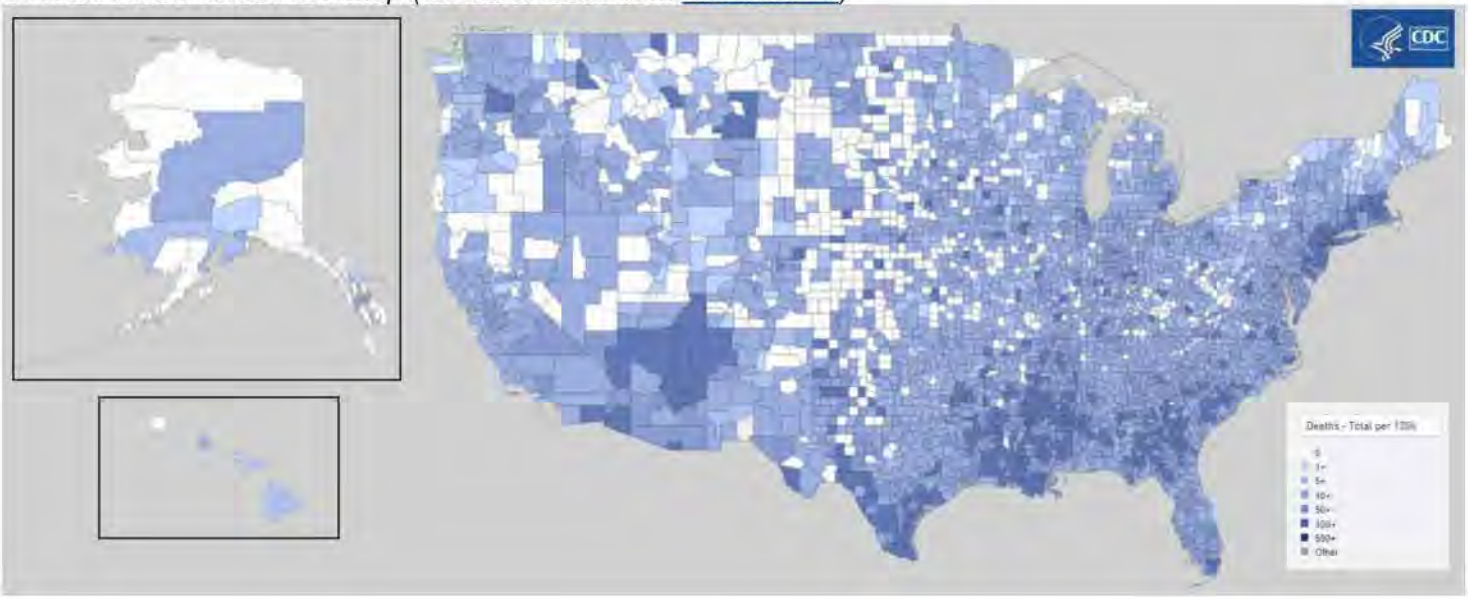
Sources: HHS Protect, US Census

Total Number of COVID-19 Cases in the United States by County per 100,000 Population
Data Through: 30 Sep 2020 *Last Updated: 02 Oct 2020, 08:00*
Source: HHS Protect: OneMap (based on data from USAFACTS)



Total Number of COVID-19 Deaths in the United States by County per 100,000 Population

Data Through: 30 Sep 2020 *Last Updated: 02 Oct 2020, 08:00*
Source: HHS Protect: OneMap (based on data from USAFACTS)

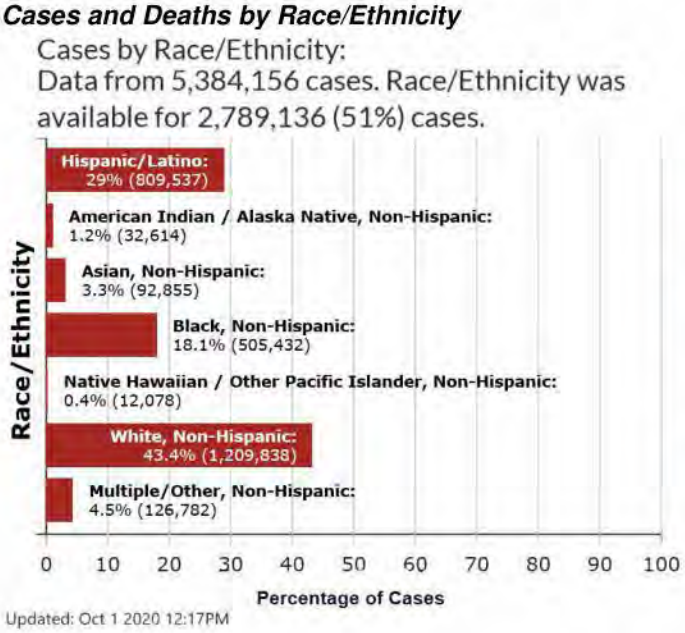


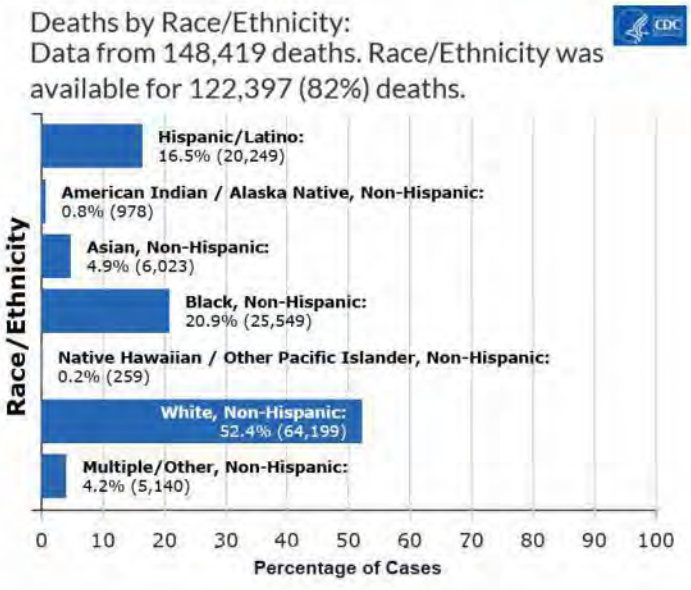
Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC[10]

Demographic Trends of COVID-19 Cases and Deaths in the US Reported to the CDC

Data through 30 Sep 2020 *Last Updated: 01 Oct 2020 12:17*
Source: Data Reported to CDC from States/Jurisdictions on CDC COVID Data Tracker

Cases and Deaths by Race/Ethnicity

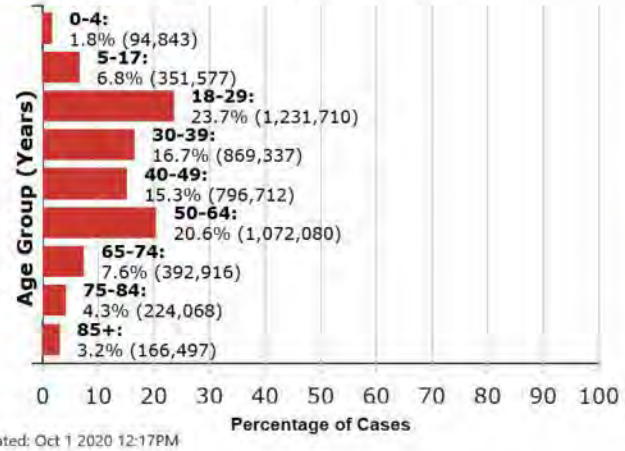




[10] CDC is working with states to provide more information on race/ethnicity for reported cases. The percent of reported cases that include race/ethnicity data is increasing. These data only represent the geographic areas that contributed data on race/ethnicity. Every geographic area has a different racial and ethnic composition. These data are not generalizable to the entire U.S. population. If cases were distributed equally across racial and ethnic populations, one would expect to see more cases in those populations that are more highly represented in geographic areas that contributed data. Percentages displayed in the charts below represent the percent of cases or deaths for which the demographic variable of interest is known.

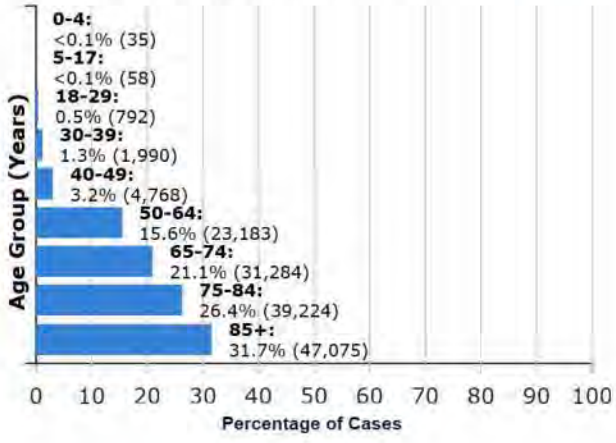
Cases and Deaths by Age Group

Cases by Age Group:
Data from 5,384,156 cases. Age group was available for 5,199,740 (96%) cases.



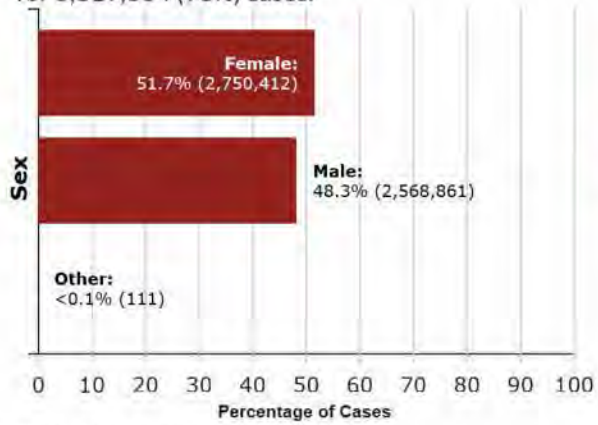
Updated: Oct 1 2020 12:17PM

Deaths by Age Group:
Data from 148,419 deaths. Age group was available for 148,409 (99%) deaths.



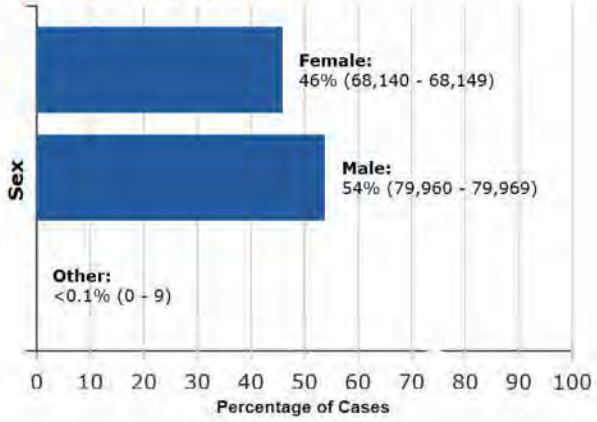
Cases and Deaths by Sex

Cases by Sex:
Data from 5,384,156 cases. Sex was available for 5,319,384 (98%) cases.



Updated: Oct 1 2020 12:17PM

Deaths by Sex:
Data from 148,419 deaths. Sex was available for 148,111 (99%) deaths.

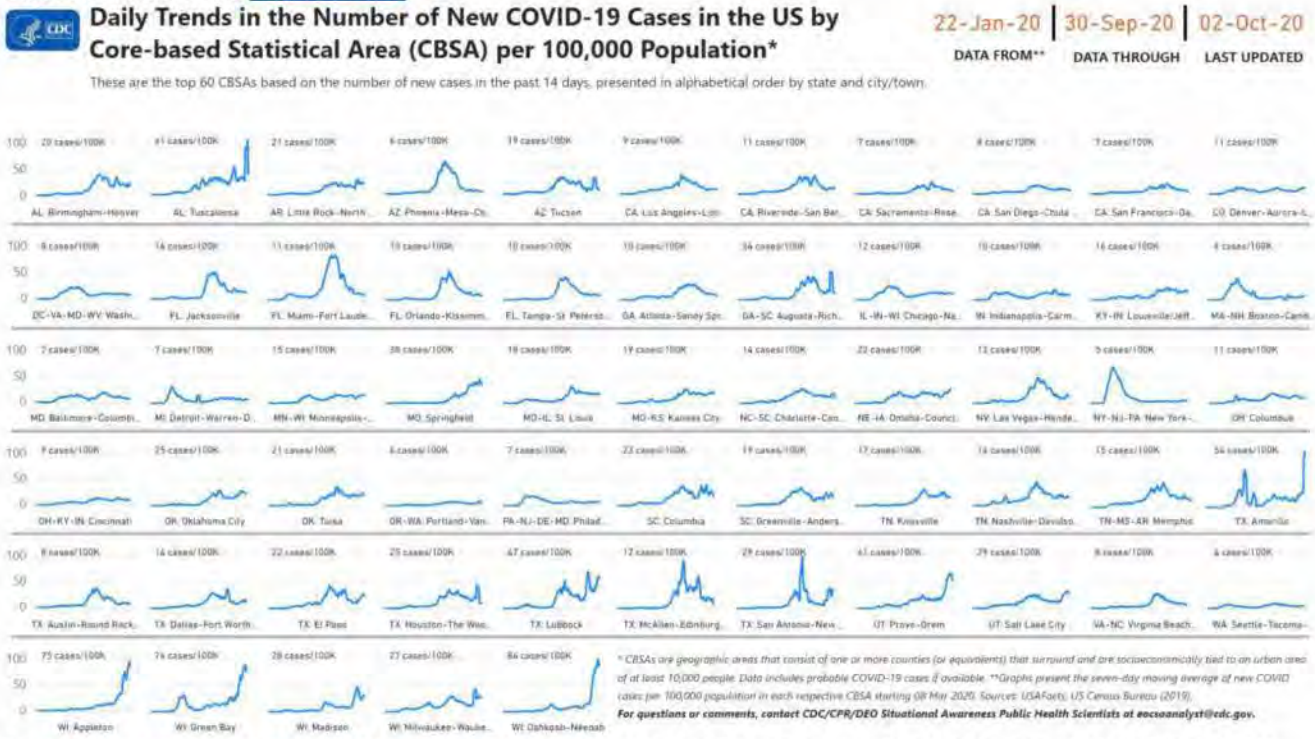


Cases/Deaths by CBSA [11,12]

Daily Trends in New COVID-19 Cases in the United States per 100,000 Population by CBSA

Data 22 Jan 2020 through 30 Sep 2020 Last Updated: 02 Oct 2020, 08:00

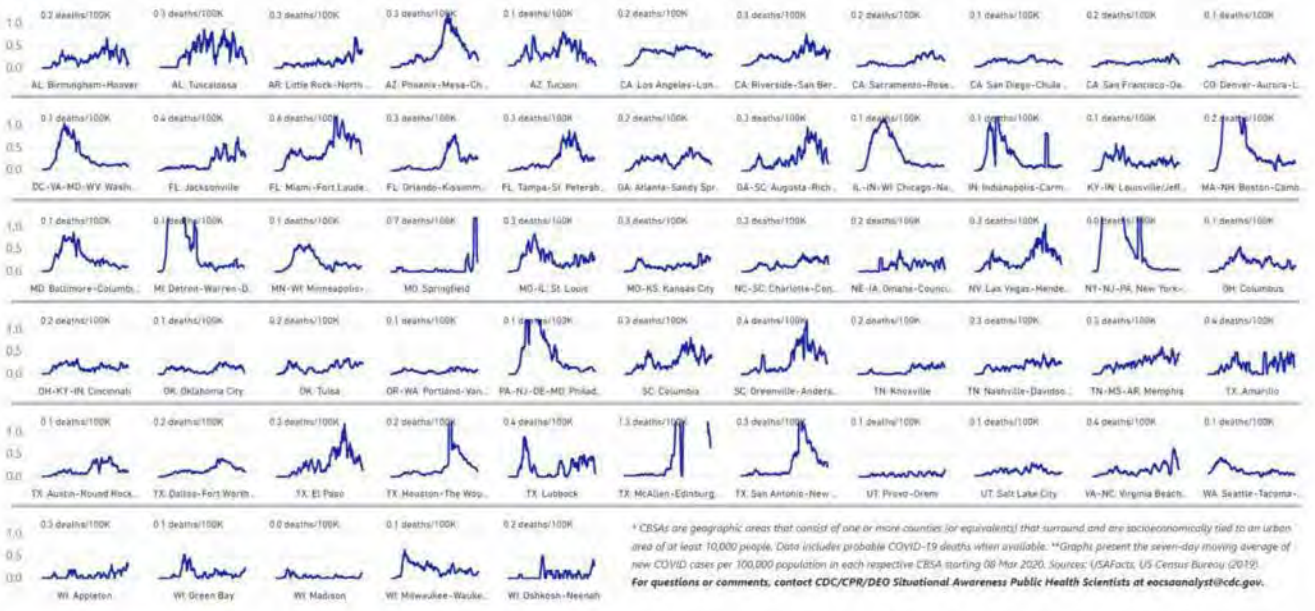
Source: Data from USAFACTS



Daily Trends in New COVID-19 Deaths in the United States per 100,000 Population by CBSA

Data 22 Jan 2020 through 30 Sep 2020 Last Updated: 02 Oct 2020, 08:00

Source: Data from USAFACTS

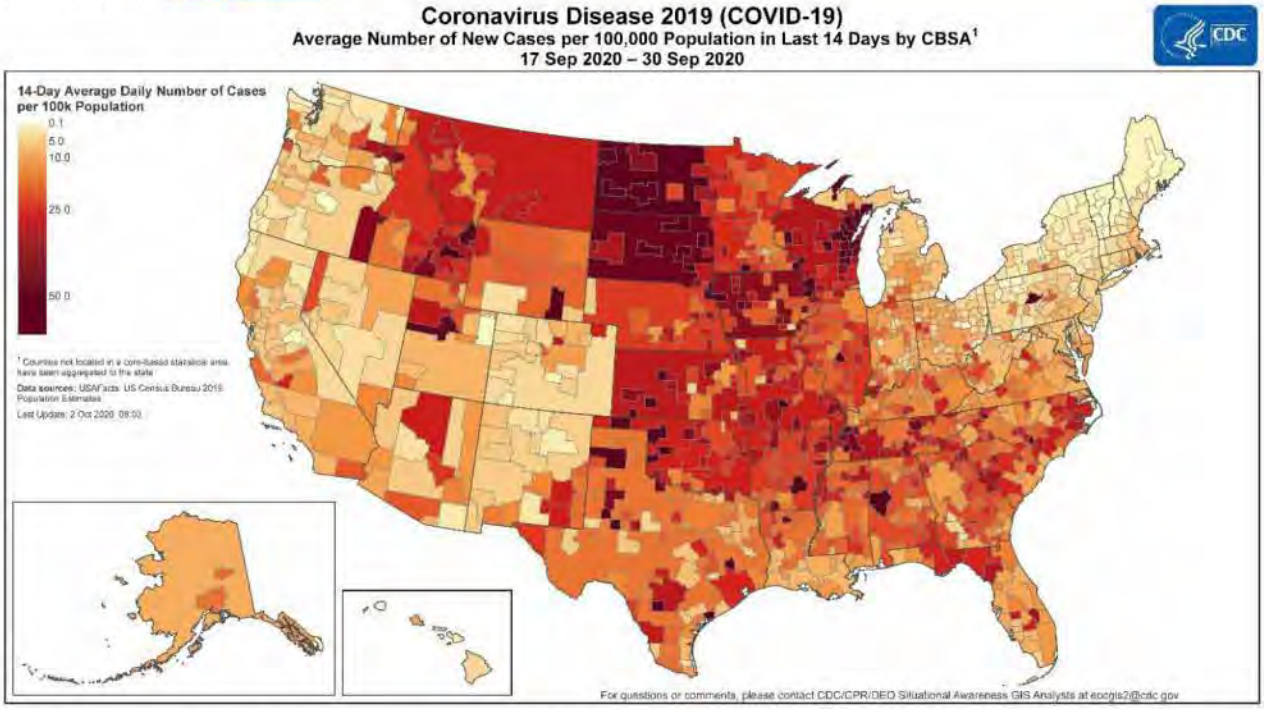


[11] See methodology and sources for data reported by *USAFACTS*.
[12] See information on Core-Based Statistical Area (CBSA) from the US Census Bureau.

Cases/Deaths by CBSA (Maps) [13,14]

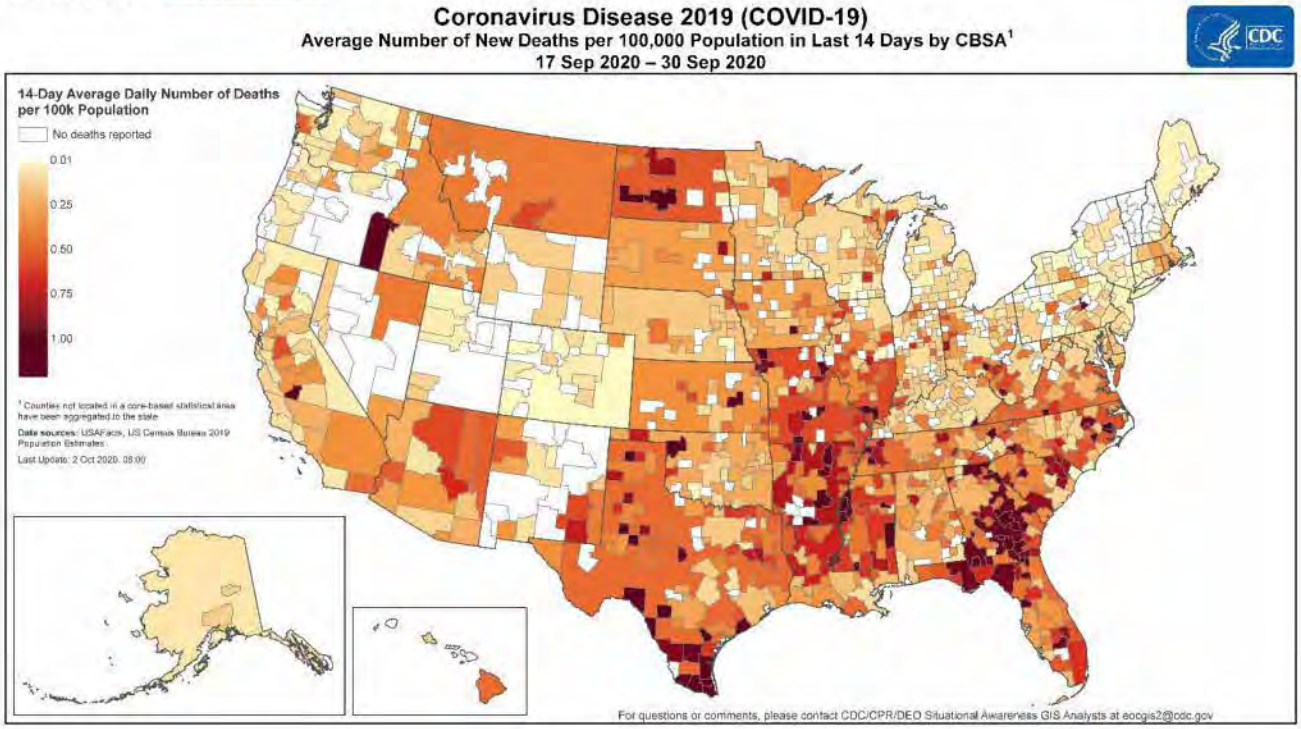
Total Cases due to COVID-19 per 100,000 Population by CBSA

Data:17 Sep 2020 – 30 Sep 2020 Last Updated: 02 Oct 2020
Source: Data USAFACTS



Total Deaths due to COVID-19 per 100,000 Population by CBSA

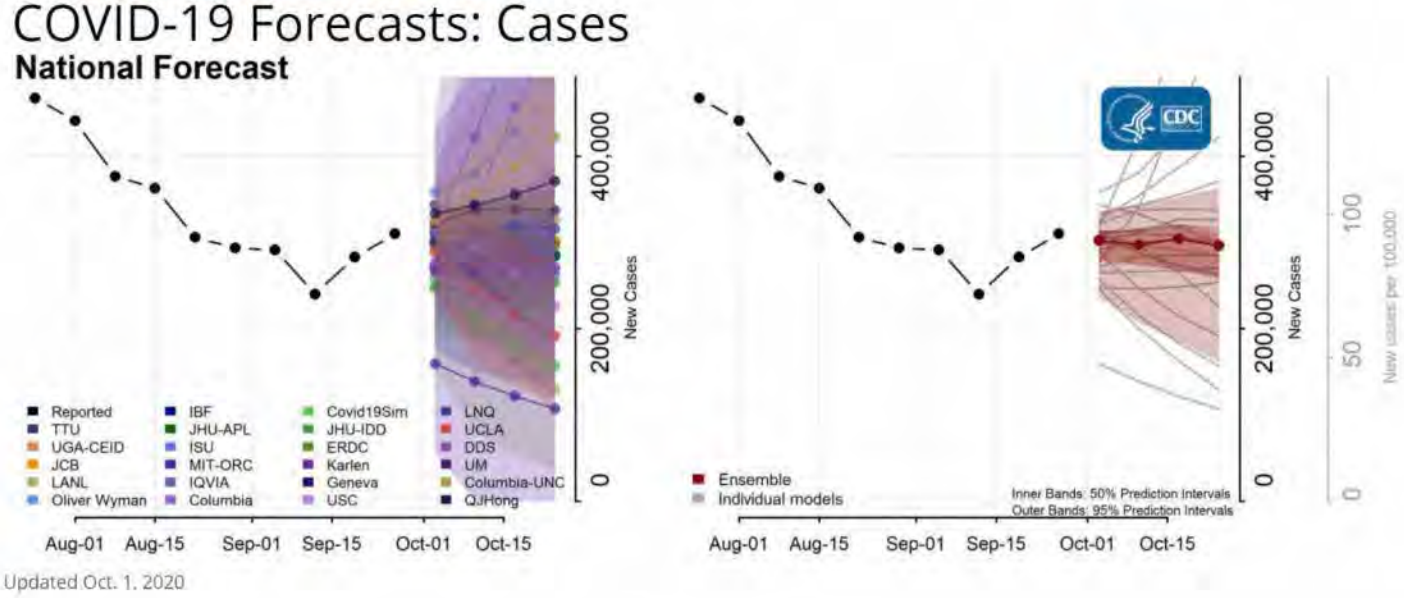
Data: 17 Sep 2020 – 30 Sep 2020 Last Updated: 02 Oct 2020
Source: Data USAFACTS



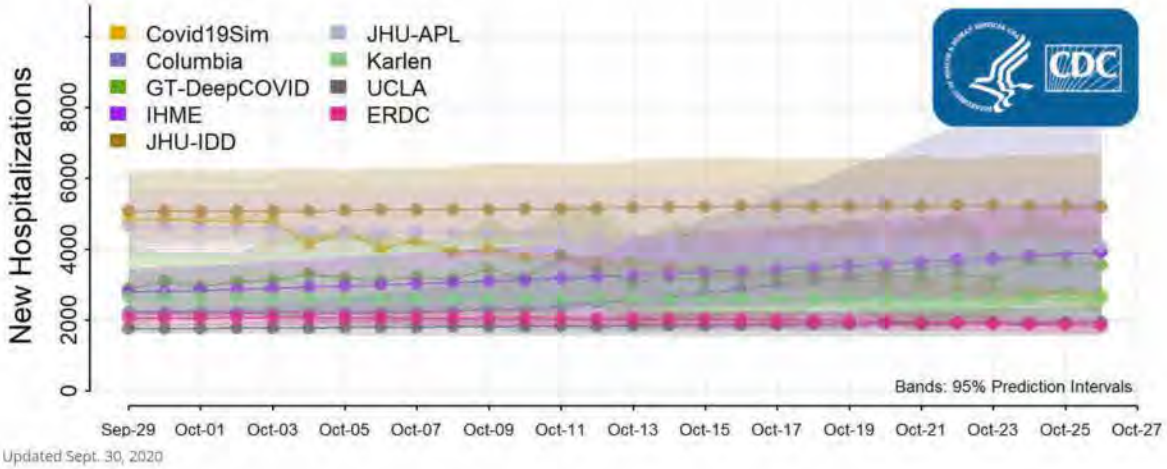
[13] See methodology and sources for data reported by *USAFACTS*.
[14] See information on Core-Based Statistical Area (CBSA) from the US Census Bureau.

COVID-19 Forecasts

COVID-19 National Forecasts: New Weekly Cases
Data: 25 Jul 2020 – 26 Sep 2020 Last Updated: 01 Oct 2020
Forecasts Through: 24 Oct 2020
Source: CDC COVID-19 Forecasts: Cases



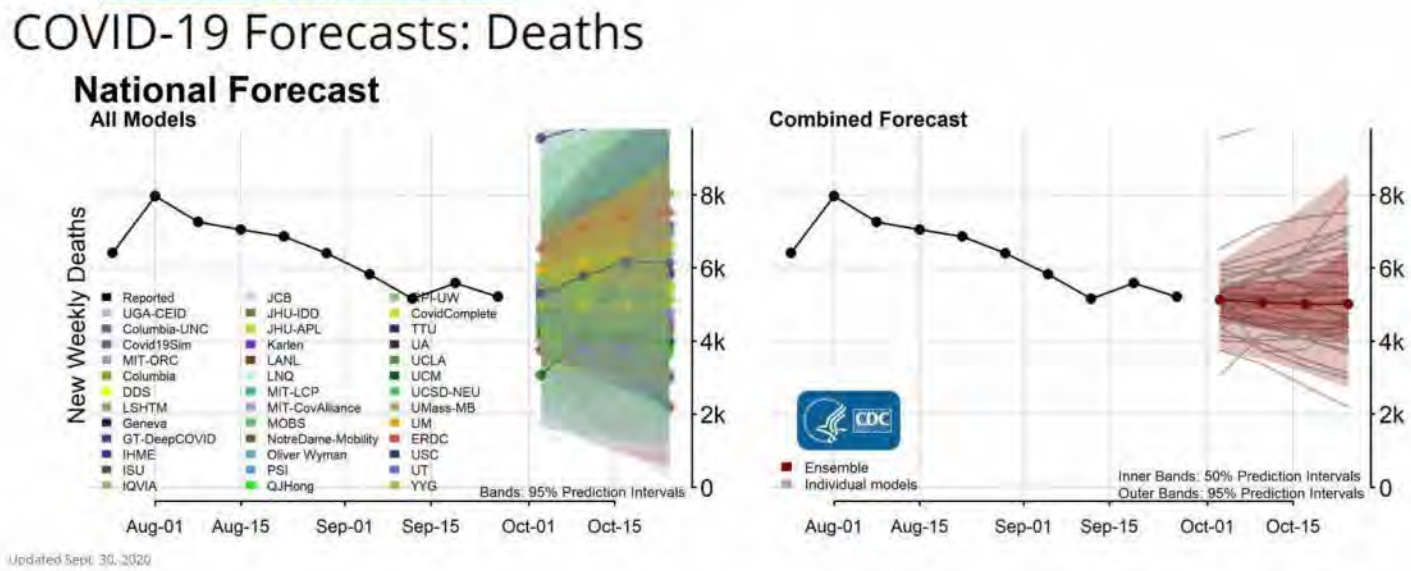
COVID-19 National Forecasts: Hospitalizations[15]
Data: 18 Jul 2020 – 27 Sep 2020 Last Updated: 01 Oct 2020
Forecasts Through: 26 Oct 2020
Source CDC COVID-19 Forecasts: Hospitalizations



[15] See Technical Information

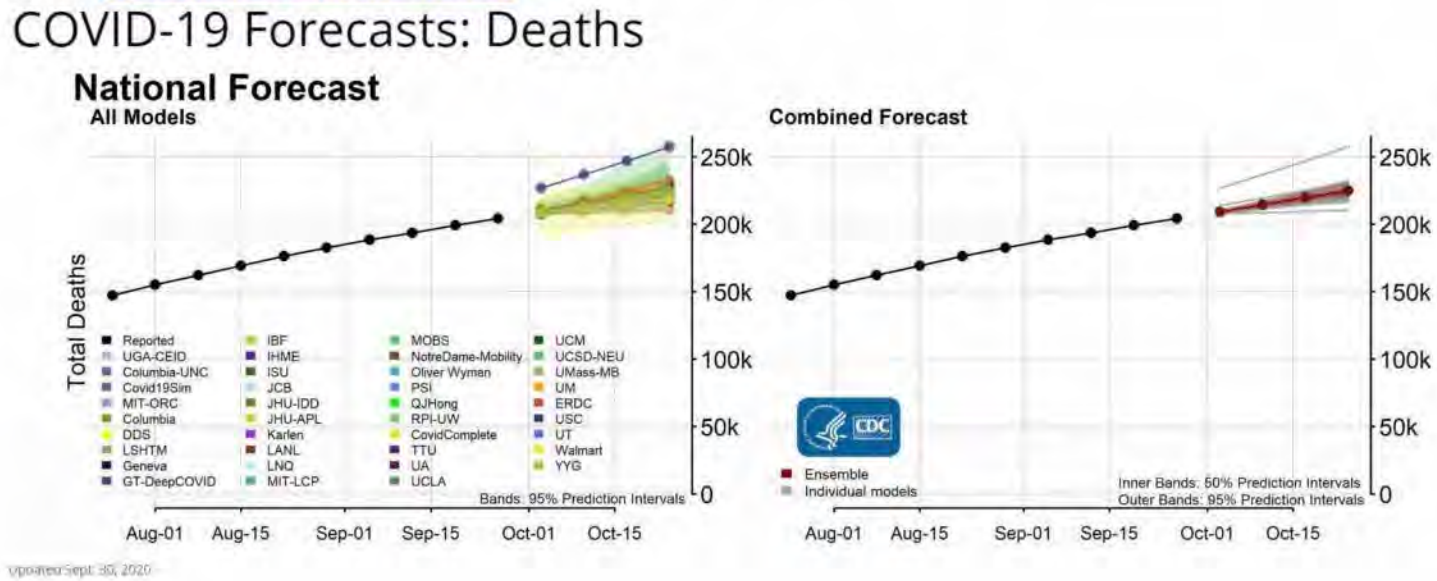
COVID-19 National Forecasts: New Weekly Deaths

Data: 25 Jul 2020 – 26 Sep 2020 Last Updated: 30 Sep 2020
Forecasts Through: 24 Oct 2020
Source: CDC COVID-19 Forecasts: Deaths



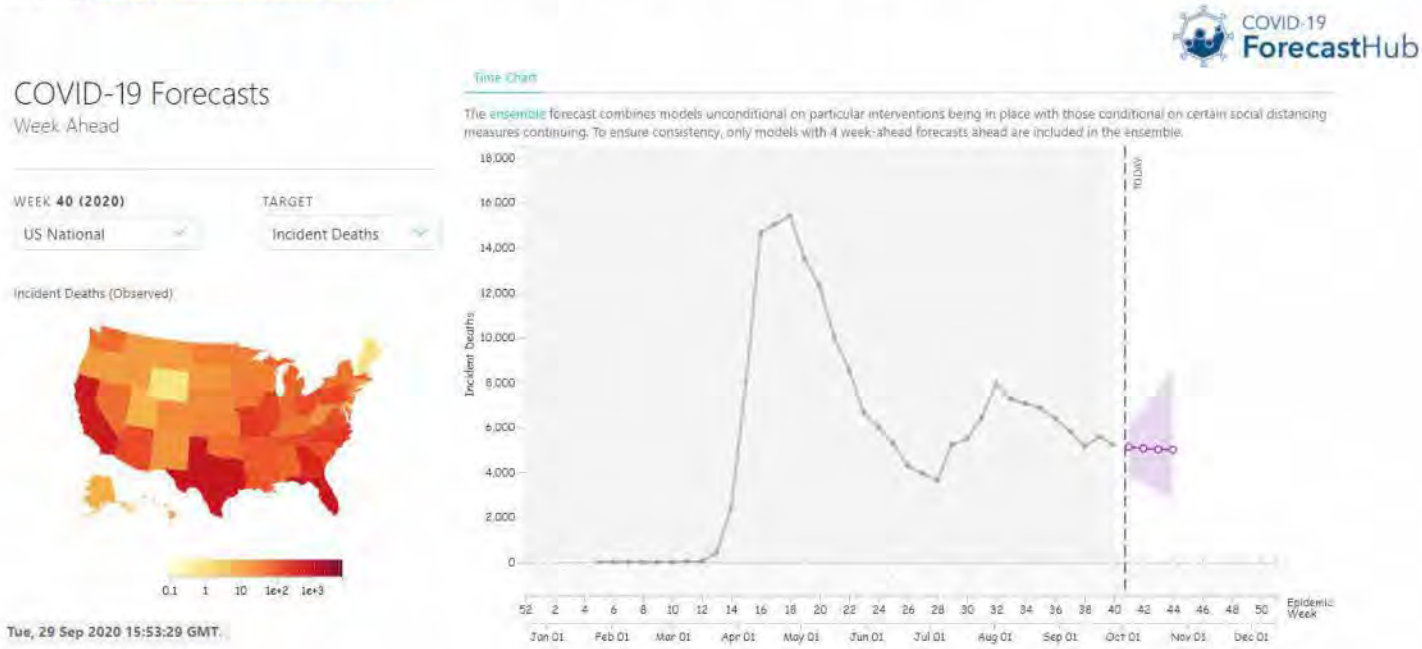
COVID-19 National Forecasts: Total Deaths

Data: 25 Jul 2020 – 26 Sep 2020 Last Updated: 30 Sep 2020
Forecasts Through: 24 Oct 2020
Source: CDC COVID-19 Forecasts: Deaths



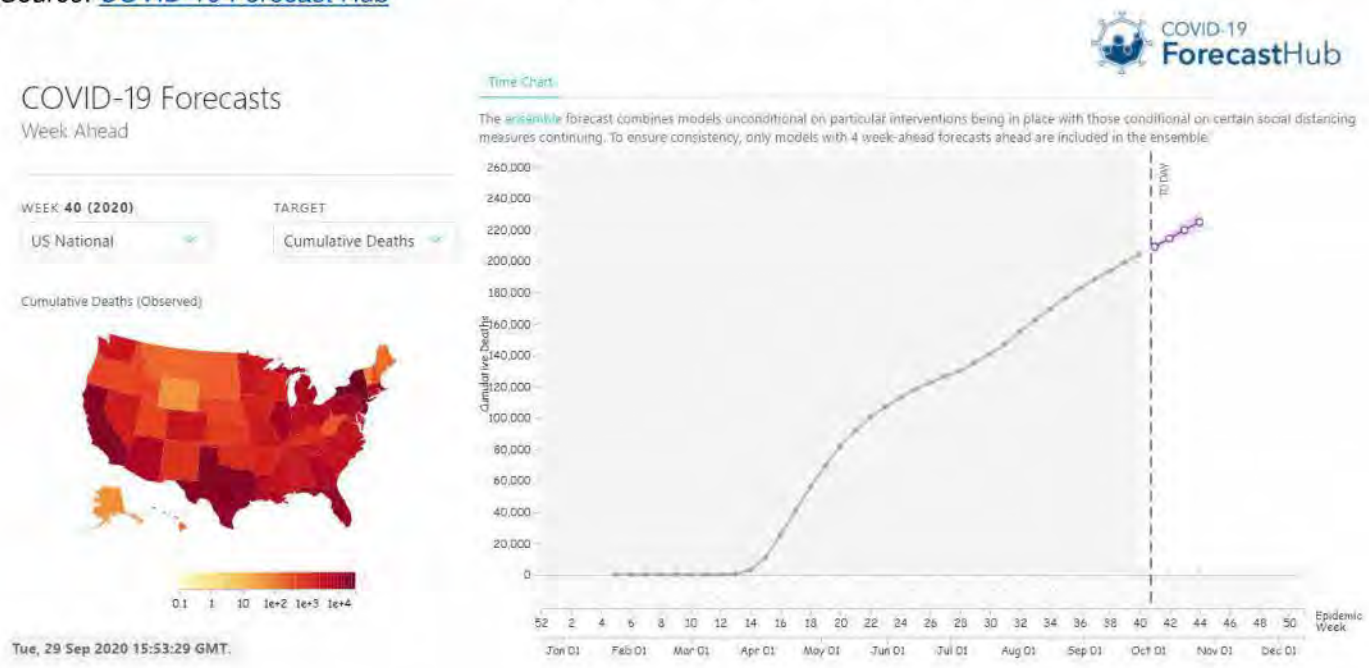
COVID-19 National Forecasts: Incident Deaths (Forecast Hub)

Data: 27 Jan 2020 – 26 Sep 2020 Last Updated: 29 Sep 2020, 15:53 GMT
Source: COVID-19 Forecast Hub



COVID-19 National Forecasts: Cumulative Deaths (Forecast Hub)

Data: 27 Jan 2020 – 26 Sep 2020 Last Updated: 29 Sep 2020, 15:53 GMT
Source: COVID-19 Forecast Hub



COVID-19 Among Specific Populations

US Healthcare Workers

Data as of 01 Oct 2020

Healthcare Workers in US - Case Count Reported in Case-Based Surveillance

N = 169,514 (+451)

- 736 Deaths (+3)
  - 189 in IL
  - 185 in CA
  - 63 in OH
  - 46 in MA
  - 33 in MI
  - 29 in NV[16]
  - 26 in TN
  - 25 in NY
  - 21 in NC
  - 20 in PA
  - 18 in WA
  - 13 in AR
  - 12 in IA
  - 11 in LA
  - 11 in MN
  - 8 in NH
  - 7 in KS
  - 7 in NJ
  - 4 in CO
  - 3 in DC
  - 2 in PR
  - 1 in UT
  - 1 in VI

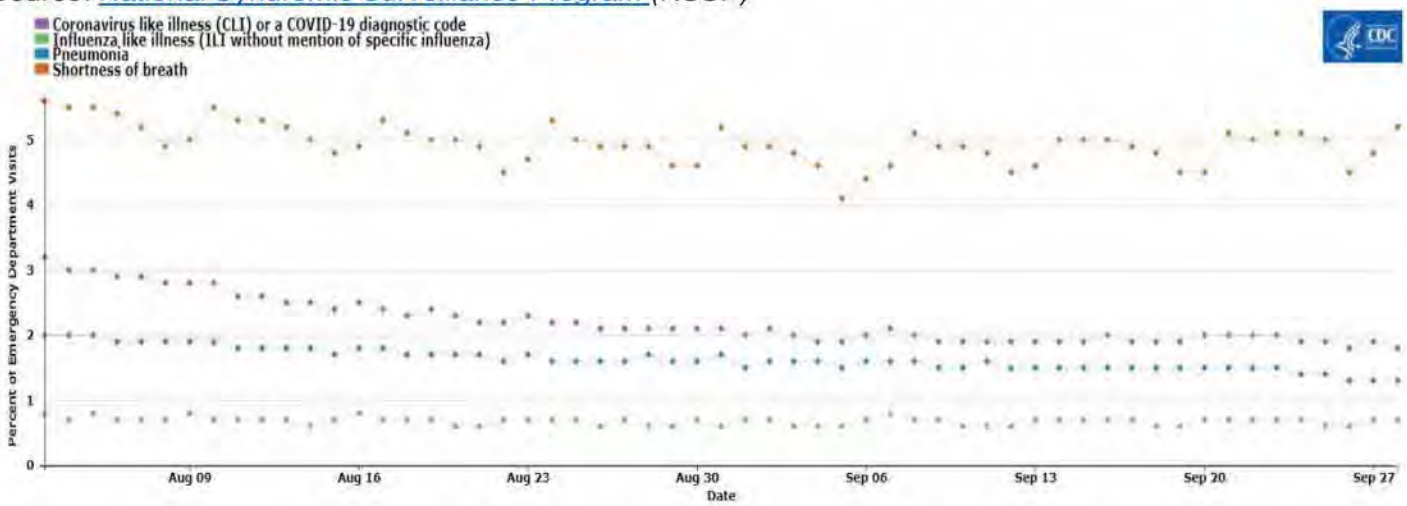
Healthcare Utilization

US Trends in Emergency Department Visits

Percentage of ED Visits by Syndrome in United States: COVID-19-Like Illness, Shortness of Breath, Pneumonia, and Influenza-Like Illness

Data: 03 Aug 2020 – 28 Sep 2020 *Last Updated: 02 Oct 2020*

Source: National Syndromic Surveillance Program (NSSP)



[16] The number of HCP death decreased by 1 for NV. The decrease in deaths is most likely due to data cleaning.

Laboratory Testing

Status of Laboratory Testing

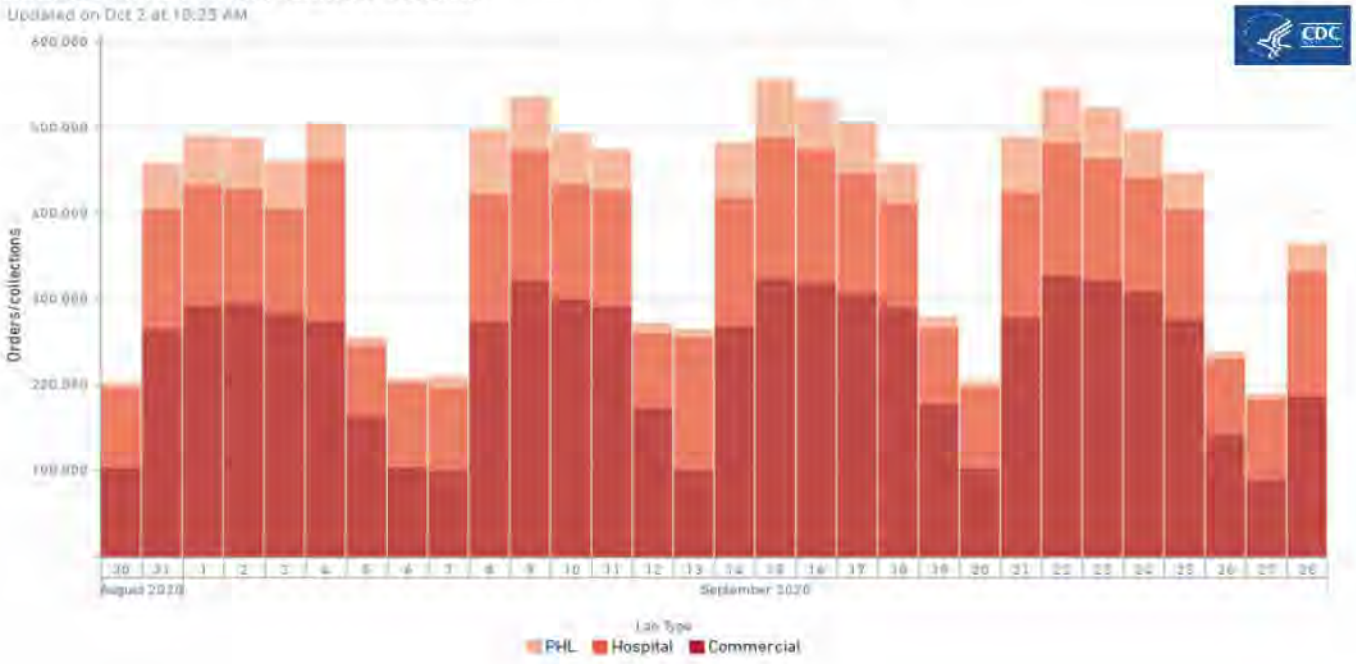
Data Through: 28 Sep 2020 *Last Updated: 01 Oct 2020, 22:56*
Source: HHS Protect[17,18]

Report	Total New Orders	Cumulative Orders	New With Results	Cumulative Results	New Positives	Cumulative Positives	Percent Positive	% Positive Last 7 Days
Hospital[19]	144,526	19,454,117	117,157	19,454,509	4,494	1,343,750	6.91%	3.90%
Commercial labs[20]	186,647	42,291,329	106,449	41,428,617	6,275	3,475,911	8.39%	4.73%
State/Local PHL[21]	32,820	6,529,245	31,165	6,490,896	1,272	480,578	7.40%	4.90%
Total	363,993	68,274,691	254,771	67,374,022	12,041	5,300,239		

			Cumulative Total With Results		Cumulative Total Positive		Cumulative Total % Positive	% Positive Last 7 Days
Total Incl. State HD's[22]			115,475,940		8,903,548		7.71%	4.48%

Laboratory Orders/Collections per Day by Facility Type[23]

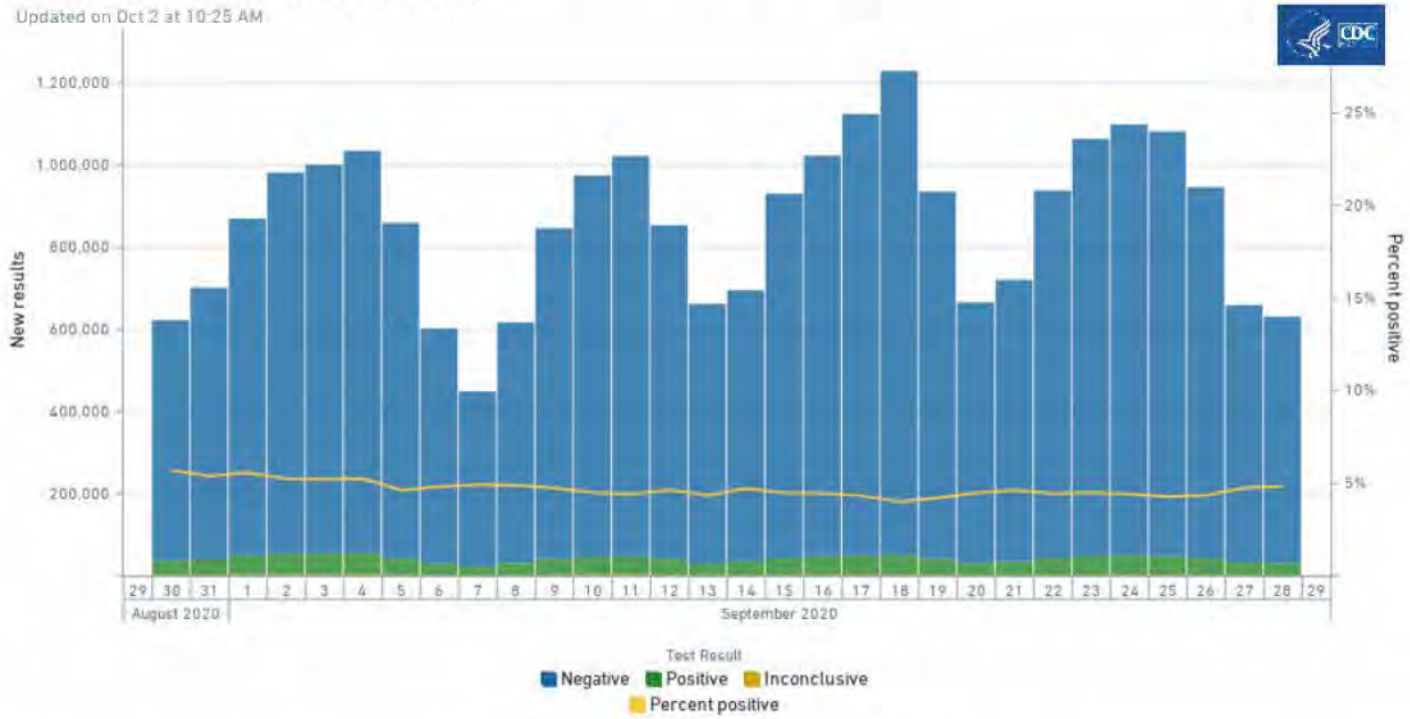
Data: 30 Aug 2020 - 28 Sep 2020 *Last Updated: 02 Oct 2020, 10:25*
Source: HHS Protect Unified Dataset



[17] Data Source: HHS Protect is the data source for hospital and commercial lab data starting 23 Apr and PHL labs starting 08 May. Beginning 31 Aug, new results are the numbers as reported in HHS Protect at the time the data were exported.
[18] As of 03 Aug, Laboratory Data in HHS Protect uses data through the most recent day for which all jurisdictions have reported in order to report data for all jurisdictions along a consistent time window.
[19] Hospital laboratory data are reported directly to HHS via an online form, beginning 11 Apr. Respondents are asked to report all tests run in the hospital laboratory and not sent out to commercial laboratories.
[20] Includes 6 commercial labs: LabCorp, Quest Diagnostics, BioReference, ARUP, Mayo Clinic, and Sonic Healthcare.
[21] Reporting public health labs are all 50 state public health labs, the District of Columbia, New York City, Puerto Rico, USAF, and 17 California counties.
[22] Includes laboratory results reported to CDC from additional state health departments not reported through HHS Protect including additional lab orders received prior to 23 Apr not included in HHS Protect.
[23] Reported by test order date if available, otherwise the date the specimen was collected. Due to reporting lags, data for the most recent three days may be underrepresented.

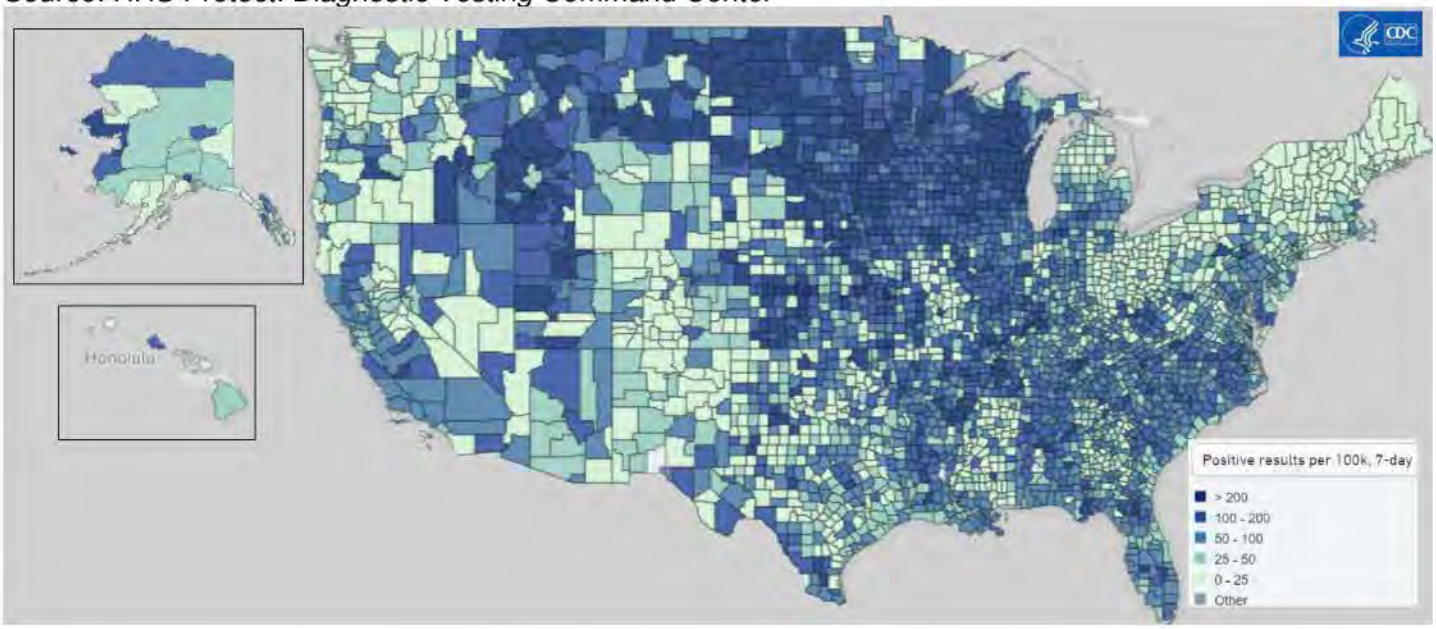
COVID-19 Positive/Negative Results and Percent Positive from Public Health, Commercial, and Hospital Laboratories[24]

Data: 30 Aug 2020 - 28 Sep 2020 *Last Updated: 02 Oct 2020, 10:25*
Source: HHS Protect Unified Dataset



Positive Results per 100,000 Population Last 7-Days by County [25, 26]

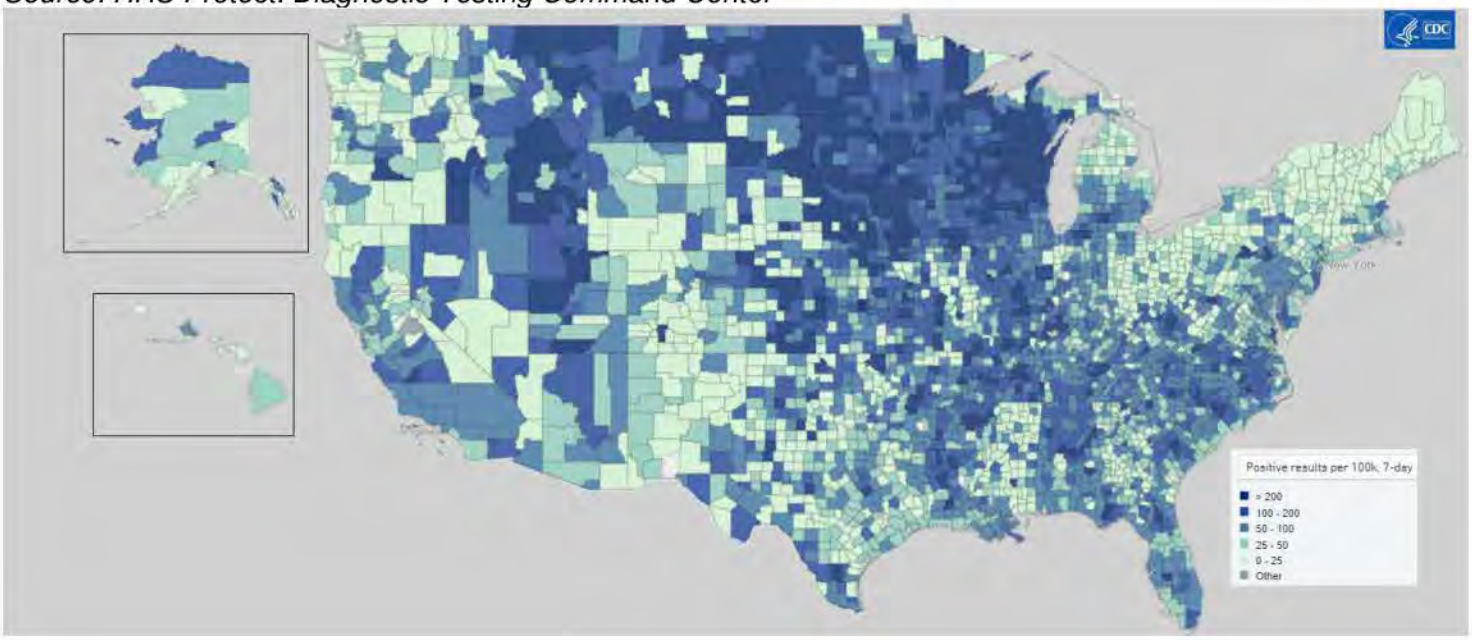
Data: 22 Sep 2020 - 28 Sep 2020 *Last Updated: 02 Oct 2020, 11:00*
Source: HHS Protect: Diagnostic Testing Command Center



[24] Reported by test result date. Due to reporting lags, data for the most recent three days may be underrepresented.
[25] Data represent (total number of positive results/total population) * 100.One person may have multiple tests and positive results.
[26] See CDC COVID-19 Data Tracker for the latest visualizations on US laboratory testing by state.

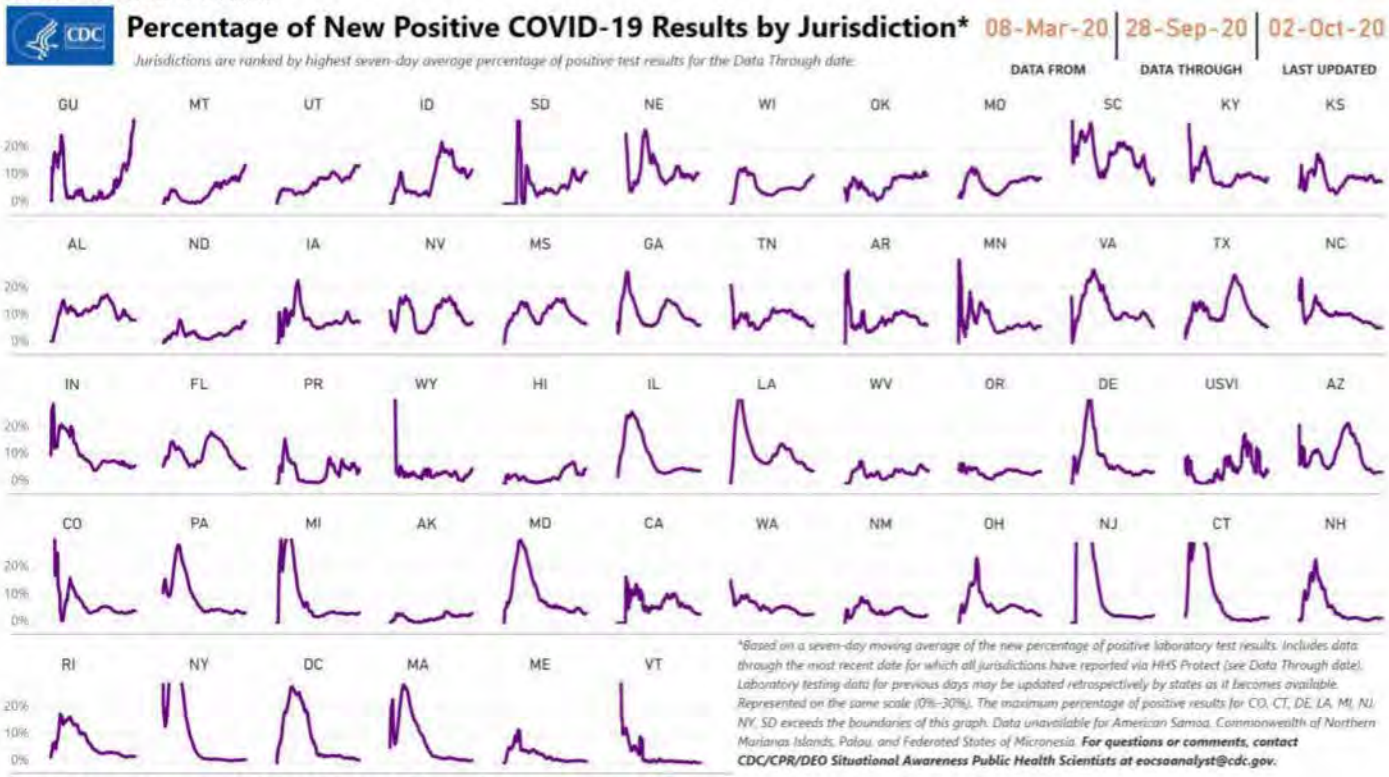
Percent Positive Results Last 7-Days by County [26]

Data: 22 Sep 2020 - 28 Sep 2020 Last Updated: 02 Oct 2020, 11:00
Source: HHS Protect: Diagnostic Testing Command Center



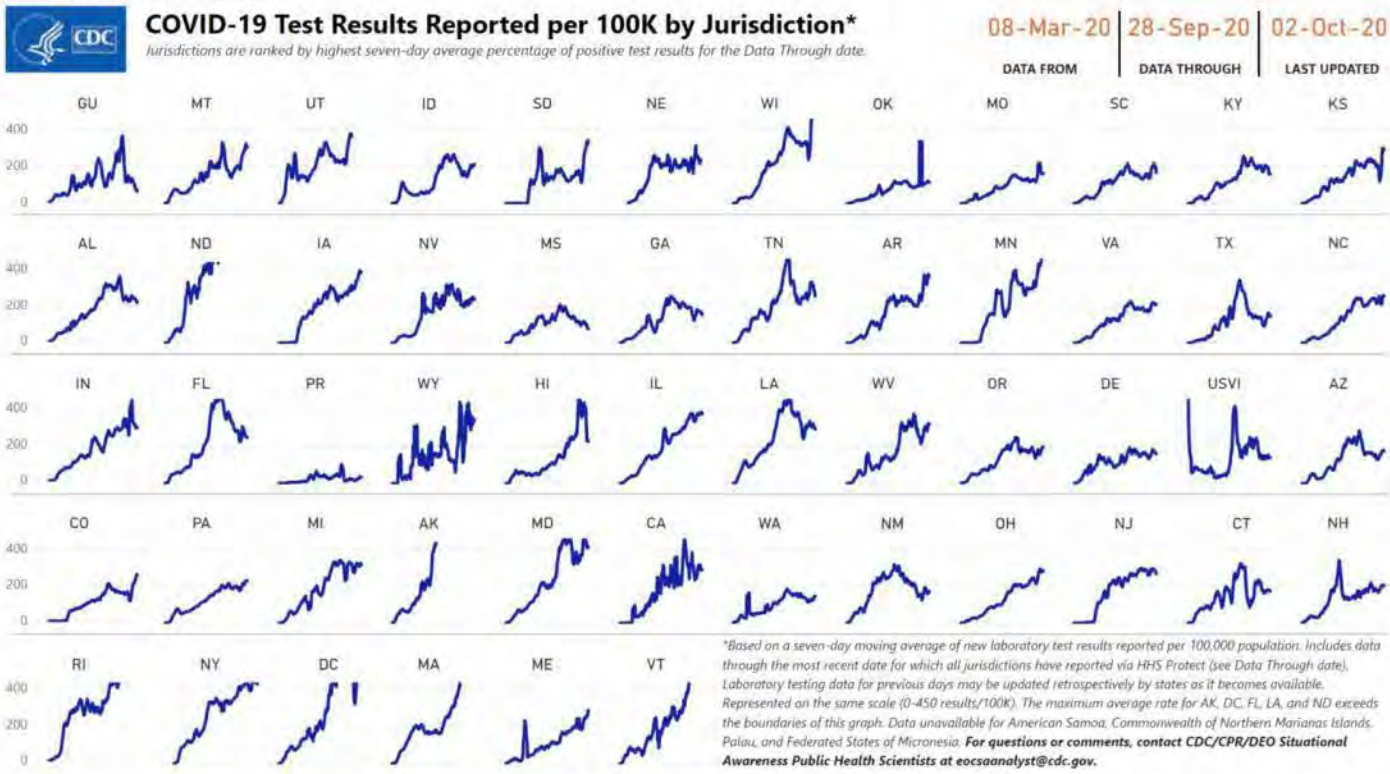
Percentage of New Positive COVID-19 Test Results by Jurisdiction

Data: 08 Mar 2020 – 28 Sep 2020 Last Updated: 02 Oct 2020, 09:00
Source: HHS Protect



New Positive COVID-19 Test Results per 100,000 Population by Jurisdiction

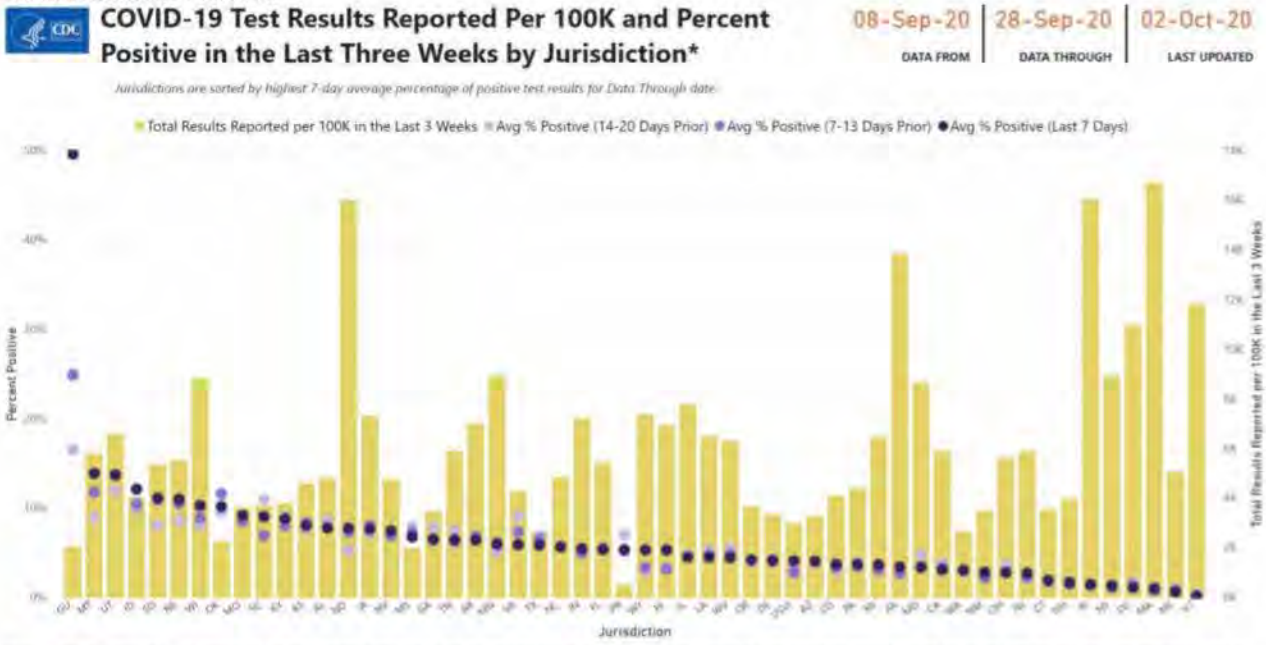
Data: 08 Mar 2020 – 28 Sep 2020 Last Updated: 02 Oct 2020, 09:00
Source: HHS Protect



COVID-19 Test Results per 100,000 and Percent Positive in the Last 3 Weeks by Jurisdiction[27,28, 29]

Data 08 Sep 2020 – 28 Sep 2020 *Last Updated: 02 Oct 2020, 09:00*

Source: HHS Protect



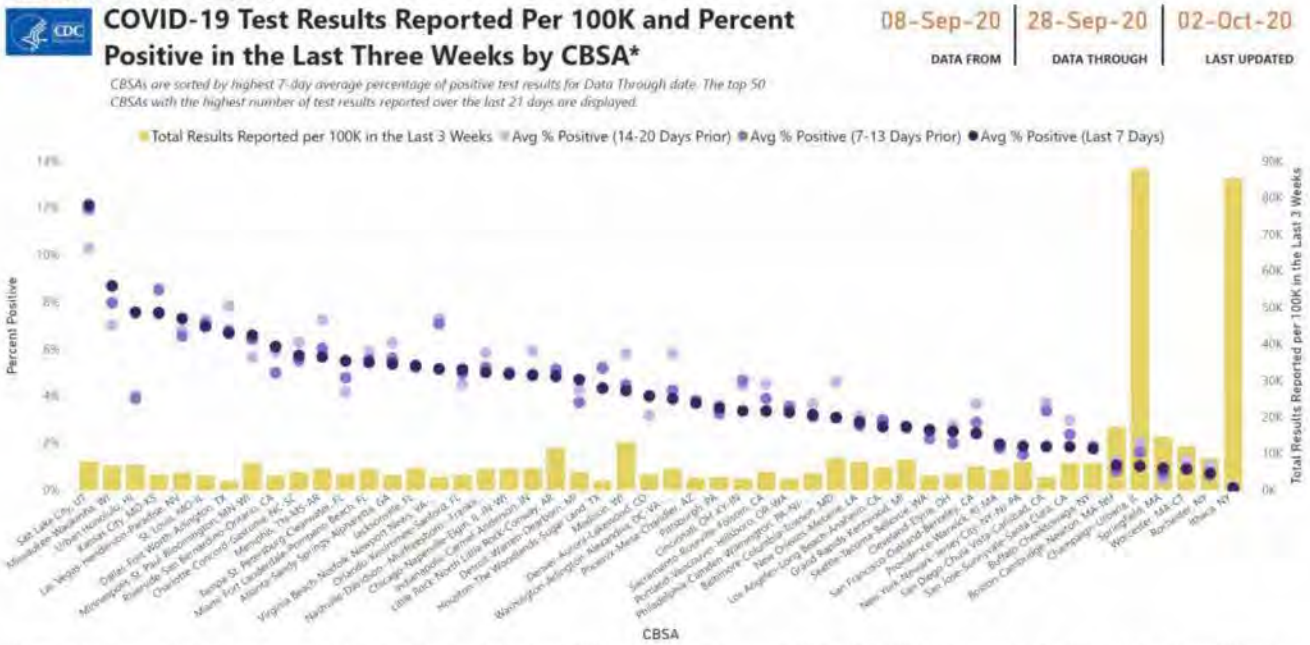
Based on total laboratory test results reported per 100,000 population in the last 21 days. Includes data through the most recent date for which all jurisdictions have reported via HHS Protect (see Data Through date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Data unavailable for American Samoa, Commonwealth of Northern Mariana Islands, Guam, US Virgin Islands, Palau, and Federated States of Micronesia.

For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

COVID-19 Test Results per 100,000 and Percent Positive in the Last 3 Weeks by CBSA[28, 29]

Data 08 Sep 2020 – 28 Sep 2020 *Last Updated: 02 Oct 2020, 09:00*

Source: HHS Protect



Metropolitan and Micropolitan Statistical Areas are collectively referred to as Core-Based Statistical Areas (CBSA); new definitions were announced by OMB on 06 Jun 2003, based on application of the 2000 standards with Census 2000 data. Figure based on total laboratory test results reported per 100,000 population in the last 21 days. Includes data through the most recent date for which all jurisdictions have reported via HHS Protect (see Data Through date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Guam, US Virgin Islands, Palau, and Federated States of Micronesia.

For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

[27] Data from state health departments, state public health labs, commercial labs, and hospitals.

[28] Metropolitan and Micropolitan Statistical Areas are collectively referred to as Core-Based Statistical Areas (CBSA). Due to reporting lags, data for the most recent three days may be underrepresented.

[29] Line level laboratory data for 28 Sep may be incomplete and the latest 7-day average should be interpreted with caution.

Comparison of U.S. Case Counts with Laboratory Testing Data

COVID-19 Cases, Deaths and Lab Comparison by Jurisdiction

Data Through: 28 Sep 2020 *Last Updated: 02 Oct 2020, 11:30*
Source: HHS Protect

COVID-19 Epi/Lab Overview -- US States, Territories & DC

Data for case and laboratory data includes data through the most recent date for which most jurisdictions have reported via HHS protect. *Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Lab data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Palau, and Federated States of Micronesia .*
** Calculation omitted where the number of total new tests was less than five.*

28-Sep-20 | 02-Oct-20
DATA THROUGH | LAST UPDATED

State/ Territory	Cases/ 100K	Deaths/ 100K	Total Tests	New Tests	Tot. Tests/ 100K	New Tests/ 100K	New Pos Tests	Total Pos Tests	% Total Pos Tests	% New Pos Tests*
AK	1030.2	7.6	594,448	5,151	81,259.3	704.1	171	14,360	2.4%	3.3%
AL	[illegible]	51.2	1,750,903	6,281	35,709.5	128.1	637	203,025	[illegible]	10.1%
AR	[illegible]	44.2	1,008,425	7,731	33,415.9	256.2	479	84,786	8.4%	6.2%
AZ	[illegible]	76.4	1,911,419	7,469	26,260.4	102.6	333	219,231	[illegible]	4.5%
CA	[illegible]	39.5	14,662,765	89,274	37,109.4	225.9	2,720	923,943	6.3%	3.0%
CO	1220.1	35.9	1,214,930	10,714	21,097.2	186.0	354	54,882	4.5%	3.3%
CT	1599.6	126.0	1,078,914	4,668	30,261.6	130.9	127	66,232	6.1%	2.7%
DE	2122.5	65.7	235,045	810	24,137.8	83.2	46	17,215	7.3%	5.7%
FL	[illegible]	65.9	9,773,546	39,056	45,505.9	181.8	2,136	1,142,850	[illegible]	5.5%
GA	[illegible]	66.2	2,814,368	16,894	26,507.1	159.1	1,034	290,552	[illegible]	6.1%
HI	871.7	9.3	405,753	2,366	28,657.5	167.1	86	14,790	3.6%	3.6%
IA	[illegible]	41.9	1,217,597	6,889	38,591.8	218.3	436	100,029	[illegible]	6.3%
ID	2332.6	26.2	471,300	3,405	26,372.9	190.5	382	61,423	[illegible]	[illegible]
IL	2292.6	69.5	5,114,530	38,216	40,361.4	301.6	1,573	332,864	6.5%	4.1%
IN	1768.1	53.7	2,508,043	17,143	37,254.3	254.6	941	179,564	7.2%	4.9%
KS	2013.7	21.9	819,415	6,102	28,126.6	209.5	497	71,896	[illegible]	[illegible]
KY	1496.1	26.0	1,118,113	4,708	25,026.7	105.4	385	102,329	[illegible]	[illegible]
LA	[illegible]	117.6	2,321,194	11,154	49,831.1	239.9	470	239,235	[illegible]	4.2%
MA	2009.4	136.3	3,909,723	35,336	56,724.3	512.7	411	170,730	4.4%	1.2%
MD	[illegible]	65.5	2,870,377	12,037	47,476.1	199.1	464	200,421	[illegible]	[illegible]
ME	398.8	10.5	315,709	3,614	23,486.5	268.7	31	5,756	1.8%	0.8%
MI	1357.6	70.5	3,854,123	23,139	38,592.0	231.7	1,086	187,550	[illegible]	[illegible]
MN	1740.1	36.8	2,297,900	16,557	40,745.6	293.6	1,155	142,592	[illegible]	[illegible]
MO	2012.2	33.9	1,123,702	5,547	18,309.0	90.4	546	85,622	[illegible]	[illegible]
MS	[illegible]	97.6	638,035	1,817	21,436.3	61.1	116	73,287	[illegible]	[illegible]
MT	1168.5	16.4	329,052	3,006	30,787.7	281.2	244	19,967	[illegible]	[illegible]
NC	[illegible]	53.2	2,867,374	12,957	27,339.4	123.5	920	243,767	[illegible]	[illegible]
ND	[illegible]	31.4	615,350	3,933	80,746.0	516.1	469	23,778	[illegible]	[illegible]
NE	[illegible]	24.5	686,679	4,650	35,498.1	240.4	511	81,317	[illegible]	[illegible]
NH	605.1	32.4	374,321	1,663	27,529.5	122.3	9	13,318	3.6%	0.5%
NJ	[illegible]	[illegible]	3,097,147	16,342	34,869.2	184.0	528	109,155	[illegible]	[illegible]
NM	1383.2	41.7	769,407	2,139	36,693.8	102.0	66	31,674	4.1%	3.1%
NV	[illegible]	53.6	1,056,674	5,257	34,305.9	170.7	384	107,363	[illegible]	[illegible]
NY	1091.9	45.2	10,862,018	53,608	55,833.6	275.6	1,021	565,714	[illegible]	[illegible]
OH	1286.6	40.6	3,138,180	35,778	26,847.1	306.1	1,042	164,054	[illegible]	[illegible]
OK	[illegible]	25.7	629,018	3,386	15,896.3	85.6	315	52,026	[illegible]	[illegible]
OR	787.3	13.1	1,112,748	6,576	26,382.6	155.9	276	44,100	[illegible]	[illegible]
PA	1224.5	63.3	3,306,772	18,625	25,830.1	145.5	854	210,838	[illegible]	[illegible]
RI	[illegible]	[illegible]	760,797	6,174	71,816.6	582.8	146	34,490	[illegible]	[illegible]
SC	[illegible]	65.6	1,191,097	1,791	23,133.9	34.8	377	186,016	[illegible]	[illegible]
SD	[illegible]	24.7	215,576	2,771	24,368.3	313.2	278	15,081	[illegible]	[illegible]
TN	[illegible]	35.3	2,840,144	2,322	41,588.4	34.0	254	264,858	[illegible]	[illegible]
TX	[illegible]	34.1	7,086,474	15,676	24,439.6	54.8	1,051	1,035,370	[illegible]	[illegible]
UT	[illegible]	14.3	1,356,307	7,069	42,305.8	220.5	942	118,102	[illegible]	[illegible]
VA	1731.9	37.4	2,175,275	12,737	25,485.0	149.2	930	248,057	[illegible]	[illegible]
VT	278.6	9.3	294,000	1,040	47,116.2	166.7	3	2,762	0.9%	0.3%
WA	1149.7	27.9	1,542,803	6,475	20,260.3	85.0	226	79,208	[illegible]	[illegible]
WI	[illegible]	22.2	2,621,983	22,791	45,032.4	391.4	2,737	160,706	[illegible]	[illegible]
WV	859.0	18.7	627,387	3,286	35,007.6	183.4	155	24,763	[illegible]	[illegible]
WY	996.0	8.7	183,095	1,525	31,635.8	263.5	76	5,738	[illegible]	[illegible]
CNMI	123.1	3.5								
DC	[illegible]	[illegible]	404,499	2,137	57,314.9	302.8	38	19,428	[illegible]	[illegible]
GU	[illegible]	[illegible]	40,046	105	24,157.9	63.3	59	2,405	[illegible]	[illegible]
PR	[illegible]	[illegible]	164,980	480	5,165.8	15.0	59	5,064	[illegible]	[illegible]
USVI	[illegible]	[illegible]	22,787	142	21,768.2	135.7	1	1,229	[illegible]	[illegible]

This table also summarizes official CDC US case counts for COVID-19, reviewed and validated by states and territories, posted daily on the CDC COVID-19 webpage (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html). Sources: CDC DCIPHER, HHS Protect, US Census Bureau. ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.***

Comparison New Cases per 100,000 Population and Percent Positive Test Results, Last 7-Days

Data: 22 Sep 2020 – 28 Sep 2020 *Last Updated: 02 Oct 2020, 11:30*
Source: HHS Protect

Seven-Day Average of New COVID-19 Cases Per 100K by Seven-Day Average of New Percentage of Positive Test Results* -- US States, Territories, & DC

22-Sep-20 | 28-Sep-20 | 02-Oct-20
DATA FROM | DATA AS OF | LAST UPDATED

** Includes data through the most recent date for which all jurisdictions have reported laboratory data via HHS Protect (see Data As Of date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Figure represents official CDC US case counts for COVID-19, including both confirmed and probable cases, reviewed and validated by states and territories and posted daily on the CDC COVID-19 webpage (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html). New test results reported per 100,000 population is based on a seven-day moving average. Laboratory Data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Palau, and Federated States of Micronesia.* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.***

CDC Response Statistics

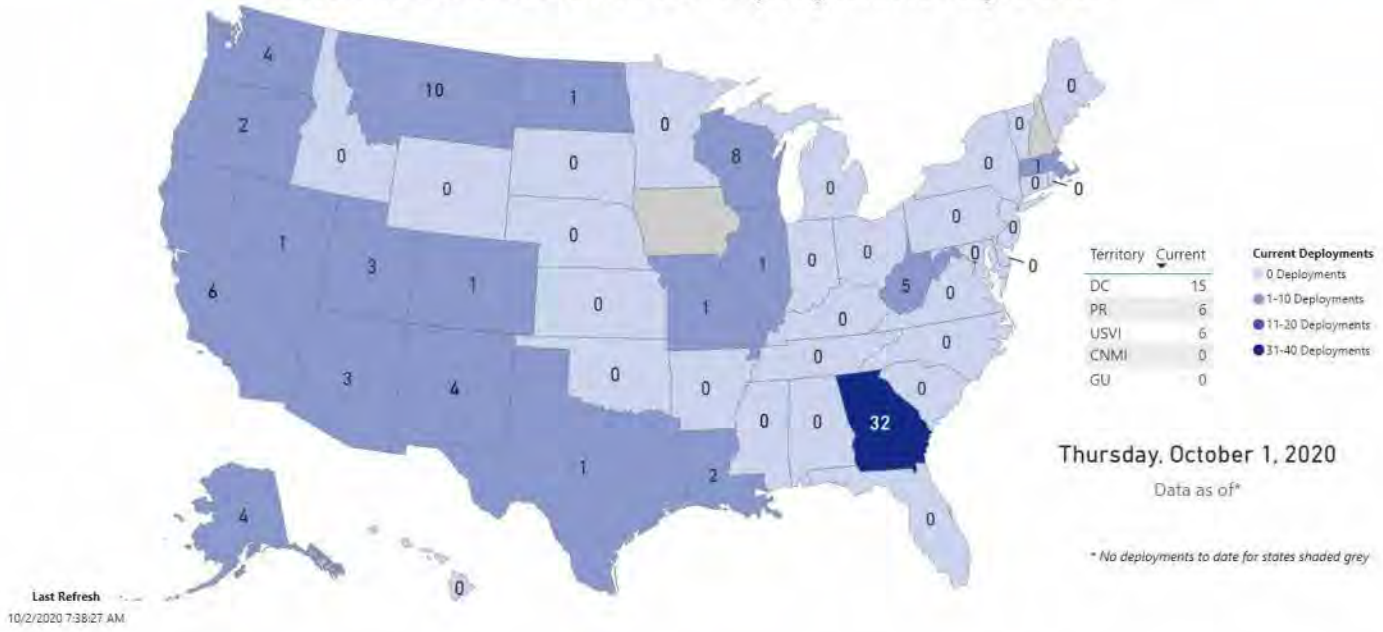
Deployments

CDC COVID-19 Domestic Deployments[30]

Data as of 01 Oct 2020 *Last Updated: 02 Oct 2020, 7:38*

Source: CDC Personnel Workforce Management System (PWMS)

Current # States/Territories	Total Current Deployments	Total Completed Deployments	Cumulative Deployments	Pending Deployments
22	117	2,172	2,289	66



[30] A single person may have multiple deployments over time. Data in PWMS is from the previous day.

CDC Website Updates – COVID-19 Response

As of 01 Oct 2020, 07:00[31]

New/Updated Guidance, Recommendations, Considerations[32]

- Interim Operational Considerations for Public Health Management of Healthcare Workers Exposed to or with Suspected or Confirmed COVID-19: non-U.S. Healthcare Settings

New/Updated Webpages

- Cases & Deaths by County
- CDC's Response
- COVID-19 Forecasts: Hospitalizations
- Previous COVID-19 Forecasts: Cases

New MMWR Publications[33]

- CDC Deployments to State, Tribal, Local, and Territorial Health Departments for COVID-19 Emergency Public Health Response — United States, January 21–July 25, 2020
- Changing Age Distribution of the COVID-19 Pandemic — United States, May–August 2020
- COVID-19 Trends Among School-Aged Children - United States, March 1-September 19, 2020
- COVID-19 Trends Among School-Aged Children — United States, March 1–September 19, 2020
- Multiple COVID-19 Clusters on a University Campus — North Carolina, August 2020
- Recent Increase in COVID-19 Cases Reported Among Adults Aged 18–22 Years — United States, May 31–September 5, 2020

International Updates

WHO Epidemiological Update

WHO Global Cases and Deaths

Data: 23 Jan 2020 – 02 Oct 2020 Last Updated: 02 Oct 2020 10:54 CEST
Source: WHO Coronavirus Disease (COVID-19) Dashboard

WHO Coronavirus Disease (COVID-19) Dashboard
Global Cases and Deaths
Data Last Updated: 02 Oct 2020 10:54 CEST

Cases		Deaths	
Cumulative Total	Newly Reported Last 24 Hours	Cumulative Total	Newly Reported Last 24 Hours
34,079,542	303,414	1,015,963	6,128

[31] Updates since last report. CDC's COVIDView provides a weekly summary and interpretation of key indicators that have been adapted to track the COVID-19 pandemic in the United States. See also CDC's "What's New" page and "Latest Updates" on the CDC COVID-19 webpage for the latest communication resources, Communication Resources for links to all guidance and reports, the COVID-19 Science Update page for summaries of new COVID-19-related studies (released every Tuesday and Friday) and the Health Alert Network (HAN) page for urgent information for state, local, tribal, and territorial partners.

[32] A complete list of Guidance Documents can be found on the CDC COVID-19 Guidance Page.

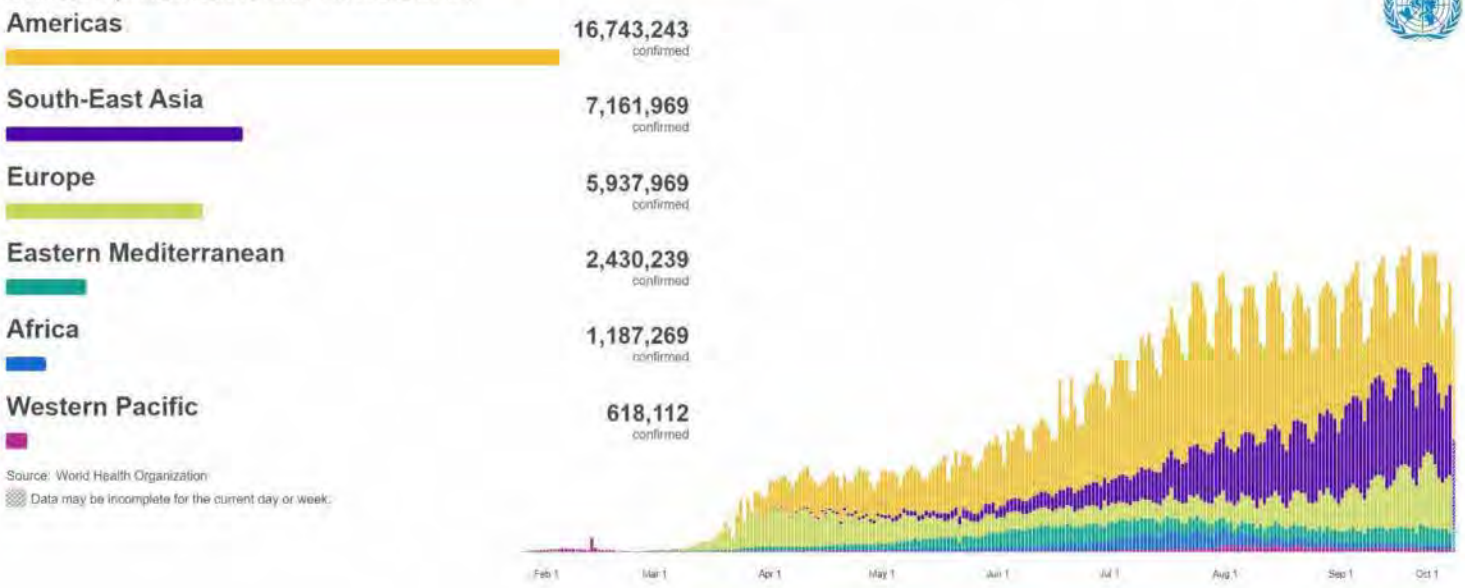
[33] A comprehensive list of COVID-19 Morbidity and Mortality Weekly Reports (MMWR) COVID-19 publications can be found on the MMWR Publications page.

Global Epidemic Curve of Confirmed COVID-19 Cases by Date of Report and WHO Region

Data: 23 Jan 2020 – 02 Oct 2020 Last Updated: 02 Oct 2020 10:54 CEST

Source: WHO Coronavirus Disease (COVID-19) Dashboard

Data last updated: 2020/10/2, 10:54am CEST

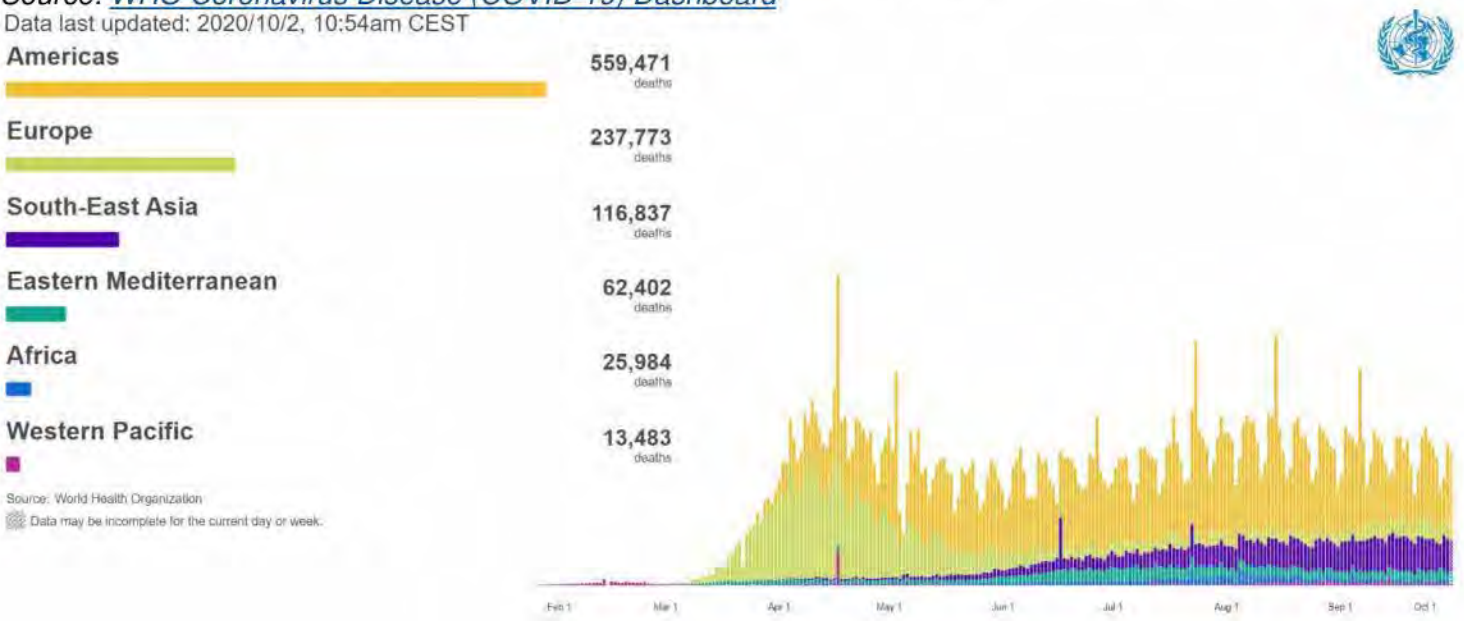


Global Epidemic Curve of Confirmed COVID-19 Deaths by Date of Report and WHO Region

Data: 23 Jan 2020 – 02 Oct 2020 Last Updated: 02 Oct 2020 10:54 CEST

Source: WHO Coronavirus Disease (COVID-19) Dashboard

Data last updated: 2020/10/2, 10:54am CEST



COVIDView

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

Key Updates for Week 39, ending September 26, 2020

Nationally, indicators that track COVID-19 activity continued to decline or remain stable (change of ≤0.1%); however, three regions reported an increase in the percentage of specimens testing positive for SARS-CoV-2, the virus causing COVID-19, and two of those regions also reported an increase in the percentage of visits for influenza-like illness (ILI) or COVID-like illness (CLI) to emergency departments (EDs) or outpatient providers. Mortality attributed to COVID-19 declined but 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 5.0% during week 38 to 4.8% during week 39. National percentages of specimens testing positive for SARS-CoV-2 by type of laboratory are listed.

- Public health laboratories – decreased from 5.1% during week 38 to 4.9% during week 39
- Clinical laboratories – increased slightly from 6.2% during week 38 to 6.3% during week 39
- Commercial laboratories – decreased from 4.8% during week 38 to 4.6% during week 39

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 24th consecutive week and is at levels that are typical for this time of year.
- Nationally, the percentage of visits for ILI reported by ILINet participants and the percentage of visits for COVID-like illness (CLI) reported to NSSP remained stable (change of ≤0.1%) in week 39 compared with week 38.
- Recent changes in health care seeking behavior, including increasing use of telemedicine, recommendations to limit ED visits to severe illnesses, and increased social distancing, are likely affecting 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 was 178.2 per 100,000, with the highest rates in people aged 65 years and older (481.5 per 100,000) and 50–64 years (266.3 per 100,000).

Mortality

Based on death certificate data, the percentage of deaths attributed to pneumonia, influenza, or COVID-19 (PIC) for week 39 is 6.4%. This is currently lower than the percentage during week 38 (9.5%); however, the percentage remains above the epidemic threshold and 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

- Nationally, since mid-July, there has been an overall decreasing trend in the percentage of specimens testing positive for SARS-CoV-2 and a decreasing or stable (change of ≤0.1%) trend in the percentage of visits for ILI and CLI; however, there has been some regional variation.
- 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 5.0% during week 38 to 4.8% during week 39.
    - Regionally, the percentage of respiratory specimens testing positive for SARS-CoV-2 increased in Regions 7 (Central), 8 (Mountain) and 10 (Pacific Northwest) and decreased or remained stable in the remaining seven regions.
    - The highest percentage of specimens testing positive for SARS-CoV-2 were seen in Regions 6 (South Central, 8.0%), 7 (Central, 9.1%), and 8 (Mountain, 7.3%). Compared to week 38, the percentage of specimens testing positive during week 39 is increasing in Regions 7 and 8 and decreasing in Region 6.
- The percentage of outpatient or ED visits to ILINet providers for ILI is below baseline nationally and in all 10 regions of the country.
    - Compared with week 38, the percentage of visits for ILI during week 39 remained stable nationally and decreased or was stable (change of ≤0.1%) in nine of the 10 regions. Region 10 (Pacific Northwest) reported a slight increase.
- Nationally, the percentage of visits to EDs for CLI and ILI remained stable (change of ≤0.1%) in week 39 compared with week 38. This is the 11th consecutive week of a declining or stable percentage of visits for CLI and ILI.
    - Regions 5 (Midwest) and 8 (Mountain) reported an increase in the percentage of visits for CLI in week 38 compared to week 37, and Region 10 (Pacific Northwest) reported an increase in the percentage of visits for ILI. The remaining regions reported a stable (change of ≤0.1%) or decreasing percentage.
- The overall cumulative COVID-19-associated hospitalization rate was 178.2 per 100,000; rates were highest in people 65 years of age and older (481.5 per 100,000) followed by people 50–64 years (266.3 per 100,000).
    - From the week ending August 1 (MMWR week 31) to the week ending September 26 (MMWR week 39), weekly hospitalization rates declined for all adult age groups. However, over this same time period, weekly rates remained steady for the pediatric age groups. Data for the most recent weeks may change as additional admissions occurring during those weeks are reported.
    - The age-adjusted hospitalization rate for Hispanic or Latino persons was approximately 4.6 times that of non-Hispanic White persons. Age-adjusted hospitalization rates for both non-Hispanic Black persons and non-Hispanic American Indian or Alaska Native persons were approximately 4.5 times that of non-Hispanic White persons.
- Based on death certificate data, the percentage of deaths attributed to pneumonia, influenza, or COVID-19 (PIC) for week 39 was 6.4%, which was lower than the percentage during week 38 (9.5%), but above the epidemic threshold. These percentages will likely increase as more death certificates are processed.
- 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.

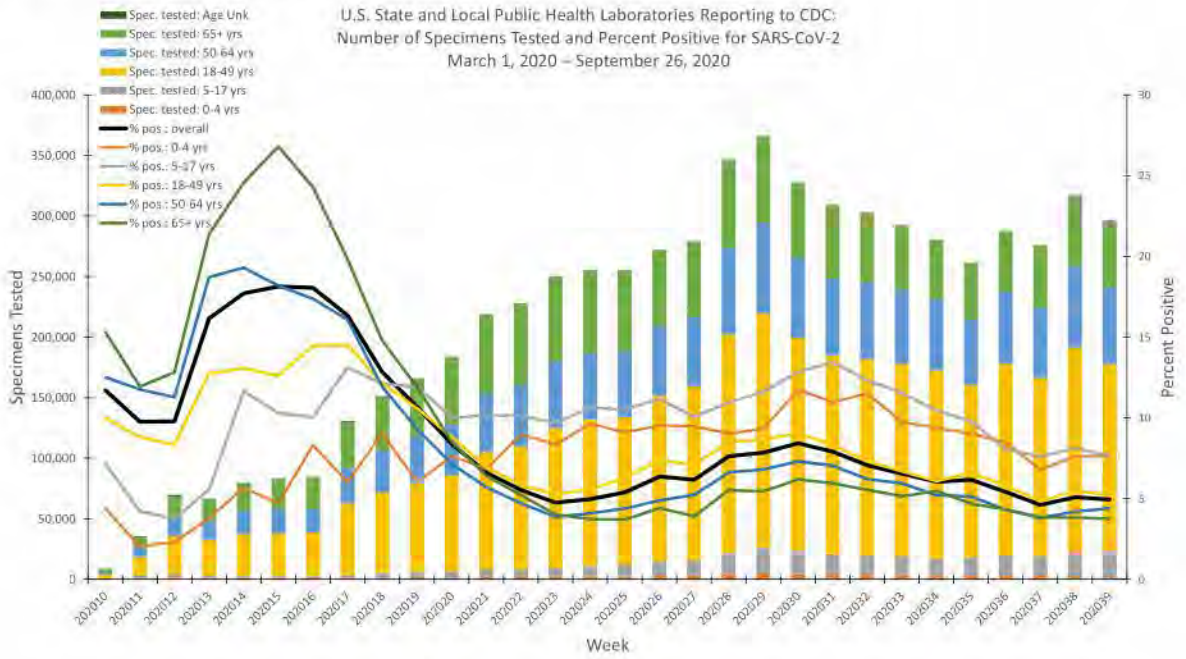
U.S. Virologic Surveillance

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 39 (Sept. 20–Sept. 26, 2020)	Cumulative since March 1, 2020
No. of specimens tested	2,080,268	53,644,944
Public Health Laboratories	296,373	6,481,480
Clinical Laboratories	216,040	6,403,163
Commercial Laboratories	1,567,855	40,760,301
No. of positive specimens (%)	99,950 (4.8%)	4,292,225 (8.0%)
Public Health Laboratories	14,670 (4.9%)	480,199 (7.4%)
Clinical Laboratories	13,629 (6.3%)	390,489 (6.1%)
Commercial Laboratories	71,651 (4.6%)	3,421,537 (8.4%)

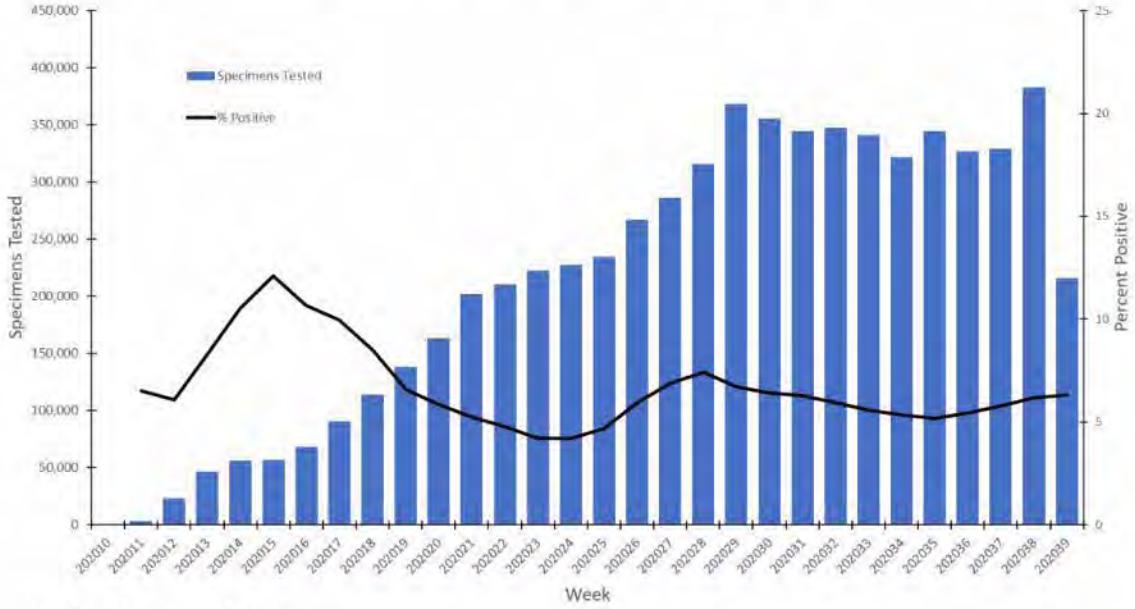
* Commercial and clinical laboratory data represent select laboratories and do not capture all tests performed in the United States.

Public Health Laboratories



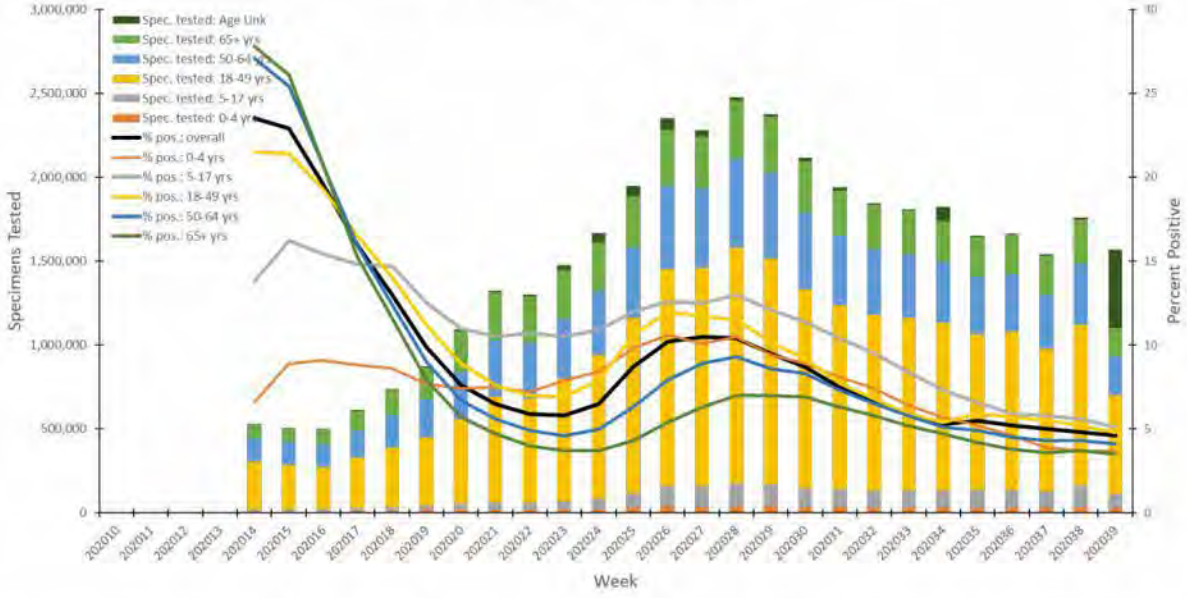
Clinical Laboratories

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 – September 26, 2020



Commercial Laboratories

Select Commercial Laboratories Reporting to CDC:
Number of Specimens Tested and Percent Positive for SARS-CoV-2
March 29, 2020 – September 26, 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

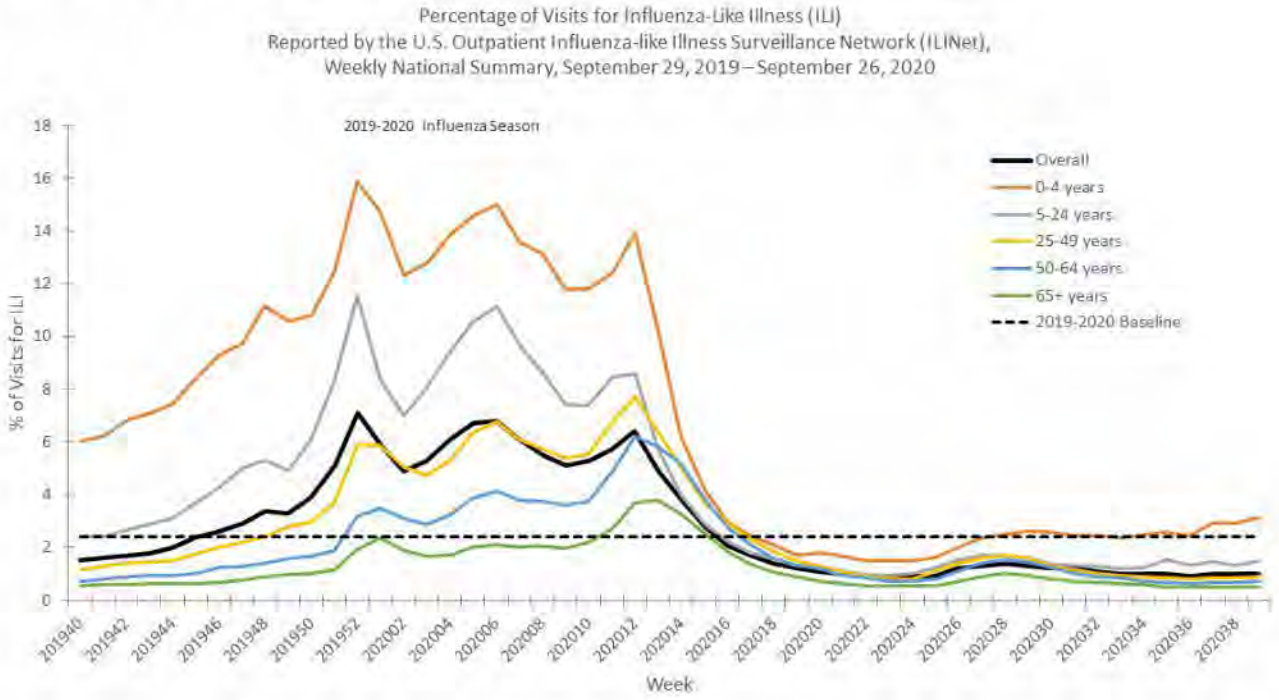
Outpatient/Emergency Department Illness

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 39, 1.0% of patient visits reported through ILINet were due to ILI. This percentage is below the national baseline of 2.4% and is typical for this time of year compared to previous influenza seasons. Compared with week 38, the percentage of visits for ILI during week 39 remained increased among those aged 0 to 4 years and 5 to 24 years but remained stable overall and among the adult age groups.



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

On a regional level, the percentage of outpatient visits for ILI ranged from 0.7% to 1.4% during week 39 and was below the region-specific baseline in all regions. Compared with week 38, the percentage during week 39 increased in Region 10 (Pacific Northwest) and decreased or remained stable (change of ≤0.1%) in the remaining nine regions.

Note: In response to the COVID-19 pandemic, new data sources are being incorporated into ILINet through the summer weeks, when lower levels of influenza and other respiratory virus circulation are typical. Starting in week 21, enrollment of new sites began, leading to increases in the number of patient visits. 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 U.S. Virgin Islands, the District of Columbia, and New York City. The mean reported percentage of visits due to ILI for the current week is compared with 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 39 and changes compared with the previous week are summarized in the table below and shown in the following maps.

Activity Level	Number of Jurisdictions	
	Week 39 (Week ending September 26, 2020)	Compared with Previous Week
Very High	0	No change
High	0	No change
Moderate	1	No change
Low	0	-1
Minimal	49	No change
Insufficient Data	4	+1

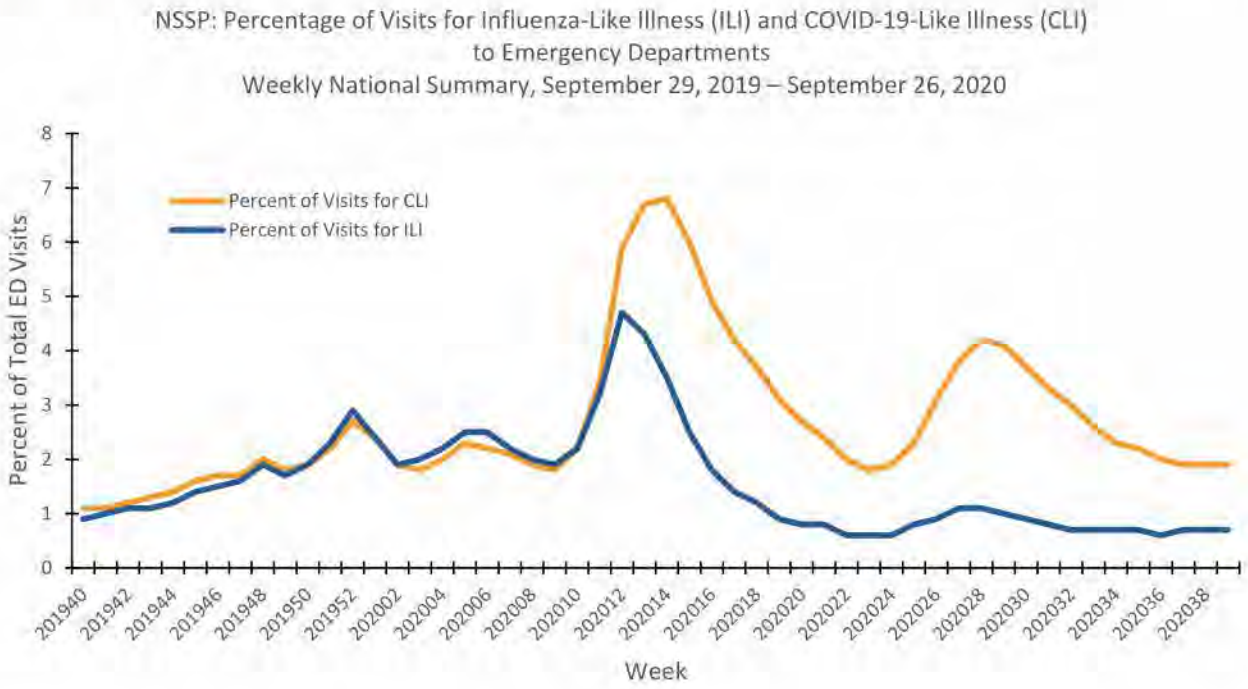
ILI Activity Level Map, Week ending 38September 19, 2020

ILI Activity Level Map, Week 39 ending September 26, 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.

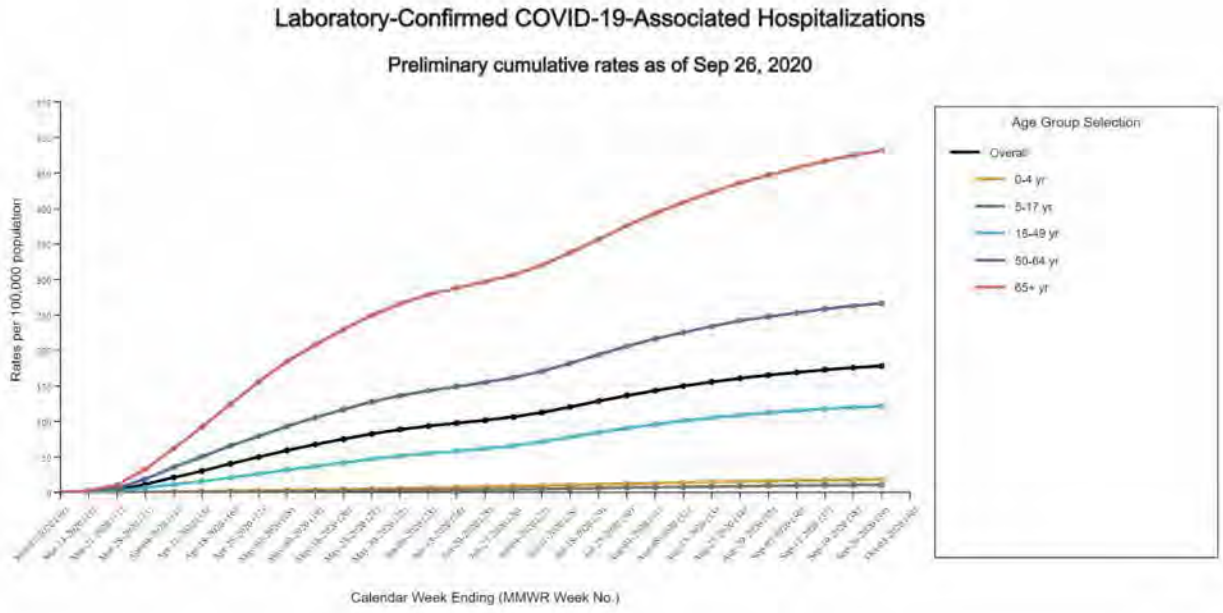
Nationwide during week 39, 1.9% of ED visits captured in NSSP were due to CLI and 0.7% were due to ILI. Compared with week 38, the percentage of visits for CLI and the percentage of visits for ILI this week decreased or remained stable (changes of ≤0.1%) nationally and in eight of 10 HHS regions. Regions 5 (Midwest) and 8 (Mountain) saw an increase in CLI while ILI percentages remained stable compared with week 38.



Additional information about medically attended outpatient and emergency department visits for ILI and CLI: Surveillance Methods

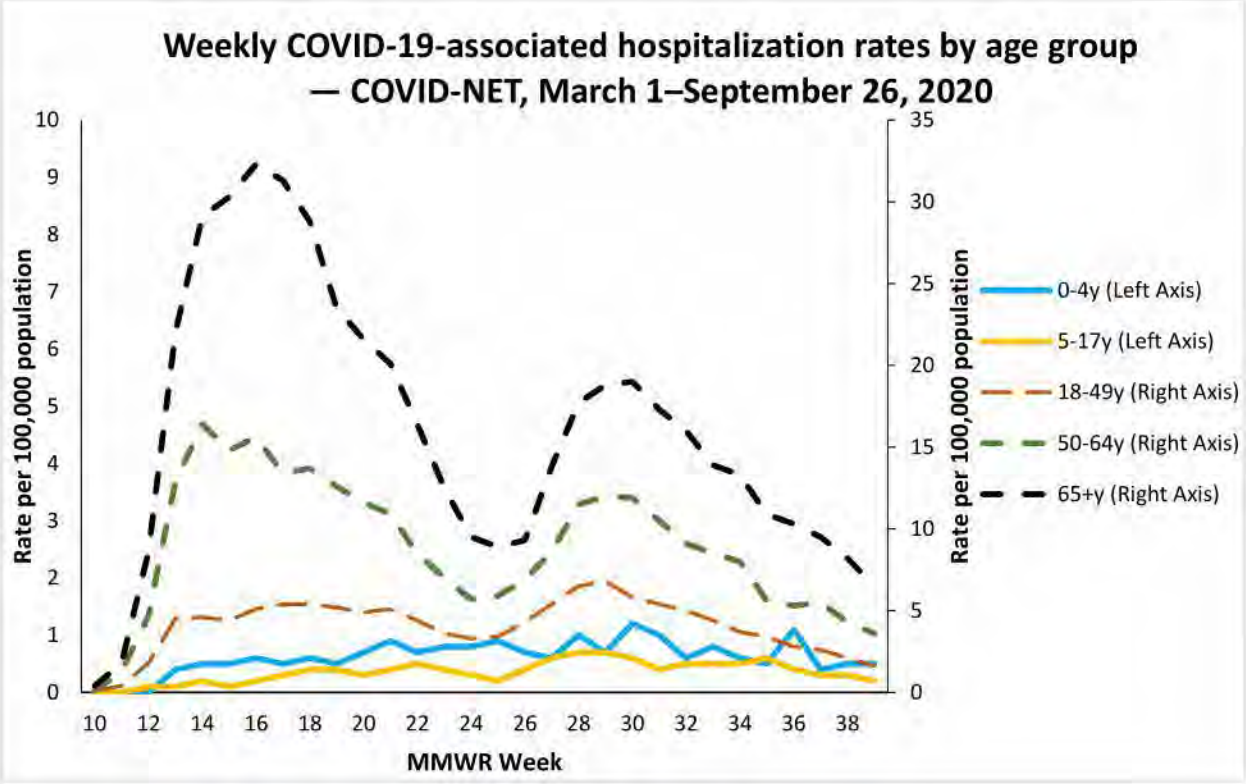
Hospitalizations
The COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) conducts population-based surveillance for laboratory-confirmed COVID-19-associated hospitalizations in select counties participating in the Emerging Infections Program (EIP) and the Influenza Hospitalization Surveillance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

A total of 58,088 laboratory-confirmed COVID-19-associated hospitalizations were reported by sites between March 1, 2020 and September 26, 2020. The overall cumulative hospitalization rate was 178.2 per 100,000 population. Among those aged 0–4 years, 5–17 years, 18–49 years, 50–64 years, and ≥65 years, the highest rate of hospitalization was among adults aged ≥65 years, followed by adults aged 50–64 years and adults aged 18–49 years.

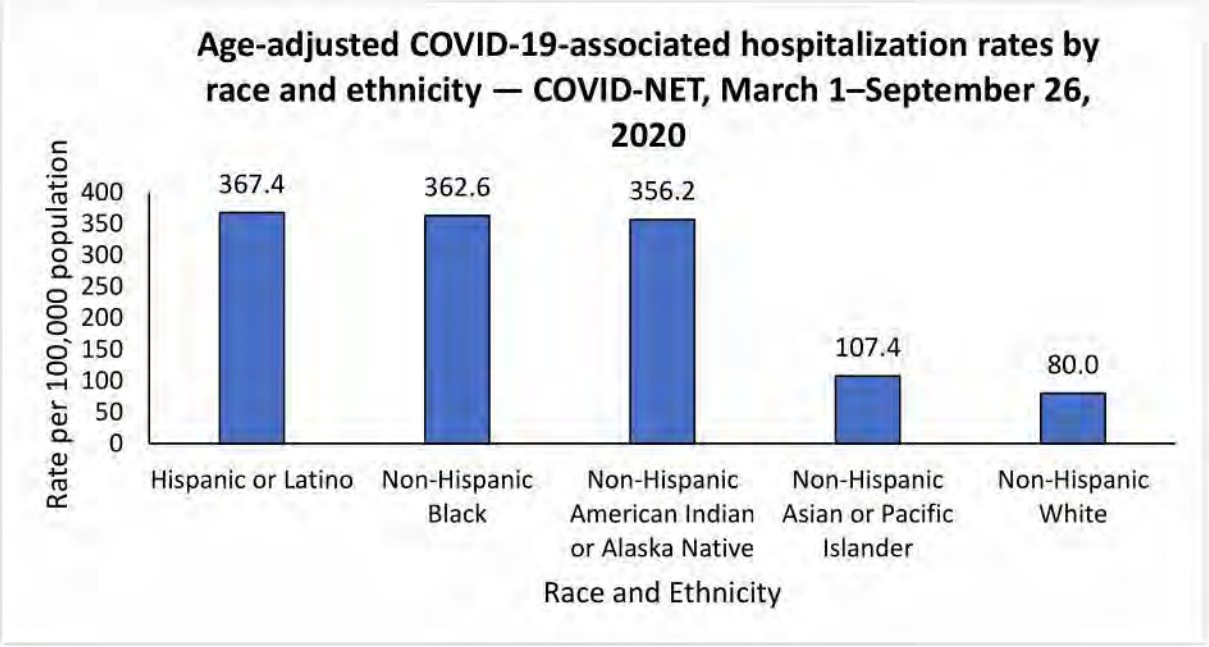


Age Group	Cumulative Rate per 100,000 Population
Overall	**178.2**
0–4 years	**18.4**
5–17 years	**10.6**
18–49 years	**121.4**
18–29 years	78.5
30–39 years	121.4
40–49 years	176.8
50–64 years	**266.3**
65+ years	**481.5**
65–74 years	361.5
75–84 years	572.6
85+ years	865.8

Weekly hospitalization rates among all ages first peaked during the week ending April 18 (MMWR week 16), followed by a second peak during the week ending July 18 (MMWR week 29). From the week ending August 1 (MMWR week 31) to the week ending September 26 (MMWR week 39), weekly hospitalization rates declined for all adult age groups. However, over this same time period, weekly rates remained steady for the pediatric age groups. Data for the most recent weeks may change as additional admissions occurring during those weeks are reported.



Among the 58,088 laboratory-confirmed COVID-19-associated hospitalizations, 55,241 (95.1%) had information on race and ethnicity, while collection of race and ethnicity was still pending for 2,847 (4.9%) cases. When examining overall age-adjusted rates by race and ethnicity, the rate for Hispanic or Latino persons was approximately 4.6 times the rate among non-Hispanic White persons. Age-adjusted hospitalization rates for both non-Hispanic Black persons and non-Hispanic American Indian or Alaska Native persons were approximately 4.5 times that of non-Hispanic White persons.



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 7.5 times higher among Hispanic or Latino persons aged 0–17 years; 8.2 times higher among Hispanic or Latino persons aged 18–49 years; 6.1 times higher among non-Hispanic American Indian or Alaska Native persons aged 50–64 years; and 3.7 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–September 26, 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]
0–17 years	11.7	3.4	19.2	5.6	25.5	**7.5**	6.6	1.9	3.4	1
18–49 years	269.2	7.8	198.2	5.7	285.2	**8.2**	57.0	1.6	34.7	1
50–64 years	654.0	**6.1**	553.3	5.2	610.4	5.7	170.3	1.6	107.2	1
65+ years	719.2	2.4	1091.0	**3.7**	807.2	2.7	327.9	1.1	298.2	1
Overall rate[4](age-adjusted)	356.2	4.5	362.6	4.5	367.4	**4.6**	107.4	1.3	80.0	1

[1] COVID-19-associated hospitalization rates by race and ethnicity are calculated using COVID-NET hospitalizations 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 and 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 and 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 hospitalizations 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 hospitalizations as compared with the overall population of the catchment area. Prevalence ratios were highest among non-Hispanic American Indian or Alaska Native persons, followed by non-Hispanic Black persons and Hispanic or Latino persons.

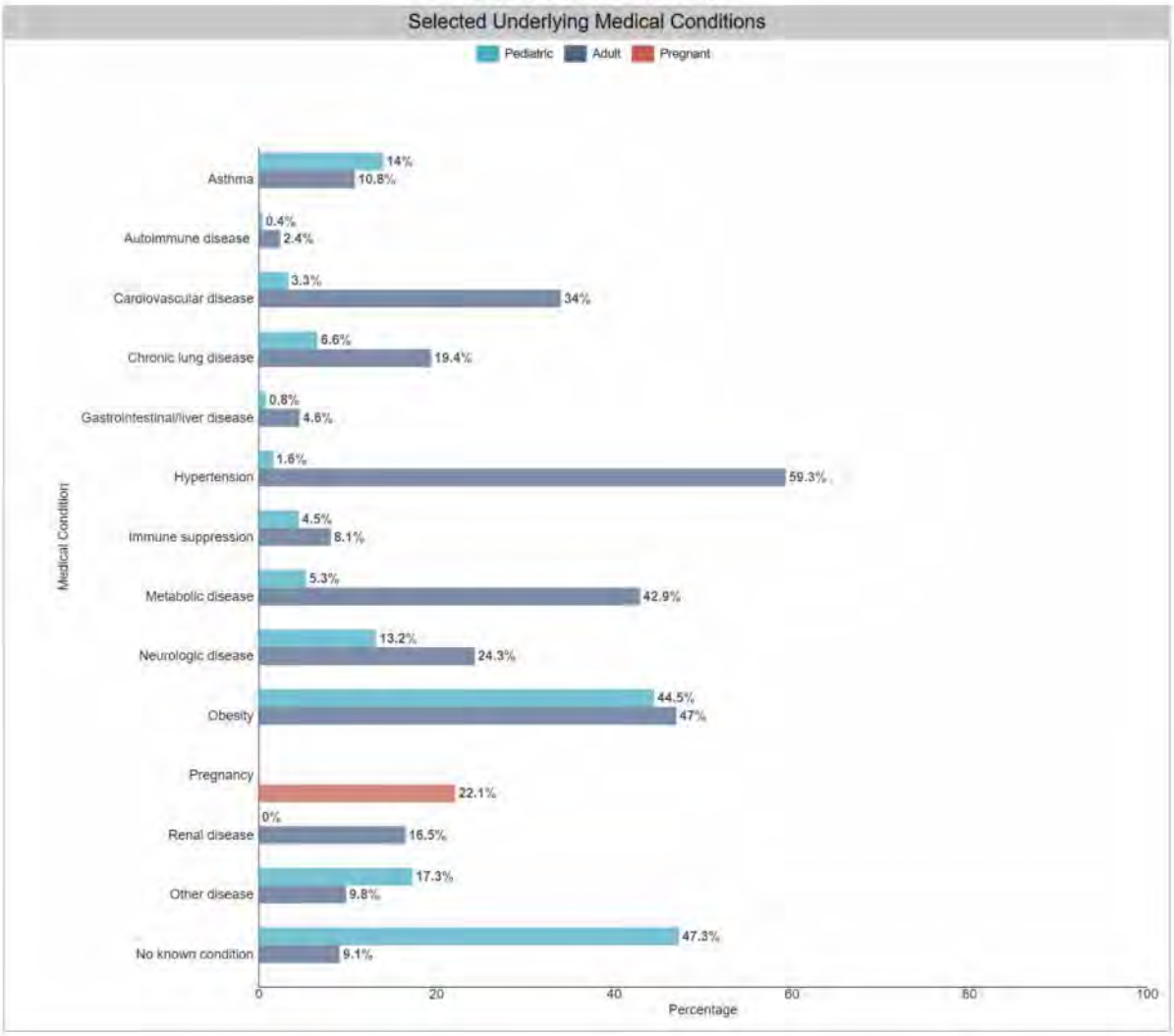
Comparison of proportions of COVID-19-associated hospitalizations by race and ethnicity, COVID-NET, March 1–September 26, 2020

	Non-Hispanic American Indian or Alaska Native	Non-Hispanic Black	Hispanic or Latino	Non-Hispanic Asian or Pacific Islander	Non-Hispanic White
Proportion of COVID-NET hospitalizations[1]	1.3%	32.8%	23.1%	5.1%	32.1%
Proportion of population in COVID-NET catchment area	0.7%	17.9%	14.1%	8.9%	58.5%
Prevalence ratios[2]	1.9	1.8	1.6	0.6	0.5

[1] Persons of multiple races (0.3%) or unknown race and ethnicity (5.3%) 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 COVID-NET hospitalizations over the proportion of population in COVID-NET catchment area.

For underlying medical conditions, data were restricted to cases reported during March 1–May 31, 2020, due to delays in reporting. During this time frame, sampling was conducted among hospitalized adults; therefore, weighted percentages are reported. Among 7,865 sampled adults hospitalized during March 1–May 31, 2020, 90.9% reported at least one underlying medical condition. The most commonly reported were hypertension, obesity, metabolic disease, and cardiovascular disease. No sampling was conducted among hospitalized children. Among 243 children hospitalized during March 1–May 31, 2020, 52.7% reported at least one underlying medical condition. The most commonly reported underlying medical conditions were obesity, asthma, and neurologic disease.

COVID-19 Laboratory-Confirmed Hospitalizations
Preliminary data as of Sep 26, 2020



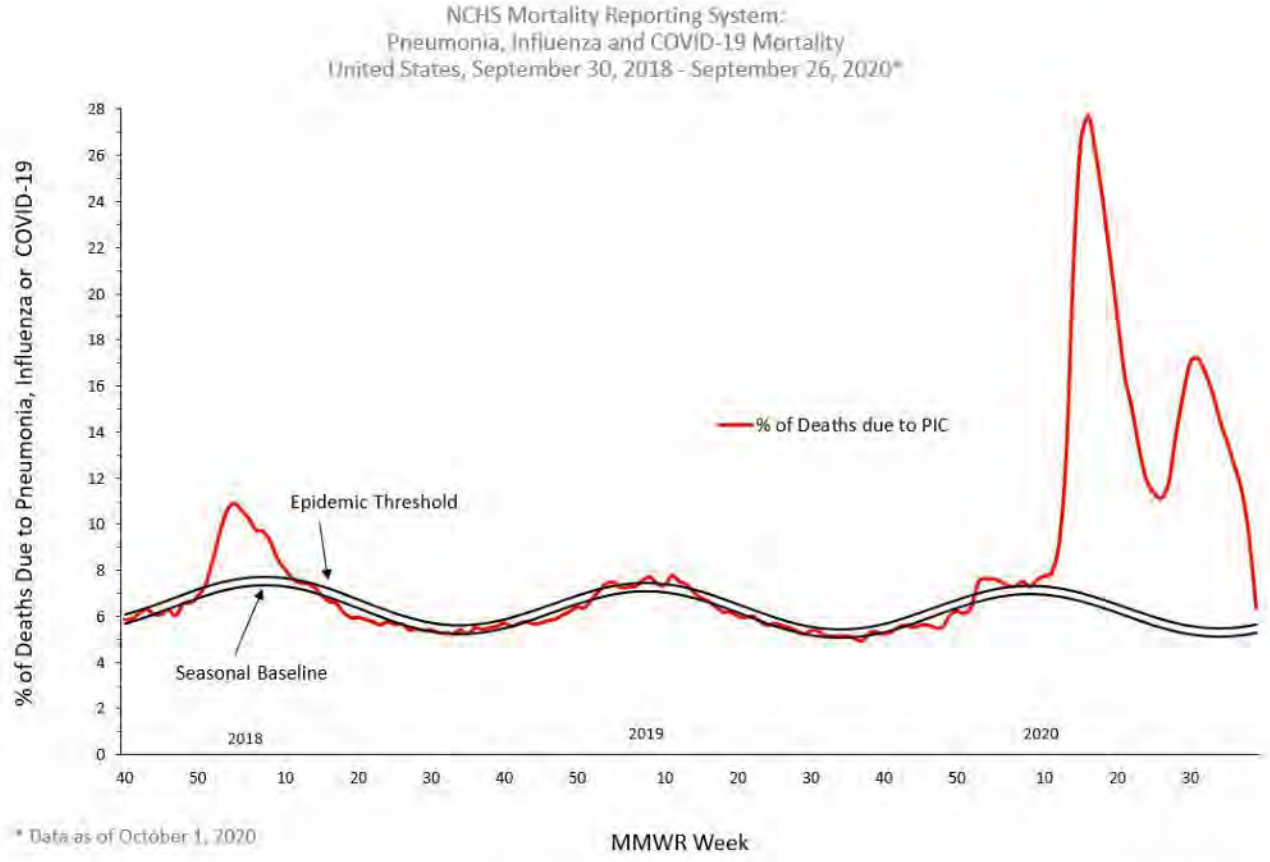
Additional data on demographics, signs and symptoms at admission, underlying conditions, interventions, outcomes and discharge diagnoses, stratified by age, sex and race and ethnicity, are available.

Additional hospitalization surveillance information:
Surveillance Methods | Additional rate data | Additional demographic and clinical data

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 October 1, 2020, the percentage of deaths attributed to pneumonia, influenza, or COVID-19 (PIC) for week 39 is 6.4% and, while lower than the percentage during week 38 (9.5%), 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.



*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: October 1, 2020

Detailed data tables are available on the COVIDView page

From: (b)(3):50 USC 3024(i); (b)(6)
Sent: Monday, October 5, 2020 5:12 AM
To: (b)(3):10 USC 424; (b)(6)
Cc:
Subject: CDC COVID-19 Update 04Oct2020 (For Internal USG only)
Attachments: (FOUO) CDC COVID-19 RESPONSE UPDATE 20201004.pdf; 2020_10_02 Science Update_Final Public.pdf

Good evening,

Please see attached CDC Reports.

Cases/deaths as of 04 Oct 2020:
- 7,359,952 confirmed and probable U.S. cases, +49,327 since yesterday
- 208,821 U.S. deaths reported to CDC, +703 since yesterday
- 34,804,348 confirmed cases worldwide (WHO dashboard data)

Highlights:
- Case Counts and Deaths: 7-day case average is down 3% from the previous 7-days. 7-day death average is down 10% from the previous 7-days.
- Travel Health Notices (THNs): https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html, no changes since 28 Aug.

Science Update Notables:
- Surveillance of COVID-19 school outbreaks, Germany, March to August 2020: https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.38.2001645#html_fulltext, Germany reported only a few small school outbreaks when their schools were partially open from March through August, and most transmissions occurred within the same grade, suggesting preventive measures can prevent spillover to other grades. Continued surveillance and contact tracing must continue when schools fully reopen.
- COVID-19 public health measures and respiratory syncytial virus: https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30307-2/fulltext,

Implementation of public health measures to prevent SARS-CoV-2 infection during peak RSV season in Australia was strongly associated with a large decrease in the burden of RSV disease among children.
- Whole-genome sequencing to track SARS-CoV-2 transmission in nosocomial outbreaks: https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1433/5909421, the majority of nosocomial transmissions early in the pandemic occurred through close contact. Nosocomial transmission rates decreased following implementation of consistent mask usage in both clinical and non-clinical areas.
- Cardiology and COVID-19: https://jamanetwork.com/journals/jama/fullarticle/2770858, Review of the direct and indirect cardiac complications of COVID-19.
- What to expect from first-generation COVID-19 vaccines: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31976-0/fulltext, Review of the challenges around first-generation COVID-19 vaccines, including generating sterilizing immunity, duration of protection, and vaccine hesitancy.

MMWR:
- No additional publications

Please regularly refer to CDC's COVID-19 webpage; information and guidance is updated daily: https://covid.cdc.gov/covid-data-tracker/

VR/

(b)(6)
Dept of Defense Liaison to the Centers for Disease Control and Prevention, Atlanta, GA
(b)(6)

(b)(3):50 USC 3024(i); (b)(6)

COVID-19 Science Update

From the Office of the Chief Medical Officer, CDC COVID-19 Response, and the CDC Library, Atlanta, GA.
Intended for use by public health professionals responding to the COVID-19 pandemic.

***** Available on-line at https://www.cdc.gov/library/covid19 *****

Epidemiology

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SARS-CoV-2 seroprevalence among healthcare, first response, and public safety personnel, Detroit metropolitan area, Michigan, USA, May – June 2020. Akinbami *et al.* Emerging Infectious Diseases (September 21, 2020).

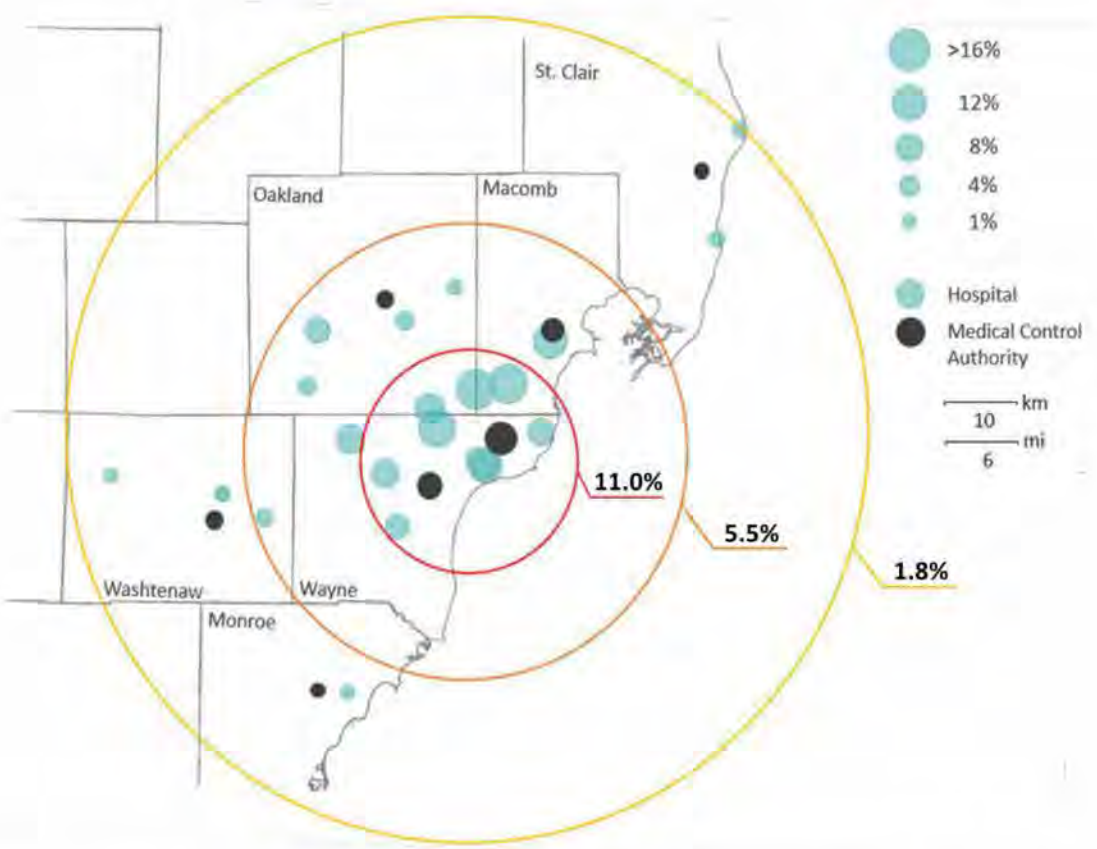
Key findings:

- Of 16,397 participants, 6.9% (95% CI 6.5% – 7.3%) were positive for SARS-CoV-2 IgG.
- Seroprevalence was highest (11.0%, 95% CI 10.3% – 11.7%) at facilities within 15 km of Detroit's center and lowest (1.8%, 95% CI 1.4% – 2.2%) at locations 30 – 55 km away (Figure).
- Exposure to a household member with confirmed COVID-19 (adjusted odds ratio [aOR] 6.18, 95% CI 4.81 – 7.93) and working within 15 km of Detroit's center (aOR 5.60, 95% CI 3.98 – 7.89) were strongly associated with seropositivity.
- Consistently using N95 respirators (aOR 0.83, 95% CI 0.72 – 0.95) or surgical facemasks (aOR 0.86, 95% CI 0.75 – 0.98) decreased the likelihood of seropositivity.

Methods: Seroprevalence study in adults (≥18 years of age) working as first responders, healthcare providers, or in public safety settings from May to June 2020. *Limitations*: Convenience sample with ~80% response rate; comprehensive exposure data were not collected; infected participants may have failed to seroconvert or antibody levels may have decayed in cases of remote infection, or not yet present in cases of recent infection, leading to false negatives.

Implications: The association between seropositivity and working closer to the Detroit city center and exposure to a household member with COVID-19 illustrates the major role of community acquisition of SARS-CoV-2, even in healthcare personnel. Measures to reduce community transmission will be protective for all community members including health care personnel who may be at risk in settings where social distancing and personal protective equipment use may be difficult.

Figure:



Note: From Akinbami *et al*. Seropositivity of study population by hospital or medical control authority agency location within the Detroit Metropolitan Area. Mean SARS-CoV-2 seroprevalence within **15 km** was 11.0%; **15 – 30 km range** was 5.5%; 31 – 55 km **31 – 55 km range** was 1.8%. Open access journal; all content freely available.

The effect of vascular risk factor burden on the severity of COVID-19 illness, a retrospective cohort study. Du *et al.* Respiratory Research (September 21, 2020).

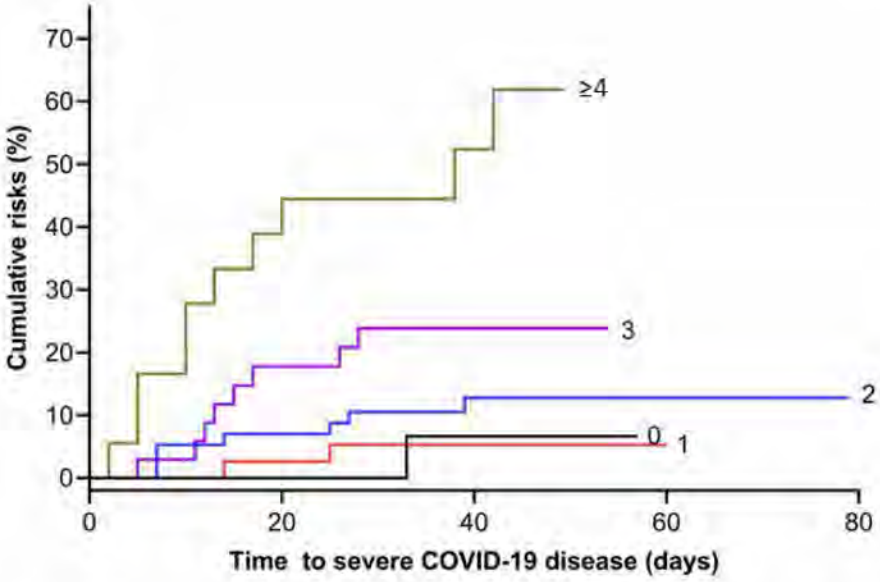
Key findings:

- 90.2% (n = 148) of COVID-19 patients had at least one vascular risk factor.
- There was an increased association between vascular risk factors and severe COVID-19 (adjusted hazard ratio 1.55, 95% CI 1.09 – 2.21, p <0.01).
- Increasing burden of vascular risk factors was associated with increased risk of severe COVID-19 illness (log rank p <0.001) (Figure).

Methods: Retrospective cohort of patients with COVID-19 (n = 164) between February 14 and March 14, 2020, admitted to a single center in Wuhan, China. Study evaluated progression to severe COVID-19 illness among those with increasing burden of cardiovascular risk factors, including: hypertension, diabetes, dyslipidemia, atrial fibrillation, current smoking, regular alcohol drinker, physical inactivity, and overweight status. *Limitations*: Single-center study with small sample size; some risk factors were self-reported; vascular risk factors not evaluated may confound results.

Implications: Vascular risk factor burden is associated with progression to severe COVID-19 illness. Self-isolation or increased personal precautions and interventions to modify vascular risk factors such as exercise, smoking cessation, medication adherence, weight loss, and reducing alcohol intake may benefit this population.

Figure:



Note: Adapted from Du *et al*. Cumulative probability of severe COVID-19 stratified by 0, 1, 2, 3, and ≥4 vascular risk factors. Licensed under CC 4.0.

Surveillance of COVID-19 school outbreaks, Germany, March to August 2020. Otte im Kampe, *et al.* Eurosurveillance. (September 24, 2020).

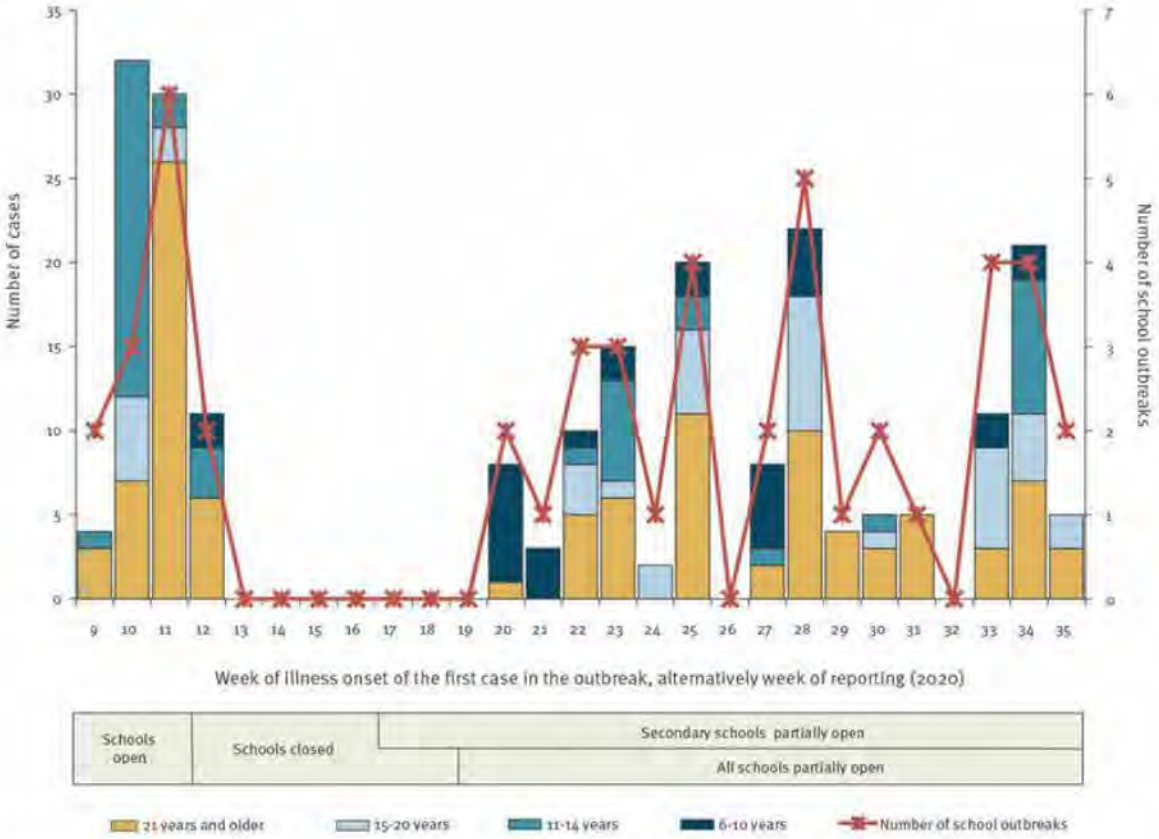
Key findings:

- Schools accounted for 48 (0.5%) of 8,841 COVID-19 outbreaks in Germany and included 61,540 cases.
  - 58% of school outbreaks included individuals only in the same grade.
  - 21% of school outbreaks occurred in non-students (<21 years of age) only.
  - Non-students accounted for 47% of cases from all outbreaks.
- On average, 2.2 school outbreaks occurred per week with 4 cases per outbreak following school re-openings (Figure).
- 75% of cases with available clinical data reported symptoms; reporting of symptoms increased with age.

Methods: Analysis of German COVID-19 national surveillance system for school outbreaks (≥2 laboratory-confirmed cases in persons from the same school) from January 28 to August 31, 2020. *Limitations*: Methodology used for investigation not described; outbreaks with large proportion of asymptomatic cases may not have been detected; no clear school denominator for different time periods.

Implications: Few school outbreaks were reported and most were reported within the same grade suggesting preventive measures can prevent spillover to other grades. As younger students were less likely to be symptomatic, symptomatic surveillance should focus on older individuals. These analyses were done as schools were only partially open, which underscores the need for continued surveillance and contact tracing when schools fully reopen.

Figure:



Note: Adapted from Otte im Kampe, *et al*. School outbreaks of COVID-19. Primary y-axis shows number of cases reported among school outbreaks by week (x-axis) between January 28 and August 31, 2020 by age: cases >21 years old, 15-20, 11-14, and 6-10. Secondary y-axis shows **number of school outbreaks reported weekly**. Licensed under CC 4.0.

COVID-19 and Long-term Care Communities

PEER-REVIEWED

The increased risk of COVID-19 morbidity and mortality in residents of nursing homes has been recognized. While nursing homes tend to have patients who require care due to physical or mental conditions, persons in assisted living facilities are also vulnerable based on age, underlying comorbidities and communal living conditions. The following two articles examine factors related to infection and case fatality rates at both nursing homes and assisted living facilities.

Racial and ethnic disparities in COVID-19 infections and deaths across U.S. nursing homes. Li *et al*. Journal of Gerontology. (September 21, 2020).

Key findings:

- Nursing homes with >30.2% of racial/ethnic minority residents had an average of 1.5 new resident cases, 1.3 new staff cases, and 0.4 new resident deaths per week per facility compared with those in the bottom quartile, that had an average of 0.4 new resident cases, 0.3 new staff cases, and 0.1 new resident deaths (Table).

- Nursing homes with between 2.9% and 30.2% racial/ethnic minority residents and those with >30.2% minority residents were 25% and 76% more likely to have a new resident case compared with those with the fewest minorities residents (OR 1.25, 95% CI 1.03 – 1.51, p = 0.025 and OR 1.76, 95% CI 1.38 – 2.25, p <0.001, respectively).

Methods: A cross-sectional analysis of national Center for Medicare and Medicaid Services (CMS) COVID-19 data (collected in CDC's National Healthcare Safety Network) in 12,576 nursing homes stratified into quartiles by percentage of racial/ethnic minority residents. *Limitations:* Cross-sectional data only allows for association; data on staff death were too limited for analysis.

Table:

		Nursing homes by proportion of racial/ethnic minority residents			
	All nursing homes (n = 12,576)	Low (<2.9%) N = 3,143	Medium (2.9% – 11.1%) N = 3,149	Medium-high (11.1% – 30.2%) N = 3,140	High (≥30.2%) N = 3,144
	Mean ± SD or N (%)				
Cases among *residents*	0.9 ± 4.7	0.4 ± 2.5	0.7 ± 4.0	0.9 ± 5.2	1.5 ± 6.3
Deaths among *residents*	0.3 ± 1.5	0.1 ± 1.1	0.3 ± 1.5	0.3 ± 1.2	0.4 ± 2.0
Cases among *staff*	0.7 ± 3.0	0.3 ± 1.4	0.6 ± 2.4	0.8 ± 2.8	1.3 ± 4.4

Note: Adapted from Li *et al.* Numbers of incident laboratory-confirmed COVID-19 cases and deaths reported in US nursing homes during the week of May 25 to May 31, 2020 by proportion of racial/ethnic minority residents. Permission request in process.

COVID-19 pandemic in assisted living communities: Results from seven states. Temkin-Greener *et al.* Journal of the American Geriatrics Society (September 21, 2020).

Key findings:

- COVID-19 death rates in assisted living centers were higher than state-level death rates.
- The proportion of minority residents was associated with the likelihood of COVID-19 cases (IRR = 1.08; p <0.001).
- The proportion of minority residents was *not* associated with the likelihood of deaths (IRR = 0.98; p = 0.739) after controlling for co-morbidities and assisted living center characteristics.

Methods: Observational study employing Medicare Beneficiary data and county-level COVID-19 data to examine COVID-19 outcomes, confirmed cases and deaths in assisted living centers from seven states through May 2020. The sample included 3,994 assisted living centers, 2,542 cases and 675 deaths. *Limitations:* Generalizability may be limited as only 7 states were included; observational data may be subject to unmeasured confounders.

Implications for 2 studies (Li *et al.* and Temkin-Greener): Nursing homes have structural inequities that contribute to differences in COVID-19 morbidity and mortality by race-ethnicity. While there may be important differences in visitation policies and interaction with the community, these same or similar facility-level structural inequities may extend to assisted living facilities. The impact of COVID-19 on assisted living centers may be similar to that of nursing homes and deserves consideration from policy makers.

Other Respiratory Diseases in Children During COVID-19

PEER-REVIEWED

The prevalence and consequence of coinfection of SARS-CoV-2 with other viral respiratory pathogens is unknown. In pre-pandemic years, pediatric coronavirus bronchiolitis (inflammation and congestion in the small airways of young children and infants caused by a viral infection) was often associated with coinfection with other respiratory viruses; respiratory syncytial virus (RSV) being most commonly identified (Mansbach *et al*). Here we present two studies looking at other respiratory pathogen infections in children with SARS-CoV-2 infection.

Characterizing coinfection in children with COVID-19: A dual center retrospective analysis. Zhang *et al.* Infection Control and Hospital Epidemiology (September 23, 2020).

Key findings:

- Among 767 pediatric patients tested for SARS-CoV-2 and other respiratory pathogens, 101 (13.2%) were positive for SARS-CoV-2.
    - 12.5% were coinfected with rhinovirus, enterovirus or adenovirus; 2% were coinfected with either influenza A or RSV.

Methods: Retrospective review of records at two Chicago medical centers from March 9 through April 30, 2020 of all pediatric patients tested for SARS-CoV-2 by RT-PCR who also were tested for other respiratory pathogens within 7 days of the SARS-CoV-2 test. *Limitations*: No age range is presented, limiting ability to compare with other studies among children; average age in study is 17.1, but RSV and bronchiolitis are more common in children under 5 years; study was conducted at a time of year when respiratory viral transmission rates were declining.

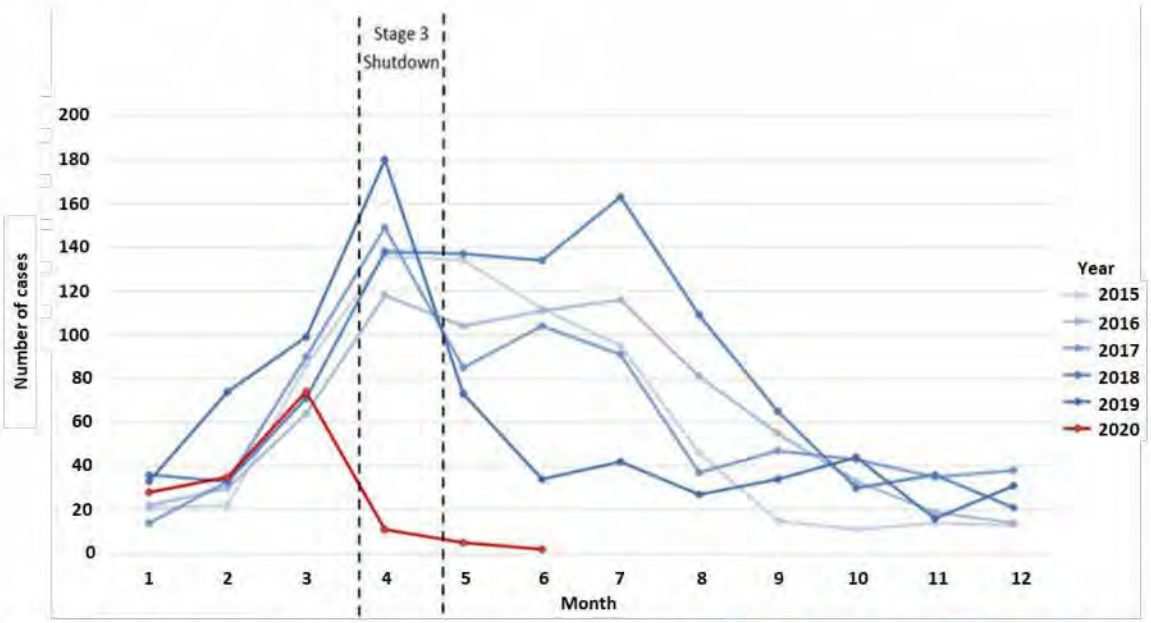
COVID-19 public health measures and respiratory syncytial virus. Britton *et al.* Lancet Child & Adolescent Health (September 18, 2020).

Key findings:

- Over a five-year medical record review, the majority of positive tests for RSV (63.7%); bronchiolitis admissions (99.6%); and respiratory-related pediatric emergency department (ED) visits (63.4%) were in the 0 – 2 year age-group (Figure 1).
- Following implementation of aggressive public health measures to prevent SARS-CoV-2 transmission, there were 94.3% fewer RSV positive tests, 85.9% fewer admissions for bronchiolitis, and 70.9% fewer ED visits in 2020, compared with previous years (Figures 1 &2).
    - The number of RSV tests done in 2020 was double that of previous years.

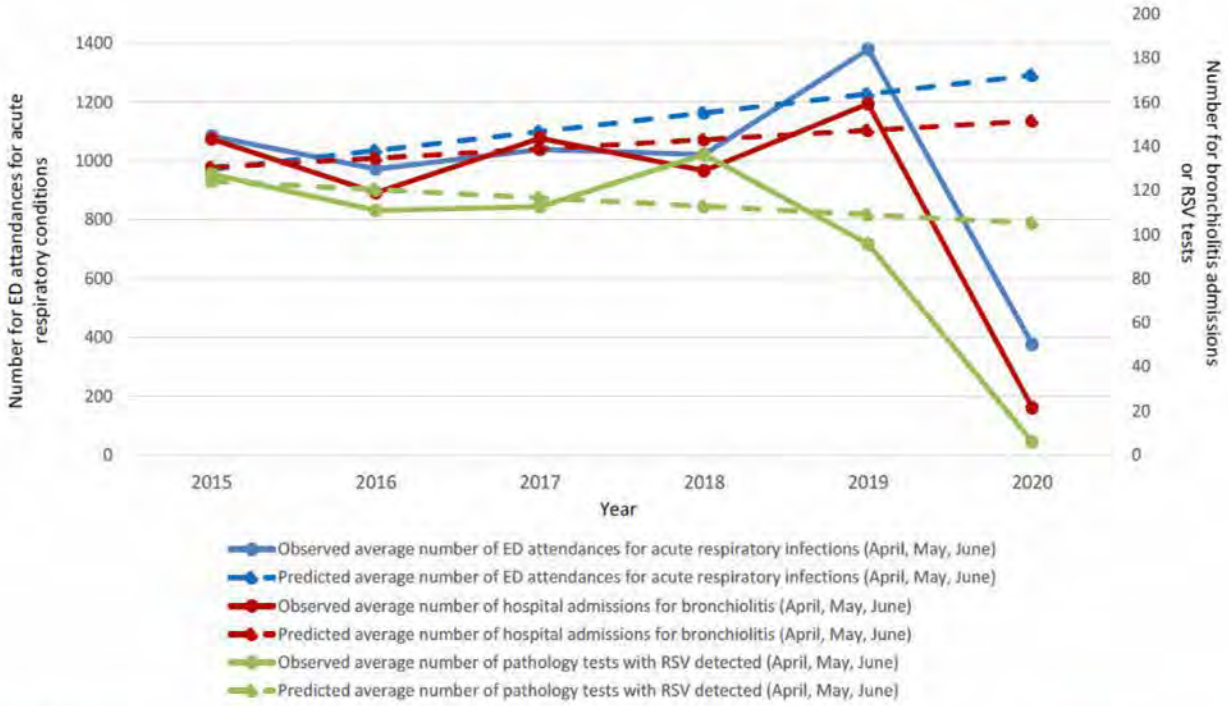
Methods: Retrospective review of records from a hospital network in New South Wales (NSW), Australia, for three events: RSV PCR test (n = 69,646), bronchiolitis hospital admission (n = 6,730), and ED visit for acute respiratory illness (n = 58,491) among children younger than 16 years between January 1 and June 30, 2020. Frequencies of events in peak RSV epidemic months (April – June) in 2020 and same time period in 2015 – 2019 were analyzed. *Limitations*: Findings may be specific to NSW; actual uptake and effect of mitigation measures such as handwashing, social distancing, and reduced population movement was not measured; study period was brief and cannot determine if results equate to true reduction in RSV.

Figure 1



Note: Adapted from Britton *et al.* Monthly RSV PCR detections for 2014–2019 (**blues**) and **January – June, 2020** with pandemic response shutdown time period noted. Permission request in process.

Figure 2



Note: Adapted from Britton *et al.* Observed and predicted trends of the frequency of **RSV PCR detections**, **Bronchiolitis admissions**, and **ED acute respiratory visits** 2015 to 2020 for children aged <16 years. Permission request in process.

Implications for 2 studies (Zhang *et al.* & Britton *et al.*): Implementation of public health measures to prevent SARS-CoV-2 infection during peak RSV season in NSW, Australia, was strongly associated with a large decrease in the burden of RSV disease among children. Compared to endemic coronaviruses, coinfections with SARS-CoV-2

appear less common in the limited pediatric population data currently available but this may be partially a result of current prevention practices including handwashing and social distancing.

Clinical Treatment & Management

PEER-REVIEWED

Risk factors for hospitalization, mechanical ventilation, or death among 10 131 US veterans with SARS-CoV-2 infection. Ioannou *et al.* JAMA Network Open (Sept 23, 2020).

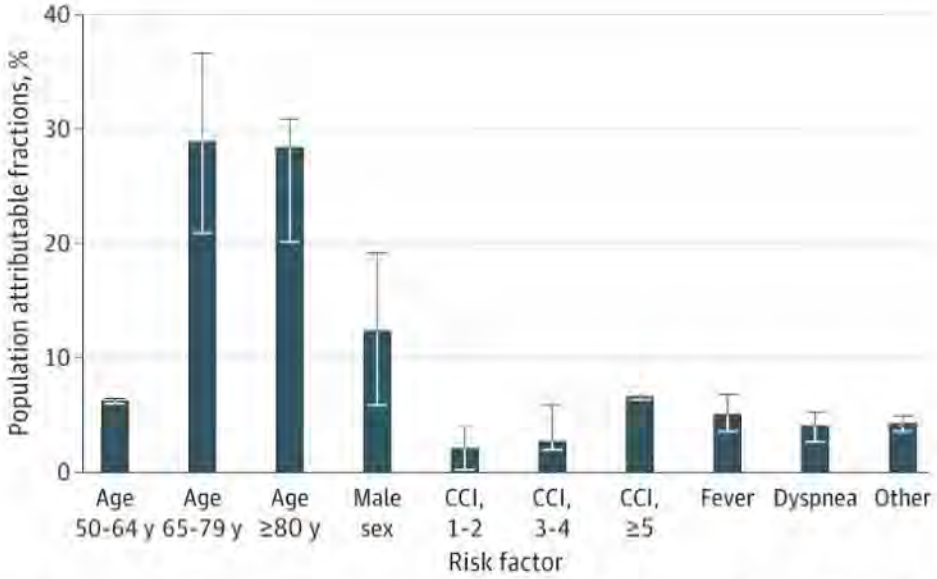
Key findings:

- Those who tested positive for SARS-CoV-2 had higher rates of 30-day hospitalization (30.4% vs 29.3%; adjusted hazard ratio (aHR) 1.13, 95% CI 1.08 – 1.17), mechanical ventilation (6.7% vs 1.7%; aHR 4.15, 95% CI 3.74 – 4.61), and death (10.8% vs 2.4%; aHR 4.44; 95% CI 4.07 – 4.83) compared with patients who tested negative.
- Among patients who tested positive for SARS-CoV-2, mortality was associated with older age, high regional COVID-19 disease burden, higher Charlson comorbidity index score (CCI, a score that quantifies burden of disease and mortality risk), fever, and dyspnea (Table).
- Most deaths (63.4%) were attributed to older age groups relative to the reference group (18 – 49 years).
    - Male sex contributed 12.3% (95% CI 5.8% – 19.1%), comorbidity burden contributed 6.5% (95% CI 6.3% – 6.6%) for CCI score of 5 or greater (Figure).
- Notable characteristics *not* significantly associated with mortality included obesity, Black race, Hispanic ethnicity, chronic obstructive pulmonary disease, hypertension, and smoking.

Methods: National cohort study of 88,747 veterans tested for SARS-CoV-2; 10,131 tested positive by RT-PCR from NP swabs between February 28 – May 14, 2020 and followed up through June 22, 2020. Outcomes were captured by ICD-10 codes in electronic health records. *Limitations*: ICD-10 codes might over- or underestimate outcomes; data describes primarily male veterans (91% male).

Implications: This national study of US veterans found that most deaths from SARS-CoV-2 occurred in older men who had comorbidities; deaths were not associated with obesity, hypertension, COPD, smoking, and race/ethnicity. This information is useful to identify veterans at risk for adverse outcomes of SARS-CoV-2 infection.

Figure:



Note: Adapted from Ioannou *et al.* Population attributable fraction of deaths due to various factors. Whisker bars represent the 95% CI. Licensed under CC-BY.

Table:

Factor	Adjusted HR (95% CI)
Age (65 – 79)	27.4 (13.5-56.0)
Age (≥ 80)	60.8 (29.7-124.6)
High regional COVID-19 disease burden (≥700 deaths/1 million residents)	1.2 (1.0-1.4)
CCI >5	1.9 (1.4-2.4)
Fever	1.5 (1.3-1.7)
Dyspnea	1.8 (1.5-2.1)

Note: Adapted from Ioannou *et al*. Sociodemographic medical factors association with mortality among 10,131 US veterans who tested positive for SARS-CoV-2. Licensed under CC-BY.

Laboratory Science

PEER-REVIEWED

Whole-genome sequencing to track SARS-CoV-2 transmission in nosocomial outbreaks. Lucey *et al.* Clinical Infectious Diseases (September 19, 2020).

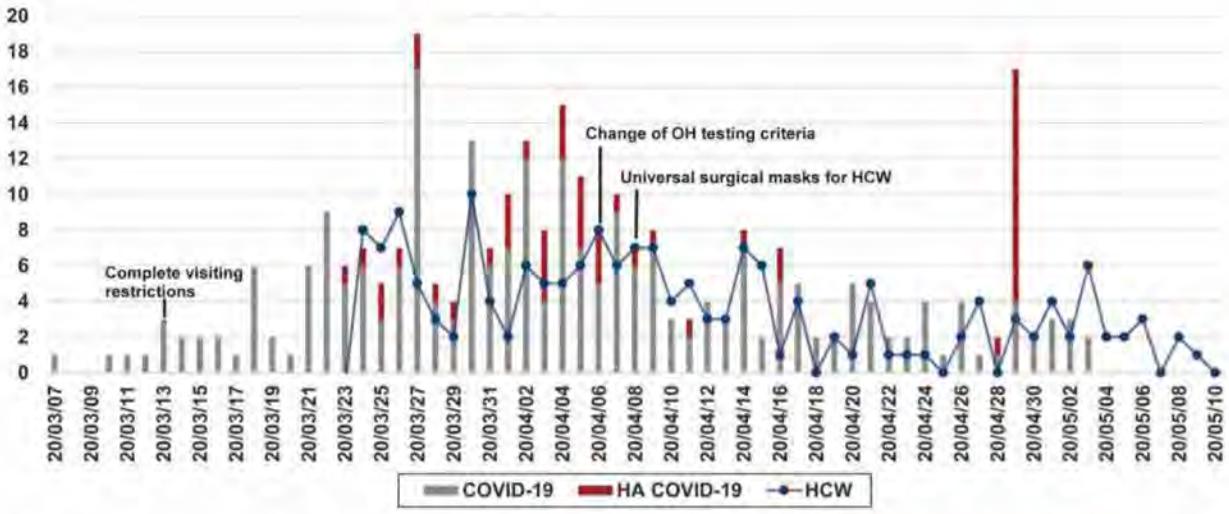
Key findings:

- 52 patients had hospital-acquired (HA) SARS-CoV-2 infection.
- Phylogenetic analysis identified six independent groups related to four outbreaks occurring in patients sharing a room, patients in private rooms, or patients who shared healthcare workers (HCWs).
- Study began before mask wearing was implemented; after mask implementation, HA cases decreased (Figure).

Methods: Study involving lab-confirmed SARS-CoV-2-infected patients and HCWs in a tertiary referral center in Ireland between March 7 and May 10, 2020. HA SARS-CoV-2 infections were defined as testing positive at least 7 days after admission. HCWs were tested by the hospital occupational health clinic based on symptoms. Whole genome sequencing and phylogenetic analysis were performed on SARS-CoV-2 RNA isolated from HCWs and patients to identify potential transmission linkages. *Limitations*: Only one location; may not be generalizable; only symptomatic HCWs were tested.

Implications: This study shows that in nosocomial infections, the majority of transmissions occurred through close contact and highlights the importance of consistent mask usage in both clinical and non-clinical areas.

Figure:



Note: From Lucey *et al.*, Number of persons with community-acquired SARS-CoV-2, **Hospital-acquired SARS-CoV-2** and **healthcare worker COVID-19** cases. Dates are in YY/MM/DD. On April 6th, 2020 the Occupational Health clinic (OH) altered its criteria for SARS-CoV-2 testing of HCW. Permission request in process.

PREPRINTS (NOT PEER-REVIEWED)

Molecular architecture of early dissemination and massive second wave of the SARS-CoV-2 virus in a major metropolitan area. Long *et al.* medRxiv (September 25, 2020).

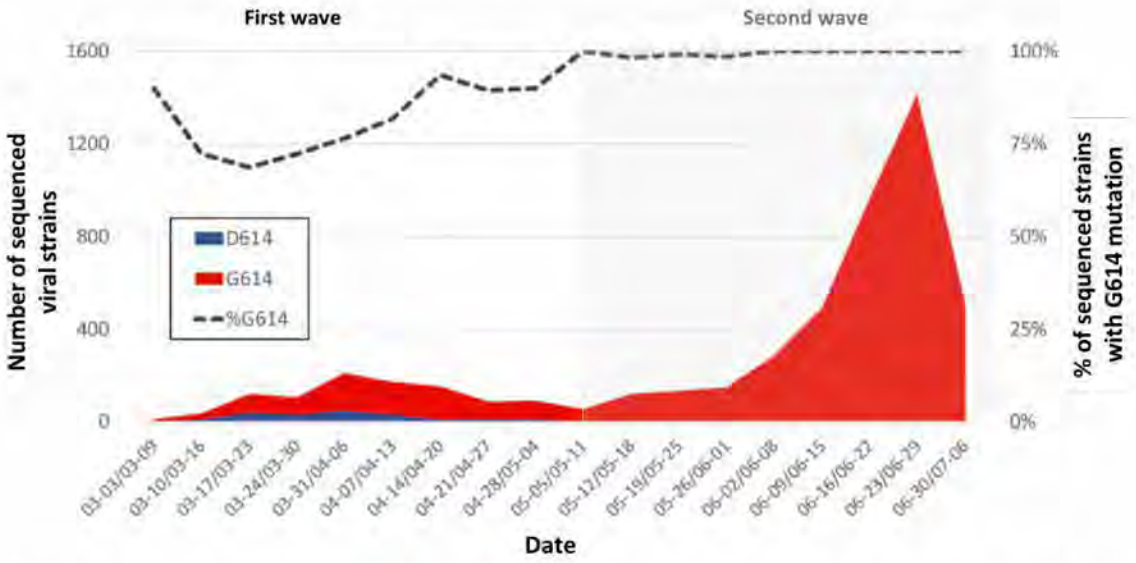
Key findings:

- Almost all of second wave virus strains were from 4 virus clades and 99.9% contained the G614 mutation in the spike protein compared to 82% from the first wave (Figure 1).
- Patients infected with the G614 variant strain had more viral RNA detected by RT-PCR as compared to the reference strain, D614 (Figure 2).
- There is no association between disease severity, length of stay, mortality, ethnicity and virus clades.

Methods: 5,085 full SARS-CoV-2 genomes were isolated from patients registered at Houston Methodist Hospitals and associated facilities between March and July, 2020. Genomic analysis was performed to identify phylogenetic differences. *Limitations*: Virus from ~10% of all infections included and might not be representative of the Houston Metropolitan Area; did not account for potential differences in timing of testing in relation to symptom onset that could have shifted over the period of study and be associated with detected viral RNA load.

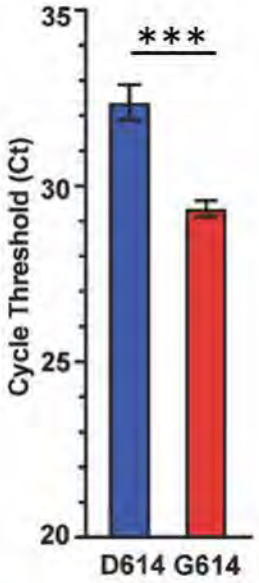
Implications: The large and diverse set of genomic information for SARS-CoV-2 virus for the Houston Metro Area may provide insights into differences among virus variants, new infection spikes, viral transmission within the population, as well as the ability to analyze potential genomic changes and their relation to disease severity. The results support laboratory studies that found that persons with infection with the G614 variant strain had higher viral burden, reflected by lower Ct values from respiratory specimens.

Figure 1



Note: Adapted from Long *et al.*, Number of **D614** and **G614** SARS-CoV-2 variants in the Houston Metro Area from March to July 2020. The percentage G614 strains from total sequenced strains is represented by the dashed line and the secondary Y-axis. The second wave of COVID19 cases are in the gray shaded area. Licensed under CC-BY-NC-ND 4.0.

Figure 2



Note: Adapted from Long *et al.* Cycle thresholds for **D614** and **G614** in Houston. Lower Ct means greater viral RNA and more viral burden. Error bars are the standard error of the mean. Bars are statistically different, ***p-value <0.001.

In Brief

- Vogel, L. Have we misjudged the role of children in spreading COVID-19? Canadian Medical Association Journal. Discusses new evidence that children can play a larger role in spreading SARS-COV-2 than previously considered.
- Bonow *et al*. Cardiology and COVID-19. JAMA. Review of the direct and indirect cardiac complications of COVID-19.
- Cevik *et al*. SARS-CoV-2 transmission dynamics should inform policy. Clinical Infectious Diseases. Review of large-scale SARS-CoV-2 studies to provide guidance in developing policies to reduce the spread of COVID-19.
- Peiris *et al*. What can we expect from first-generation COVID-19 vaccines? Lancet. Review of the challenges around first-generation COVID-19 vaccines, including generating sterilizing immunity, duration of protection, and vaccine hesitancy.
- Kupferschmidt. WHO unveils global plan to fairly distribute COVID-19 vaccine, but challenges await. Science. Challenges the WHO faces in distributing future COVID-19 vaccines outside of high-income countries.
- Han *et al*. Lessons learnt from easing COVID-19 restrictions: an analysis of countries and regions in Asia Pacific and Europe. Lancet. Health policy paper comparing several countries' approaches to lift COVID-19 restrictions with recommendations.
- Wang *et al*. COVID-19 confirmed patients with negative antibodies results. BMC infectious diseases and To *et al*. Serum antibody profile of a patient with COVID-19 reinfection. Clinical Infectious Diseases. Two articles describing patients where seroconversion was either partial or failed to occur.

cdc.gov/coronavirus

CDC COVID-19 Response Update Sunday, 04 Oct, 2020

INTERNAL - NOT FOR FURTHER DISTRIBUTION

Domestic Updates

Case Counts

The CDC numbers have been reviewed and approved by states and are suitable for use in all official communications.

Counts by Jurisdiction (Cumulative and New Cases and Deaths)[1]

Data Through 03 Oct 2020 *Last Updated: 04 Oct 2020 11:30*

57 Jurisdictions Reporting COVID-19 Cases

50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands

Reporting Area[2]	Cases	New Cases[3]		Cases Per 100K			Deaths	New Deaths[3]		Deaths per 100K			CFR[4]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
AK	8,217	143	121.4	1114.3	19.4	16.5	58	1	0.9	7.9	0.1	0.1	0.7%
AL	158,380	1,682	969.9	3240.3	34.4	19.8	2,558	8	8.1	52.3	0.2	0.2	1.6%
AR	86,525	746	824.3	2870.9	24.8	27.4	1,407	16	17.1	46.7	0.5	0.6	1.6%
AZ	220,399	636	510.4	3073.2	8.9	7.1	5,705	12	11.9	79.5	0.2	0.2	2.6%
CA	819,436	2,159	3,028.4	2071.5	5.5	7.7	16,074	88	77.4	40.6	0.2	0.2	2.0%
CO[5]	71,898	-	484.0	1262.4	-	8.5	2,057	-	2.4	36.1	-	0.0	2.9%
CT[5]	58,297	-	244.3	1631.8	-	6.8	4,513	-	1.7	126.3	-	0.0	7.7%
DE	21,243	118	140.4	2196.4	12.2	14.5	645	-	1.7	66.7	-	0.2	3.0%
FL	705,938	2,726	2,221.6	3314.4	12.8	10.4	14,628	74	86.6	68.7	0.3	0.4	2.1%
GA	322,078	1,444	1,172.1	3061.7	13.7	11.1	7,134	28	31.4	67.8	0.3	0.3	2.2%
HI[5]	12,788	-	84.4	900.3	-	5.9	142	-	1.6	10.0	-	0.1	1.1%
IA	91,964	939	910.9	2913.8	29.8	28.9	1,377	5	9.4	43.6	0.2	0.3	1.5%
ID	43,702	464	486.6	2491.3	26.5	27.7	480	6	2.9	27.4	0.3	0.2	1.1%
IL	302,827	2,442	2,001.7	2376.8	19.2	15.7	9,023	31	27.3	70.8	0.2	0.2	3.0%
IN	124,059	1,419	1,072.9	1853.9	21.2	16.0	3,669	13	13.1	54.8	0.2	0.2	3.0%
KS[5]	61,111	-	645.6	2098.9	-	22.2	698	-	9.4	24.0	-	0.3	1.1%
KY	72,001	1,274	852.1	1611.3	28.5	19.1	1,205	8	7.3	27.0	0.2	0.2	1.7%
LA[5]	168,826	-	524.9	3622.9	-	11.3	5,545	-	14.4	119.0	-	0.3	3.3%
MA	141,710	600	568.9	2053.1	8.7	8.2	9,500	17	16.3	137.6	0.2	0.2	6.7%
MD	127,290	471	555.3	2106.5	7.8	9.2	3,958	1	3.3	65.5	0.0	0.1	3.1%
ME	5,520	52	33.0	412.4	3.9	2.5	142	-	0.3	10.6	-	0.0	2.6%
MI	141,271	1,275	985.4	1413.3	12.8	9.9	7,124	14	11.4	71.3	0.1	0.1	5.0%
MN	103,826	2,460	1,166.7	1850.3	43.8	20.8	2,133	21	11.0	38.0	0.4	0.2	2.1%
MO	131,105	1,708	1,298.7	2140.0	27.9	21.2	2,169	25	15.1	35.4	0.4	0.2	1.7%
MS	100,488	321	518.4	3364.7	10.7	17.4	3,013	2	13.4	100.9	0.1	0.4	3.0%
MT	14,561	278	379.1	1370.7	26.2	35.7	186	-	2.1	17.5	-	0.2	1.3%
NC	216,886	2,202	1,542.3	2088.7	21.2	14.9	3,629	21	27.0	34.9	0.2	0.3	1.7%
ND	23,550	416	403.7	3098.4	54.7	53.1	274	3	6.1	36.0	0.4	0.8	1.2%
NE	47,403	426	543.9	2457.0	22.1	28.2	497	4	4.0	25.8	0.2	0.2	1.0%
NH	8,597	63	68.0	633.8	4.6	5.0	442	-	0.4	32.6	-	0.0	5.1%
NJ	207,576	947	675.1	2330.1	10.6	7.6	16,135	4	4.6	181.1	0.0	0.1	7.8%
NM	30,296	296	229.1	1445.8	14.1	10.9	890	3	2.9	42.5	0.1	0.1	2.9%
NV	81,812	526	479.3	2696.2	17.3	15.8	1,662	11	5.4	54.8	0.4	0.2	2.0%
NY City	247,287	548	545.1	2944.3	6.5	6.5	23,852	8	7.3	284.0	0.1	0.1	9.6%
NY State[6]	217,475	1,019	718.0	1951.6	9.1	6.4	9,057	7	4.7	81.3	0.1	0.0	4.2%
OH	157,966	1,157	1,136.7	1351.4	9.9	9.7	4,925	20	26.4	42.1	0.2	0.2	3.1%
OK	97,009	1,193	1,038.0	2460.2	30.3	26.3	1,057	7	6.6	26.8	0.2	0.2	1.1%
OR	34,511	348	275.7	823.5	8.3	6.6	571	8	3.6	13.6	0.2	0.1	1.7%
PA	161,284	-	864.6	1259.3	-	6.8	8,199	20	13.7	64.0	0.2	0.1	5.1%

[1] Data are reported voluntarily by each jurisdiction's health department. Data are reported as provided by the health department and the number of confirmed and probable cases or deaths may sum to the total. Health departments may update case data over time when they receive more complete and accurate information. If the number of cases or deaths reported by CDC is different from the number reported by jurisdiction health departments, data reported by jurisdictions should be considered the most up to date. The differences may be due to the timing of the reporting and website updates. See Technical Information about this data on the CDC Webpage. Darker shading corresponds to higher values.

[2] AS = American Samoa; DC = District of Columbia; FSM = Federated States of Micronesia; GU = Guam; CNMI = Commonwealth of the Northern Mariana Islands; PW = Palau; PR = Puerto Rico; RMI = Republic of the Marshall Islands; USVI = US Virgin Islands.

[3] These data represent new cases and deaths detected and tested in the US since the last update. Number of new cases and new deaths were included in total case numbers. Counts may have decreased from previous report due to case reclassification of cases to other jurisdictions or categories (e.g., probable to confirmed) by states.

[4] Percent change in cases, deaths and case fatality rates (CFR) are not calculated when the total number (denominator) was less than five.

[5] Jurisdiction did not provide an update.

[6] New York State excludes New York City.

57 Jurisdictions Reporting COVID-19 Cases 50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands													
Reporting Area[2]	Cases	New Cases[3]		Cases Per 100K			Deaths	New Deaths[3]		Deaths per 100K			CFR[4]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
RI[5]	25,076	-	127.9	2371.7	-	12.1	1,118	-	1.6	105.7	-	0.1	4.5%
SC	150,891	1,706	802.6	2967.9	33.6	15.8	3,442	33	17.0	67.7	0.6	0.3	2.3%
SD	23,986	464	407.6	2718.8	52.6	46.2	248	11	4.3	28.1	1.2	0.5	1.0%
TN	199,595	1,192	1,243.4	2948.2	17.6	18.4	2,560	45	26.6	37.8	0.7	0.4	1.3%
TX	763,010	7,006	4,224.6	2658.4	24.4	14.7	15,992	97	72.4	55.7	0.3	0.3	2.1%
UT	76,225	1,068	954.0	2411.3	33.8	30.2	476	2	4.0	15.1	0.1	0.1	0.6%
VA	151,870	1,067	818.0	1783.0	12.5	9.6	3,273	3	16.3	38.4	0.0	0.2	2.2%
VT	1,778	10	5.6	283.9	1.6	0.9	58	-	-	9.3	-	-	3.3%
WA[7]	89,419	609	512.7	1186.6	8.1	6.8	2,142	(1)	6.0	28.4	NA	0.1	2.4%
WI	138,002	3,054	2,538.7	2373.8	52.5	43.7	1,383	20	13.1	23.8	0.3	0.2	1.0%
WV	16,468	161	187.1	911.9	8.9	10.4	357	2	3.6	19.8	0.1	0.2	2.2%
WY	6,365	151	128.6	1101.7	26.1	22.3	53	-	0.4	9.2	-	0.1	0.8%
AS	-	-	-	-	-	-	-	-	-	-	-	-	-
CNMI[8]	73	-	-	128.3	-	-	2	-	-	3.5	-	-	-
DC	15,473	50	36.9	2202.7	7.1	5.2	629	-	0.7	89.5	-	0.1	4.1%
FSM	-	-	-	-	-	-	-	-	-	-	-	-	-
GU[5]	2,617	-	47.3	1578.7	-	28.5	49	-	1.4	29.6	-	0.9	1.9%
PR	50,665	290	623.0	1585.7	9.1	19.5	686	5	6.0	21.5	0.2	0.2	1.4%
PW	-	-	-	-	-	-	-	-	-	-	-	-	-
RMI	-	-	-	-	-	-	-	-	-	-	-	-	-
USVI	1,327	1	-	1267.7	1.0	-	20	-	-	19.1	-	-	1.5%
Total	**7,359,952**	**49,327**	**42,980.7**	**2224.1**	**14.9**	**13.0**	**208,821**	**703**	**684.0**	**63.1**	**0.2**	**0.2**	**2.8%**
Navajo[9]	10,421	17	21.7	2919.9	4.8	6.1	558	-	0.9	156.4	-	0.2	5.4%

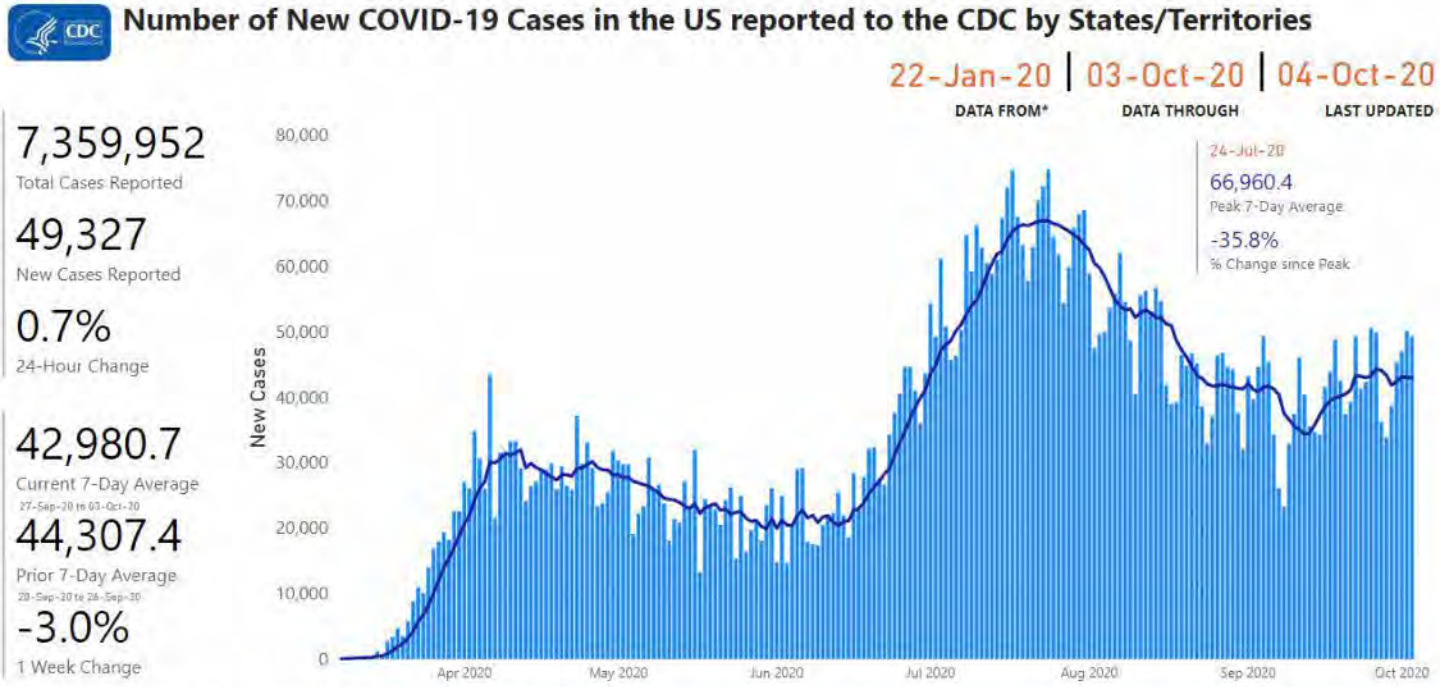
Compilations of US Case Counts

Reporting Source[10]	Data as of (all times are ET)	Cases	New Cases	Deaths	New Deaths
Official Sources (see table above)	04 Oct, 11:30	7,359,952	49,327	208,821	703
1Point3Acres	04 Oct, 10:00	7,536,830	48,472	213,549	717
Johns Hopkins	04 Oct, 9:23	7,384,422	48,476	209,401	662
USAFacts[11]	03 Oct, NA	7,269,425	94,511	206,913	1,682
New York Times	04 Oct, 08:08	7,410,214	47,697	209,271	709
WorldoMeter	04 Oct, 09:39	7,601,182	45,184	214,280	709
COVID Tracking Project	03 Oct, 16:00	7,345,232	51,203	201,351	740

[7] Washington reported one fewer death.
[8] Jurisdiction reported zero new cases and zero new deaths.
[9] Cases in the Navajo Nation are likely also reported by AZ, NM, and UT and were therefore already included in the grand total above. Counts reported separately here from Navajo Department of Health COVID-19 and Navajo Epidemiology Center Coronavirus Response Hub
[10] Data from other organizations are not reviewed or validated by CDC and may include data derived from open media sources not represented on official state public health department web pages.
[11] Reporting changes since 01 Oct

Number of New COVID-19 Cases in the US Reported to the CDC by States/Territories

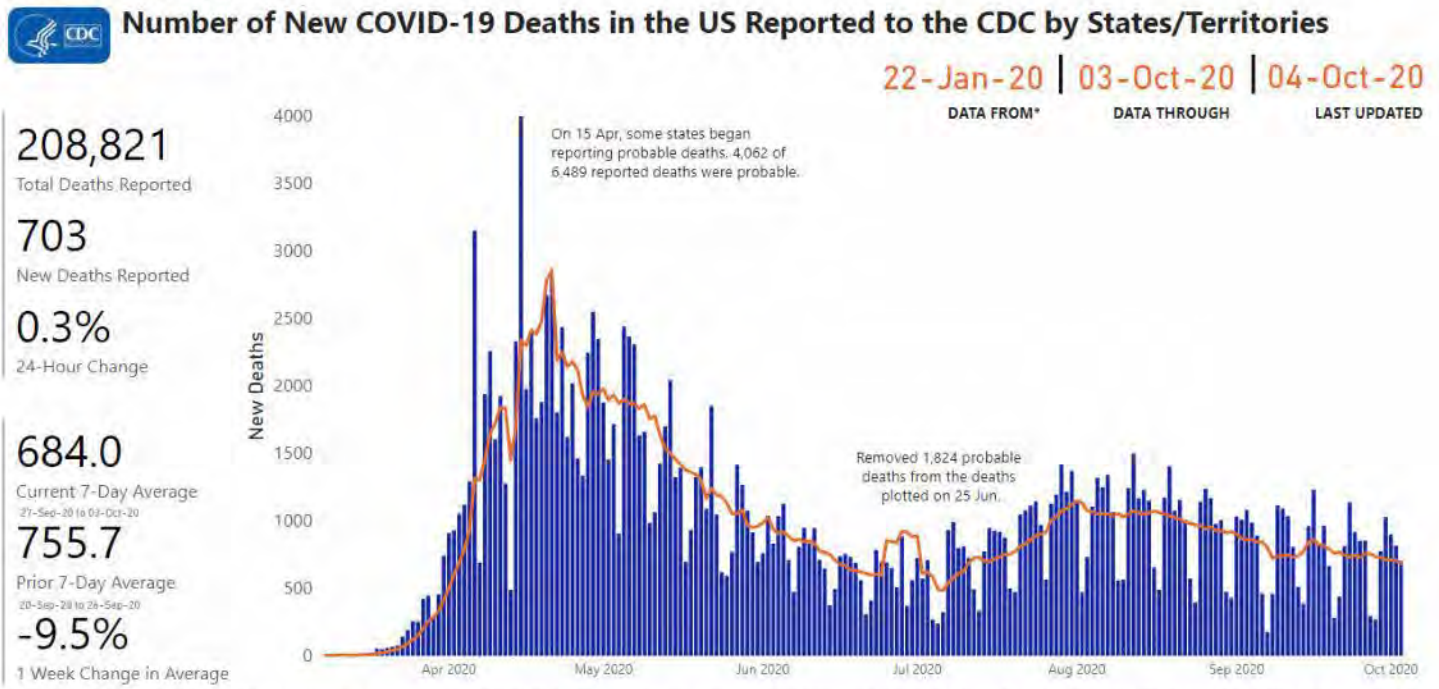
Data: 22 Jan 2020 – 03 Oct 2020 Last Updated: 04 Oct 2020, 11:30
Source: CDC DCIPHER



Data Sources, References & Notes: Total cases are based on aggregate counts of COVID-19 cases reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 22 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Numbers include confirmed and probable COVID-19 cases as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as cases/100,000 people. The 7-day moving average of new cases (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall case numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER, US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

Number of New COVID-19 Deaths in the US Reported to the CDC by States/Territories

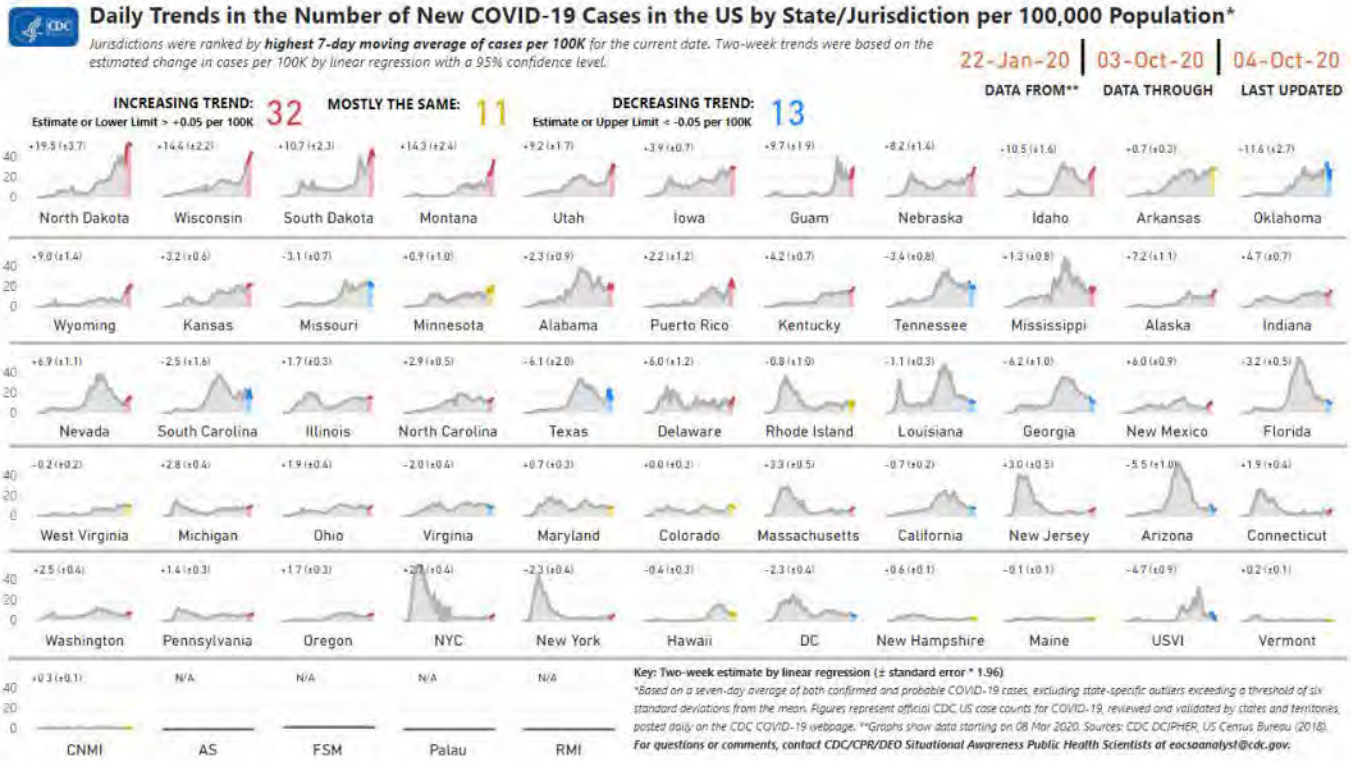
Data: 22 Jan 2020 – 03 Oct 2020 Last Updated: 04 Oct 2020, 11:30
Source: CDC DCIPHER



Data Sources, References & Notes: Total deaths are based on aggregate counts of COVID-19 deaths reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 21 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Number include confirmed and probable COVID-19 deaths as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as deaths/100,000 people. The 7-day moving average of new deaths (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall death numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER, US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

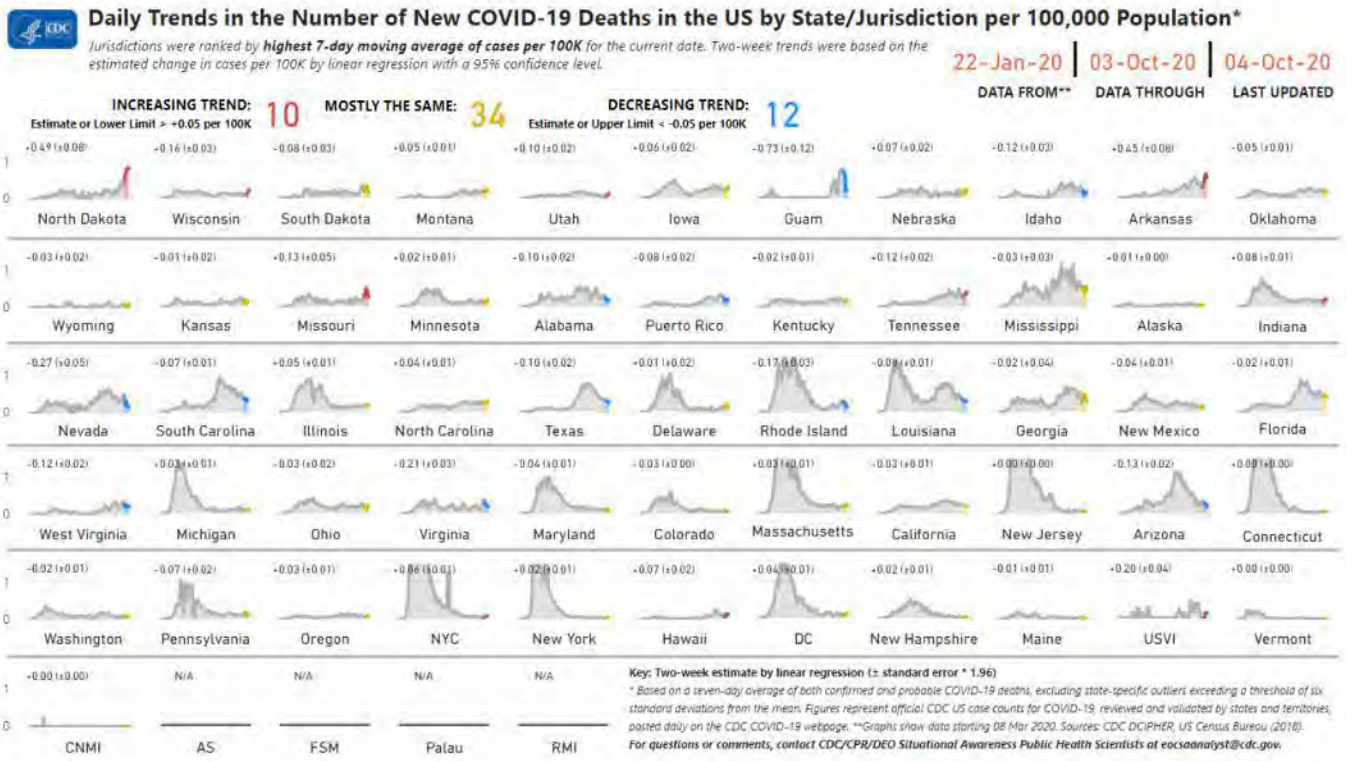
Daily Trends in the Number of New COVID-19 Cases in the United States by State/Jurisdiction per 100,000 Population

Data: 22 Jan 2020 – 03 Oct 2020 *Last Updated: 04 Oct 2020, 11:30*
Source: CDC DCIPHER



Daily Trends in the Number of New COVID-19 Deaths in the United States by State/Jurisdiction per 100,000 Population

Data: 22 Jan 2020 – 03 Oct 2020 *Last Updated: 04 Oct 2020, 11:30*
Source: CDC DCIPHER



Cases/Deaths by CBSA [12,13]

Daily Trends in New COVID-19 Cases in the United States per 100,000 Population by CBSA

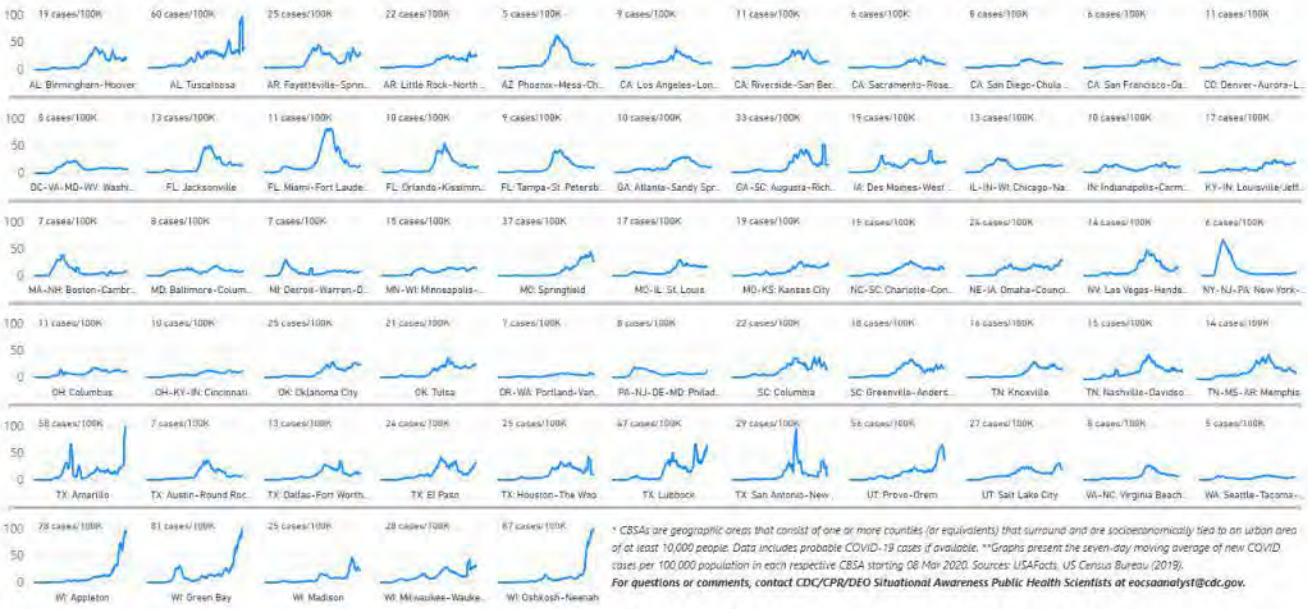
Data 22 Jan 2020 through 02 Oct 2020 Last Updated: 04 Oct 2020, 08:00

Source: Data from USAFACTS

Daily Trends in the Number of New COVID-19 Cases in the US by Core-based Statistical Area (CBSA) per 100,000 Population*

22-Jan-20 DATA FROM** | 02-Oct-20 DATA THROUGH | 04-Oct-20 LAST UPDATED

These are the top 60 CBSAs based on the number of new cases in the past 14 days, presented in alphabetical order by state and city/town.



* CBSAs are geographic areas that consist of one or more counties (or equivalents) that surround and are socioeconomically tied to an urban area of at least 10,000 people. Data includes probable COVID-19 cases if available. **Graphs present the seven-day moving average of new COVID cases per 100,000 population in each respective CBSA starting 08 Mar 2020. Sources: USAFacts, US Census Bureau (2019).

For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

Daily Trends in New COVID-19 Deaths in the United States per 100,000 Population by CBSA

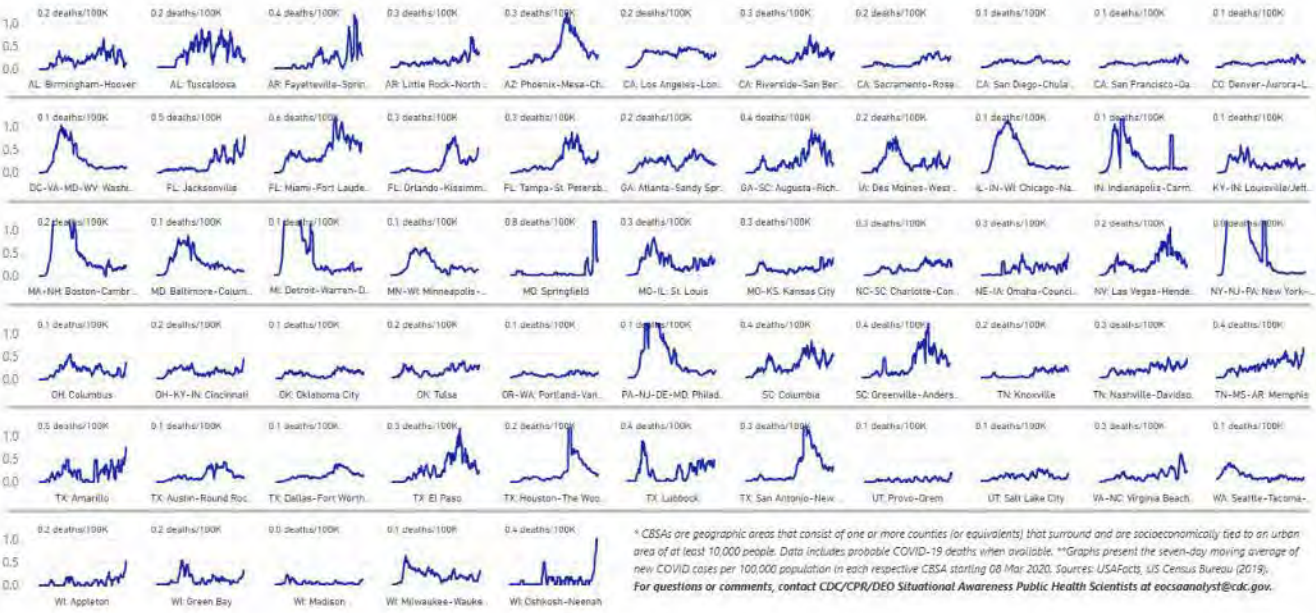
Data 22 Jan 2020 through 02 Oct 2020 Last Updated: 04 Oct 2020, 08:00

Source: Data from USAFACTS

Daily Trends in the Number of New COVID-19 Deaths in the US by Core-based Statistical Area (CBSA) per 100,000 Population*

22-Jan-20 DATA FROM** | 02-Oct-20 DATA THROUGH | 04-Oct-20 LAST UPDATED

These are the top 60 CBSAs based on the number of new deaths in the past 14 days, presented in alphabetical order by state and city/town.



* CBSAs are geographic areas that consist of one or more counties (or equivalents) that surround and are socioeconomically tied to an urban area of at least 10,000 people. Data includes probable COVID-19 deaths when available. **Graphs present the seven-day moving average of new COVID cases per 100,000 population in each respective CBSA starting 08 Mar 2020. Sources: USAFacts, US Census Bureau (2019).

For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

[12] See methodology and sources for data reported by *USAFACTS*.

[13] See information on Core-Based Statistical Area (CBSA) from the US Census Bureau.

US Healthcare Workers

Data as of 03 Oct 2020

Healthcare Workers in US - Case Count Reported in Case-Based Surveillance

N = 171,799 (+971)

- 739 Deaths (-1)
  - 191 in CA
  - 189 in IL
  - 64 in OH
  - 46 in MA
  - 31 in MI
  - 29 in NV
  - 25 in NY
  - 23 in TN[14]
  - 22 in NC
  - 20 in PA
  - 18 in WA
  - 13 in AR
  - 12 in IA
  - 12 in MN
  - 11 in LA
  - 8 in NH
  - 7 in KS
  - 7 in NJ
  - 4 in CO
  - 3 in DC
  - 2 in PR
  - 1 in UT
  - 1 in VI

[14] The number of HCP death decreased by 2 for TN. The decreases in deaths are most likely due to data cleaning.

From: (b)(3):50 USC 3024(i); (b)(6)

Sent: Monday, October 12, 2020 8:30 PM

To: (b)(3):10 USC 424; (b)(6)

Cc:

Subject: CDC COVID-19 Update 12Oct2020 (For Internal USG only)

Attachments: (FOUO) CDC COVID-19 RESPONSE UPDATE 20201012.pdf; 2020_10_09_Science Update_Final Public.pdf

Good evening,

Please see attached CDC Reports.

Cases/deaths as of 12 Oct 2020:
- 7,740,934 confirmed and probable U.S. cases, +46,069 since yesterday
- 214,108 U.S. deaths reported to CDC, +494 since yesterday
- 37,423,660 confirmed cases worldwide (WHO dashboard data)

Highlights:
- Case Counts and Deaths: 7-day case average is up 14% from the previous 7-days. 7-day death average is up 1% from the previous 7-days.
- Travel Health Notices (THNs): https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html; No changes to individual country risk determinations since 05 Oct. CDC updates to criteria for THN determinations and additional recommendations for travelers will likely be delayed 2-3 weeks. Anticipate these updates in the first week of November.

Science Update Highlights:
- US Adults' Preferences for Public Allocation of a Vaccine for Coronavirus Disease 2019: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770976, survey highlights the public's recognition of the risk to frontline medical workers and high-risk individuals
- Four studies reviewed regarding the safety and efficacy of hydroxychloroquine use against SARS-CoV-2: HCQ found to have no effective role in the management of COVID-19 or prevention of SARS-CoV-2 infection.

- Seasonal Coronavirus Protective Immunity is Short-Lasting: https://www.nature.com/articles/s41591-020-1083-1; Reinfections with seasonal coronaviruses (CoVs) frequently occurred at 12 months or sooner; Probable implications for vaccination interval strategies.

- COVID-19 vaccine BNT162b1 elicits human antibody and T_H1 T-cell responses: https://www.nature.com/articles/s41586-020-2814-7; Pfizer/BioNTech vaccine shows promise with a robust RBD-specific antibody and T-cell response.

- SARS-CoV-2 contamination of inanimate surfaces and virus viability in a health care emergency unit: https://www.clinicalmicrobiologyandinfection.com/article/S1198-743X(20)30286-X/fulltext; Study supports CDC assertion that surface contamination is not a huge risk factor for transmission.

- The major genetic risk factor for severe COVID-19 is inherited from Neanderthals: https://www.nature.com/articles/s41586-020-2818-3; Sleestak could not be reached for comment.

MMWR Pubs:

- None since Friday.

Please regularly refer to CDC's COVID-19 webpage; information and guidance is updated daily: https://covid.cdc.gov/covid-data-tracker/

VR/

(b)(6)

Dept of Defense Liaison to the Centers for Disease Control and Prevention, Atlanta, GA

(b)(6)

(b)(3):50 USC 3024(i); (b)(6)

CDC COVID-19 Response Update Monday, 12 Oct, 2020
INTERNAL - NOT FOR FURTHER DISTRIBUTION

Domestic Updates

Case Counts

The CDC numbers have been reviewed and approved by states and are suitable for use in all official communications.

Counts by Jurisdiction (Cumulative and New Cases and Deaths)[1]

Data Through 11 Oct 2020 *Last Updated: 12 Oct 2020 11:30*

57 Jurisdictions Reporting COVID-19 Cases[2]													
50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands													
Reporting Area[3]	Cases	New Cases[4]		Cases Per 100K			Deaths	New Deaths[4]		Deaths per 100K			CFR[5]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
AK	9,686	255	183.0	1313.5	34.6	24.8	60	-	0.3	8.1	-	0.0	0.6%
AL	165,342	816	881.9	3382.7	16.7	18.0	2,664	-	15.1	54.5	-	0.3	1.6%
AR	92,833	613	831.4	3080.2	20.3	27.6	1,568	18	20.4	52.0	0.6	0.7	1.7%
AZ	225,575	597	688.7	3145.4	8.3	9.6	5,759	-	7.6	80.3	-	0.1	2.6%
CA	846,579	3,803	3,264.3	2140.1	9.6	8.3	16,564	64	63.4	41.9	0.2	0.2	2.0%
CO	78,461	819	769.3	1377.6	14.4	13.5	2,113	1	6.6	37.1	0.0	0.1	2.7%
CT[6]	60,038	-	248.7	1680.5	-	7.0	4,530	-	2.4	126.8	-	0.1	7.5%
DE[6]	22,130	-	109.6	2288.1	-	11.3	654	-	1.3	67.6	-	0.1	3.0%
FL	725,415	5,414	2,523.4	3405.8	25.4	11.8	15,364	178	99.0	72.1	0.8	0.5	2.1%
GA	331,409	1,140	1,212.0	3150.4	10.8	11.5	7,416	23	36.3	70.5	0.2	0.3	2.2%
HI	13,633	262	91.7	959.7	18.4	6.5	169	1	1.9	11.9	0.1	0.1	1.2%
IA	99,685	1,094	1,014.4	3158.4	34.7	32.1	1,460	5	11.0	46.3	0.2	0.3	1.5%
ID	48,066	365	586.0	2740.0	20.8	33.4	507	-	3.6	28.9	-	0.2	1.1%
IL	322,188	2,727	2,558.3	2528.7	21.4	20.1	9,230	9	27.1	72.4	0.1	0.2	2.9%
IN	134,981	1,570	1,405.0	2017.1	23.5	21.0	3,789	7	16.4	56.6	0.1	0.2	2.8%
KS[6]	65,807	-	670.9	2260.2	-	23.0	763	-	9.3	26.2	-	0.3	1.2%
KY	80,292	847	1,096.4	1796.9	19.0	24.5	1,252	3	6.1	28.0	0.1	0.1	1.6%
LA	174,587	1,181	695.4	3746.5	25.3	14.9	5,655	20	11.1	121.4	0.4	0.2	3.2%
MA	146,064	570	532.6	2116.2	8.3	7.7	9,596	16	13.3	139.0	0.2	0.2	6.6%
MD	131,861	504	581.4	2182.1	8.3	9.6	4,003	4	6.0	66.2	0.1	0.1	3.0%
ME	5,723	27	25.4	427.6	2.0	1.9	143	-	0.1	10.7	-	0.0	2.5%
MI[6]	149,464	-	1,170.4	1495.3	-	11.7	7,219	-	13.6	72.2	-	0.1	4.8%
MN	113,439	1,171	1,373.3	2021.7	20.9	24.5	2,197	3	9.1	39.2	0.1	0.2	1.9%
MO[6]	144,230	-	1,685.6	2354.2	-	27.5	2,422	-	35.6	39.5	-	0.6	1.7%
MS[6]	104,932	-	604.1	3513.5	-	20.2	3,101	-	12.6	103.8	-	0.4	3.0%
MT	18,702	585	581.0	1760.5	55.1	54.7	210	1	3.3	19.8	0.1	0.3	1.1%
NC	231,471	1,719	1,996.4	2229.2	16.6	19.2	3,770	5	19.4	36.3	0.0	0.2	1.6%
ND	27,737	472	553.6	3649.2	62.1	72.8	345	6	9.7	45.4	0.8	1.3	1.2%
NE	52,382	1,238	653.6	2715.1	64.2	33.9	519	-	2.6	26.9	-	0.1	1.0%
NH	9,143	53	71.1	674.0	3.9	5.2	456	1	1.9	33.6	0.1	0.1	5.0%
NJ	213,628	751	775.1	2398.0	8.4	8.7	16,174	3	5.4	181.6	0.0	0.1	7.6%
NM	32,983	261	358.0	1574.0	12.5	17.1	911	4	2.7	43.5	0.2	0.1	2.8%
NV	85,871	380	523.9	2829.9	12.5	17.3	1,707	2	6.0	56.3	0.1	0.2	2.0%
NY City	251,618	356	555.3	2995.9	4.2	6.6	23,887	4	3.7	284.4	0.0	0.0	9.5%
NY State[7]	223,922	674	822.4	2009.4	6.0	7.4	9,103	3	5.0	81.7	0.0	0.0	4.1%
OH	168,749	1,291	1,406.0	1443.6	11.0	12.0	4,999	2	10.6	42.8	0.0	0.1	3.0%
OK[6]	103,382	-	828.9	2621.9	-	21.0	1,097	-	5.6	27.8	-	0.1	1.1%
OR	37,255	729	355.0	889.0	17.4	8.5	599	2	3.9	14.3	0.0	0.1	1.6%
PA	172,216	1,166	1,240.1	1344.7	9.1	9.7	8,350	42	19.1	65.2	0.3	0.1	4.8%

[1] Aggregated cases and deaths are reported voluntarily by each jurisdiction. Jurisdictions may update data reported on web pages which differ from information in the table above. If the number of cases or deaths on a jurisdictional webpage differ from what is reported above, the webpage should be considered the most up to date. See Technical Information about this data on the CDC Webpage.

[2] Darker shading in columns correspond to higher values.

[3] AS = American Samoa; DC = District of Columbia; FSM = Federated States of Micronesia; GU = Guam; CNMI = Commonwealth of the Northern Mariana Islands; PW = Palau; PR = Puerto Rico; RMI = Republic of the Marshall Islands; USVI = US Virgin Islands.

[4] These data represent new cases and deaths detected and tested in the US since the last update. Number of new cases and new deaths were included in total case numbers. Counts may have decreased from previous report due to case reclassification of cases to other jurisdictions or categories (e.g., probable to confirmed) by states.

[5] Percent change in cases, deaths and case fatality rates (CFR) are not calculated when the total number (denominator) was less than five.

[6] Jurisdiction did not provide an update.

[7] New York State excludes New York City.

57 Jurisdictions Reporting COVID-19 Cases[2]													
50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands													
Reporting Area[3]	Cases	New Cases[4]		Cases Per 100K			Deaths	New Deaths[4]		Deaths per 100K			CFR[5]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
RI[6]	26,294	-	174.0	2486.9	-	16.5	1,130	-	1.7	106.9	-	0.2	4.3%
SC	157,406	785	832.0	3096.0	15.4	16.4	3,552	1	14.1	69.9	0.0	0.3	2.3%
SD	28,564	617	592.3	3237.7	69.9	67.1	286	-	5.4	32.4	-	0.6	1.0%
TN	214,717	2,068	1,929.6	3171.6	30.5	28.5	2,767	9	27.1	40.9	0.1	0.4	1.3%
TX	792,478	2,418	3,797.7	2761.1	8.4	13.2	16,557	31	76.0	57.7	0.1	0.3	2.1%
UT	85,844	1,200	1,175.1	2715.6	38.0	37.2	517	7	5.6	16.4	0.2	0.2	0.6%
VA	159,570	854	1,001.9	1873.4	10.0	11.8	3,361	3	12.1	39.5	0.0	0.1	2.1%
VT	1,876	19	13.0	299.5	3.0	2.1	58	-	-	9.3	-	-	3.1%
WA	93,862	827	569.7	1245.6	11.0	7.6	2,190	-	6.9	29.1	-	0.1	2.3%
WI	158,315	2,713	2,626.7	2723.2	46.7	45.2	1,475	7	12.4	25.4	0.1	0.2	0.9%
WV	18,128	215	214.3	1003.9	11.9	11.9	382	1	3.4	21.2	0.1	0.2	2.1%
WY	7,611	156	158.1	1317.4	27.0	27.4	54	-	0.1	9.3	-	0.0	0.7%
AS	-	-	-	-	-	-	-	-	-	-	-	-	-
CNMI[8]	77	-	-	135.4	-	-	2	-	-	3.5	-	-	-
DC	15,984	3	66.4	2275.4	0.4	9.5	637	1	0.9	90.7	0.1	0.1	4.0%
FSM	-	-	-	-	-	-	-	-	-	-	-	-	-
GU	3,170	181	79.0	1912.3	109.2	47.7	60	2	1.6	36.2	1.2	0.9	1.9%
PR	54,234	563	418.4	1697.4	17.6	13.1	735	5	5.7	23.0	0.2	0.2	1.4%
PW	-	-	-	-	-	-	-	-	-	-	-	-	-
RMI	-	-	-	-	-	-	-	-	-	-	-	-	-
USVI[6]	1,325	-	-	1265.8	-	-	20	-	-	19.1	-	-	1.5%
Total	**7,740,934**	**46,069**	**49,172.0**	**2339.2**	**13.9**	**14.9**	**214,108**	**494**	**701.3**	**64.7**	**0.1**	**0.2**	**2.8%**
Navajo[9]	10,675	-	33.4	2991.1	-	9.4	565	-	0.9	158.3	-	0.2	5.3%

Compilations of US Case Counts

Reporting Source[10]	Data as of (all times are ET)	Cases	New Cases	Deaths	New Deaths
Official Sources (see table above)	12 Oct, 11:30	7,740,934	46,069	214,108	494
1Point3Acres	12 Oct, 10:50	7,924,440	50,466	219,037	494
Johns Hopkins	12 Oct, 10:23	7,765,684	44,212	214,844	456
USAFacts	11 Oct, NA	7,657,074	57,426	212,487	776
New York Times	12 Oct, 07:43	7,792,420	44,390	214,604	420
WorldoMeter	12 Oct, 11:35	7,998,982	49,069	219,791	487
COVID Tracking Project	11 Oct, 16:00	7,727,630	46,776	206,597	464

[8] CNMI reported zero new cases and zero new deaths since yesterday.

[9] Cases in the Navajo Nation are likely also reported by AZ, NM, and UT and were therefore already included in the grand total above. Counts reported separately here from Navajo Department of Health COVID-19 and Navajo Epidemiology Center Coronavirus Response Hub

[10] Data from other organizations are not reviewed or validated by CDC and may include data derived from open media sources not represented on official state public health department web pages.

Number of New COVID-19 Cases in the US Reported to the CDC by States/Territories

Data: 22 Jan 2020 – 11 Oct 2020 *Last Updated: 12 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER[11])

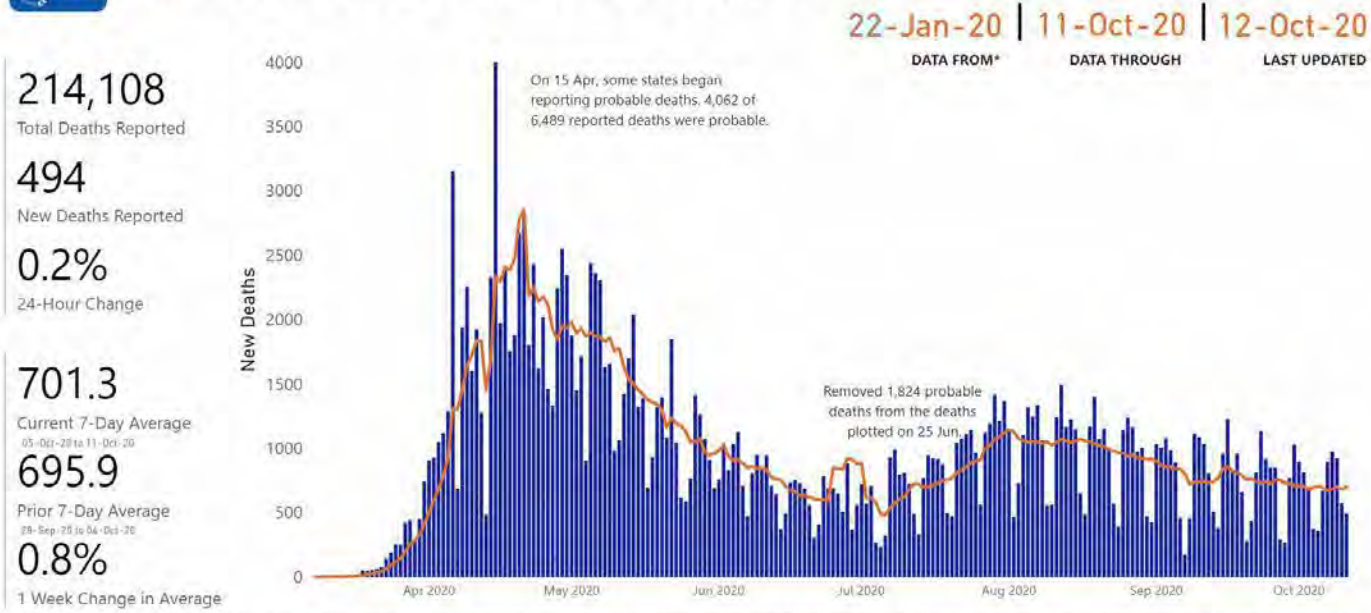
Number of New COVID-19 Cases in the US reported to the CDC by States/Territories

Data Sources, References & Notes: Total cases are based on aggregate counts of COVID-19 cases reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 22 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Numbers include confirmed and probable COVID-19 cases as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as cases/100,000 people. The 7-day moving average of new cases (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall case numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER, US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

Number of New COVID-19 Deaths in the US Reported to the CDC by States/Territories

Data: 22 Jan 2020 – 11 Oct 2020 *Last Updated: 12 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)

Number of New COVID-19 Deaths in the US Reported to the CDC by States/Territories

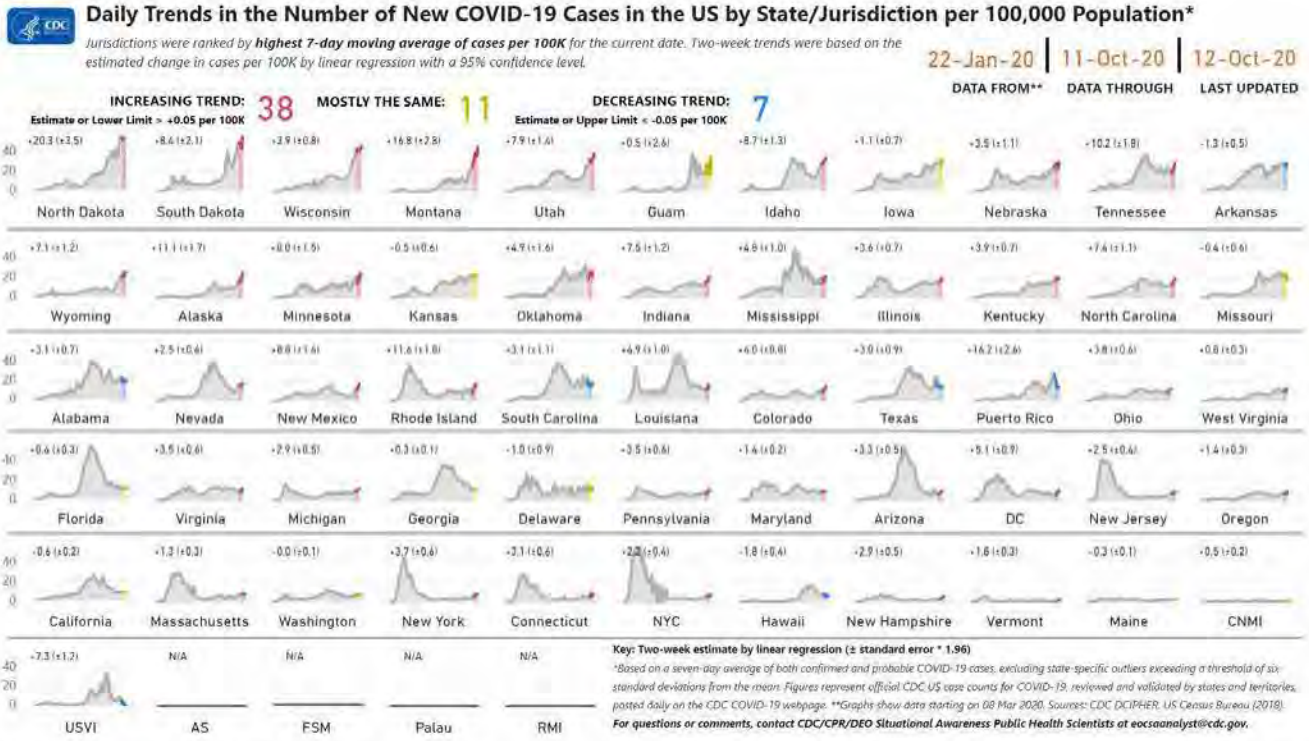


Data Sources, References & Notes: Total deaths are based on aggregate counts of COVID-19 deaths reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 21 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Number include confirmed and probable COVID-19 deaths as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as deaths/100,000 people. The 7-day moving average of new deaths (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall death numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER, US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

[11] Data Collation and Integration for Public Health Event Response.

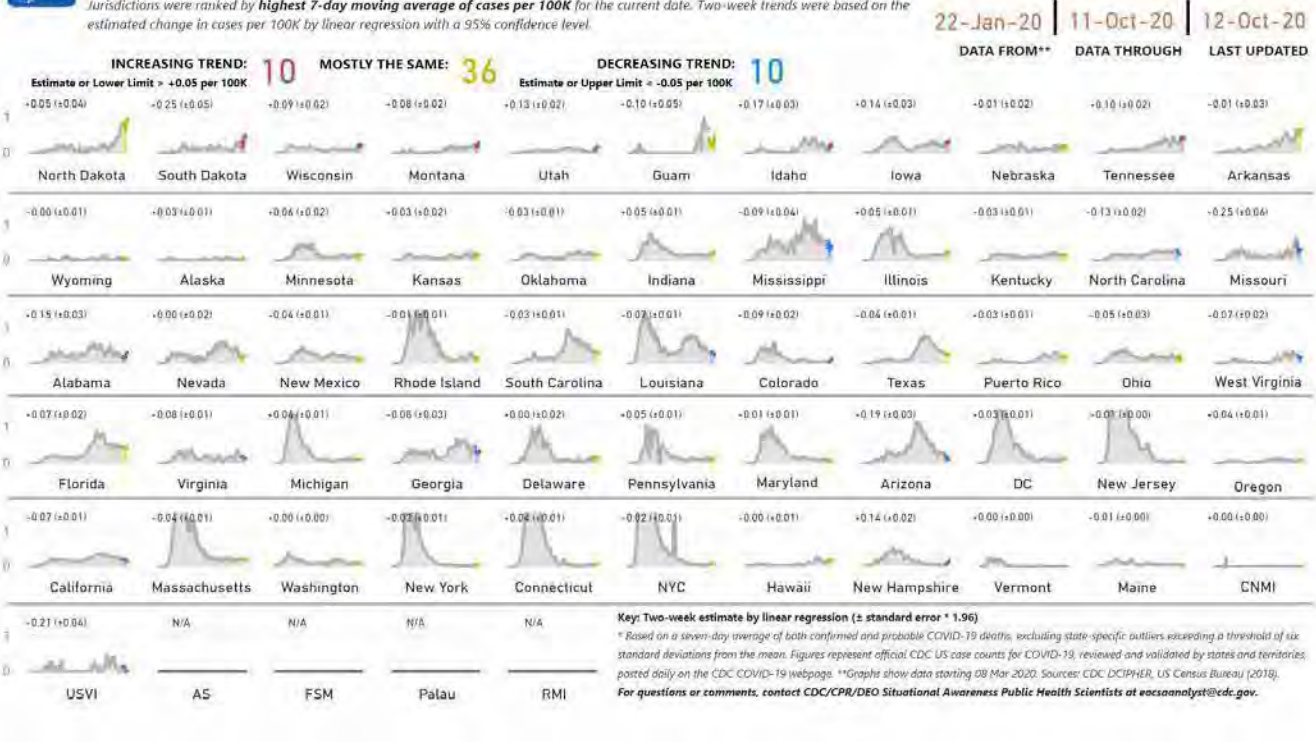
Daily Trends in the Number of New COVID-19 Cases in the United States by State/Jurisdiction per 100,000 Population

Data: 22 Jan 2020 – 11 Oct 2020 *Last Updated: 12 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)



Daily Trends in the Number of New COVID-19 Deaths in the United States by State/Jurisdiction per 100,000 Population

Data: 22 Jan 2020 – 11 Oct 2020 *Last Updated: 12 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)



Cases/Deaths by CBSA [12,13]

Daily Trends in New COVID-19 Cases in the United States per 100,000 Population by CBSA

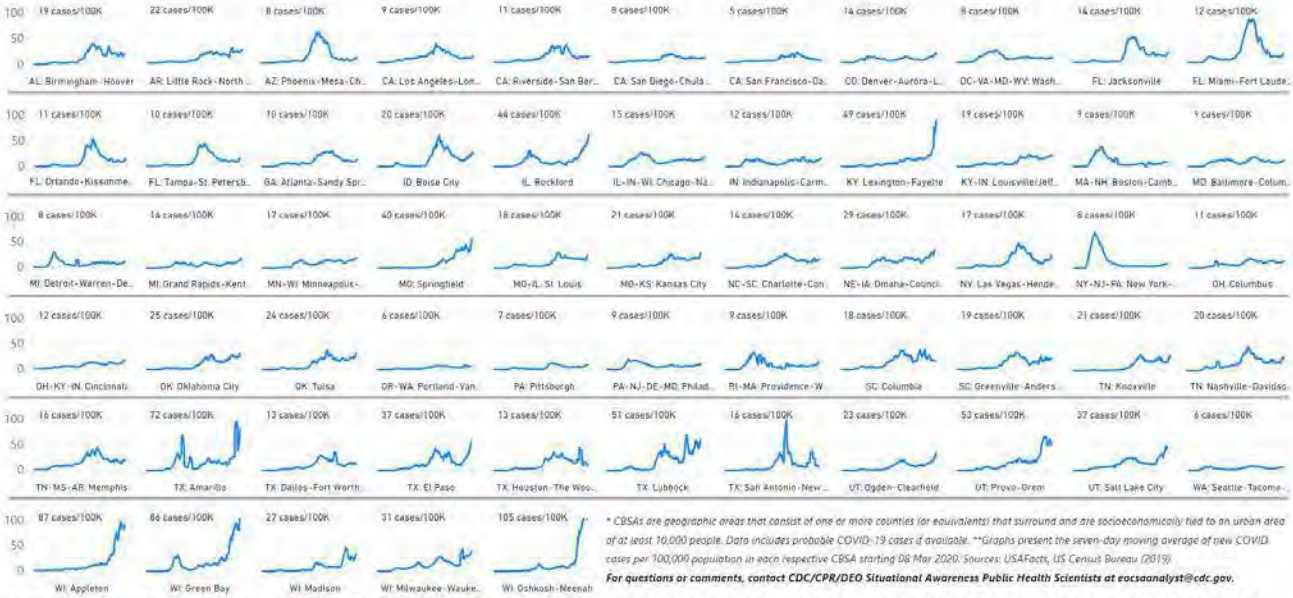
Data 22 Jan 2020 through 10 Oct 2020 Last Updated: 12 Oct 2020, 08:00

Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)

Daily Trends in the Number of New COVID-19 Cases in the US by Core-based Statistical Area (CBSA) per 100,000 Population*

22-Jan-20 DATA FROM** | 10-Oct-20 DATA THROUGH | 12-Oct-20 LAST UPDATED

These are the top 60 CBSAs based on the number of new cases in the past 14 days, presented in alphabetical order by state and city/town.



** CBSAs are geographic areas that consist of one or more counties (or equivalents) that surround and are socioeconomically tied to an urban area of at least 10,000 people. Data includes probable COVID-19 cases if available. **Graphs present the seven-day moving average of new COVID cases per 100,000 population in each respective CBSA starting 08 Mar 2020. Sources: USAFacts, US Census Bureau (2019).*

For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

Daily Trends in New COVID-19 Deaths in the United States per 100,000 Population by CBSA

Data 22 Jan 2020 through 10 Oct 2020 Last Updated: 12 Oct 2020, 08:00

Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)

Daily Trends in the Number of New COVID-19 Deaths in the US by Core-based Statistical Area (CBSA) per 100,000 Population*

22-Jan-20 DATA FROM** | 10-Oct-20 DATA THROUGH | 12-Oct-20 LAST UPDATED

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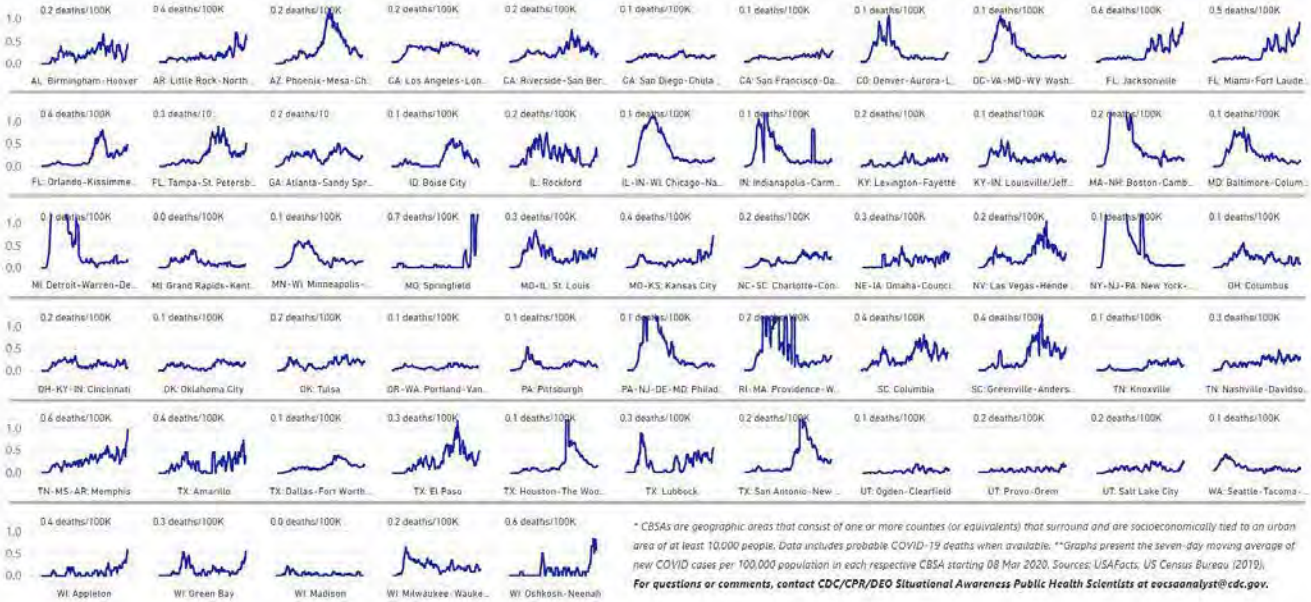


** CBSAs are geographic areas that consist of one or more counties (or equivalents) that surround and are socioeconomically tied to an urban area of at least 10,000 people. Data includes probable COVID-19 deaths when available. **Graphs present the seven-day moving average of new COVID cases per 100,000 population in each respective CBSA starting 08 Mar 2020. Sources: USAFacts, US Census Bureau (2019).*

For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

[12] See methodology and sources for data reported by *USAFACTS*.

[13] See information on Core-Based Statistical Area (CBSA) from the US Census Bureau.

COVID-19 Among Specific Populations

US Healthcare Workers

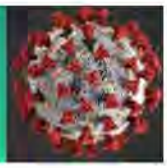
Healthcare Workers in US - Case Count Reported in Case-Based Surveillance

Data as of 11 Oct 2020

N = 178,032 (+974)

- 753 Deaths (+1)
  - 192 in CA
  - 189 in IL
  - 69 in OH
  - 46 in MA
  - 31 in MI
  - 30 in NV
  - 25 in NY
  - 25 in TN
  - 23 in NC
  - 20 in PA
  - 18 in WA
  - 16 in AR
  - 12 in IA
  - 12 in MN
  - 11 in LA
  - 8 in NH
  - 8 in KS
  - 7 in NJ
  - 4 in CO
  - 3 in DC
  - 2 in PR
  - 1 in UT
  - 1 in VI

COVID-19 Science Update



From the Office of the Chief Medical Officer, CDC COVID-19 Response, and the CDC Library, Atlanta, GA.
Intended for use by public health professionals responding to the COVID-19 pandemic.

***** Available on-line at https://www.cdc.gov/library/covid19 *****

Vaccine Development

PEER-REVIEWED

US adults' preferences for public allocation of a vaccine for coronavirus disease 2019. Gollust *et al.* JAMA Network Open (September 29, 2020).

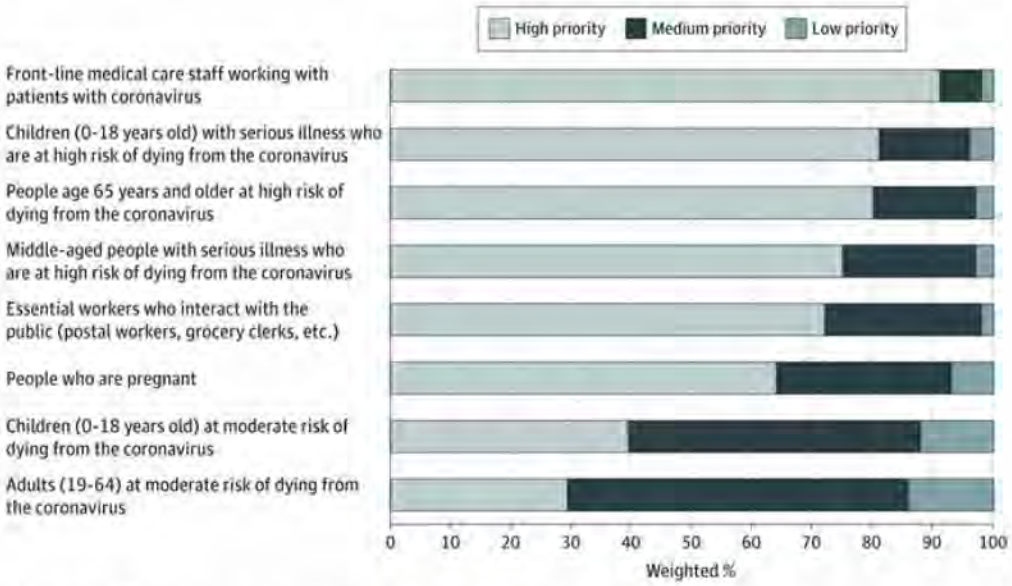
Key findings:

- Respondents rated front-line medical workers as highest priority (91.6%) followed by persons with highest risk of dying (72.2%–81.0%) (Figure).
- Persons at moderate risk of dying were more likely to receive a medium priority ranking (Figure).

Methods: Telephone- and internet-based survey of 1,007 persons representative of US households from April 23 to 27, 2020, to assess preferences about SARS-CoV-2 vaccine allocation. Respondents assigned high, medium, and low priorities to 8 groups of potential vaccine recipients. *Limitations:* No limitations on the number of high-priority selections; 17.7% of respondents selected all 8 groups as high priority; 14.4% response rate; no non-response bias analysis conducted.

Implications: This survey highlights the public's recognition of the risk to frontline medical workers and high-risk individuals in the COVID-19 pandemic and the need to prioritize these individuals for vaccines.

Figure:



Note: From Gollust *et al.* Prioritization for SARS-C0V-2 vaccine allocation. Licensed under CC-BY.

Hydroxychloroquine

Evidence is insufficient to support treatment of COVID-19 with hydroxychloroquine (HCQ) and guidance from NIH recommends *against* its use. Here we present four papers evaluating HCQ for treatment of COVID-19, as pre-exposure prophylaxis, and on fetal outcomes when used during pregnancy.

PEER-REVIEWED

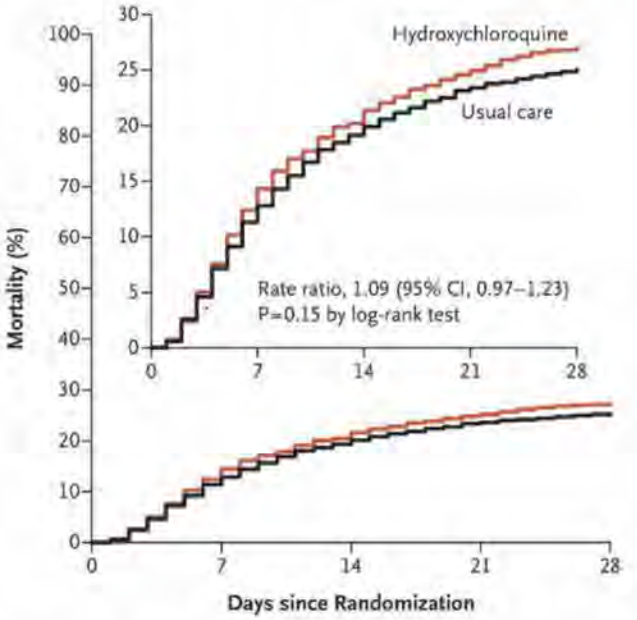
Effect of Hydroxychloroquine in Hospitalized Patients with COVID-19. The RECOVERY Collaborative Group. NEJM (October 8, 2020).

Key findings:

- Death within 28 days occurred in 421 patients (27.0%) in the hydroxychloroquine (HCQ) group and in 790 patients (25.0%) in the usual-care group, rate ratio 1.09, p = 0.15 (95% CI 0.97-1.23) (Figure).
    - Among patients not undergoing mechanical ventilation at enrollment, those in the HCQ group had a higher frequency of invasive mechanical ventilation or death (30.7% vs 26.9%); risk ratio 1.14 (95% CI 1.03-1.27).
- An interim analysis determined lack of efficacy of HCQ, and enrollment closed early.

Methods: The RECOVERY trial is a randomized, controlled, open-label platform trial comparing a range of possible treatments with usual care in patients hospitalized with COVID-19 at 176 hospitals in the UK. In this phase of the study, 1,561 COVID-19 patients were randomly assigned to receive HCQ and 3,155 received usual care. The primary outcome was 28-day mortality.

Figure:



Note: From RECOVERY Collaborative Group. Mortality at 28 days. Inset is scaled on the y-axis to show slight differences in mortality later in the trial. From NEJM, The RECOVERY Collaborative Group. Effect of Hydroxychloroquine in Hospitalized Patient with COVID-19, DOI: 10.1056/NEJMoa2022926, October 8, 2020. Copyright © 2020 Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

Hydroxychloroquine early in pregnancy and risk of birth defects. Huybrechts *et al.* American Journal of Obstetrics and Gynecology (September 19, 2020).

Key findings:

- 54.8 per 1,000 infants exposed to hydroxychloroquine (HCQ) in the first trimester were born with a major congenital malformation compared with 35.3 per 1,000 unexposed infants, pooled unadjusted relative risk (RR) 1.51 (95% CI 1.27-1.81).
- The adjusted RR (aRR) for congenital malformation in infants exposed to HCQ compared to unexposed infants was 1.26 (95% CI 1.04-1.54).
    - aRR was 1.33 (95% CI 1.08-1.65) for a daily HCQ dose ≥400mg and aRR 0.95 (95% CI 0.60-1.50) for daily HCQ dose of <400mg.
- Increased risk for oral cleft, RR 3.70 (95% CI 1.55-8.82) and urinary malformations, RR 2.21 (95% CI 1.26–3.86) in infants exposed to HCQ compared to unexposed infants.

Methods: Analysis of pregnancy cohorts from two large US national health insurance databases composed of 2,045 live-born births exposed to HCQ in the first trimester and 3,198,589 unexposed live-born births from 2000-2015. Exposure was based on filled HCQ prescription during first trimester of pregnancy. The analysis was controlled for many potential confounders including concurrent medical conditions and medications. *Limitations*: Included only women with live births; congenital diagnoses and HCQ exposure based on claim reports; did not include uninsured or self-insured women; race/ethnicity not provided.

Long-term hydroxychloroquine use in patients with rheumatic conditions and development of SARS-CoV-2 infection: A retrospective cohort study. Gentry *et al.* Lancet Rheumatology (September 21, 2020).

Key findings:

- The incidence of SARS-CoV-2 did not differ between patients receiving (31/10,703, [0.3%]) and not receiving (78/21,406, [0.4%]) hydroxychloroquine (HCQ), OR 0.79, p = 0.27 (95% CI 0.52-1.20).
- There were no differences in hospitalization, ICU admission or mortality between the two groups in patients who developed SARS-CoV-2 (Table).

Methods: A large, propensity score matched, retrospective cohort study across US Veteran Affairs Medical Centers of rheumatology patients receiving and not receiving HCQ from March to June 2020. The primary endpoint was the incidence of active SARS-CoV-2 infection. Secondary endpoints included hospital admission, ICU admission and mortality associated with SARS-CoV-2. *Limitations*: Women comprised only 24% of study participants; only the HCQ group was selected based on medication adherence; unmeasured between-group differences could have introduced bias which could have affected mortality outcomes.

Table:

	Patients receiving hydroxychloroquine (n=10703)	Patients not receiving hydroxychloroquine (n=21406)	Odds ratio (95% CI)	p value
Primary outcome				
Developed active SARS-CoV-2 infection	31 (0·3%)	78 (0·4%)	0·79 (0·52–1·20)	0·27
Secondary outcomes				
Hospital admission associated with SARS-CoV-2 infection	9/31 (29·0%)	19/78 (24·4%)	1·27 (0·50–3·23)	0·62
Intensive care requirement associated with SARS-CoV-2 infection	2/9 (22·2%)	4/19 (21·1%)	1·07 (0·16–7·31)	0·99
Mortality associated with SARS-CoV-2 infection	0	7/78 (9·0%)	–	0·19
Overall hospital admission	343 (3·2%)	733 (3·4%)	0·93 (0·82–1·06)	0·30
Overall mortality	88 (0·8%)	251 (1·2%)	0·70 (0·55–0·89)	0·0031

Data are n (%) or n/N (%) unless otherwise stated. SARS-CoV-2=severe acute respiratory syndrome coronavirus 2.

Note: From Gentry *et al*. SARS-CoV-2 and COVID-19-related outcomes in patients receiving or not receiving hydroxychloroquine for rheumatic conditions. This article was published in Lancet Rheumatology, Gentry *et al.*, Long-term hydroxychloroquine use in patients with rheumatic conditions and development of SARS-CoV-2 infection: A retrospective cohort study., DOI: https://doi.org/10.1016/ S2665-9913(20)30305-2, September 21, 2020.

Efficacy and safety of hydroxychloroquine vs placebo for pre-exposure SARS-CoV-2 prophylaxis among health care workers. A randomized clinical trial. Abella *et al.* JAMA Internal Medicine (Sept 30, 2020).

Key findings:

- There was no significant difference in SARS-CoV-2 incidence between the hydroxychloroquine (HCQ) and placebo groups (6.3% vs 6.6%), p >0.99.
    - There were more adverse events in the HCQ arm vs placebo (45% vs 26%), p = 0.03.
    - 7.4% of individuals given HCQ had detectable IgG antibody against spike proteins compared with 3.7% given placebo, p = 0.40.
    - There was no significant difference in the median change in QT interval between the HCQ and placebo arms, p = 0.98.

Methods: Single-health system, double-blind, placebo-controlled randomized trial of health care workers (64 in HCQ arm, 61 in control arm), comparing HCQ 600 mg daily to placebo taken orally for 8 weeks to prevent SARS-CoV-2 infection between April 9, 2020 and July 14, 2020, Pennsylvania. The primary outcome was infection with SARS-CoV-2; secondary outcomes were adverse events, SARS CoV-2 antibody positivity, electrocardiogram changes and clinical outcomes. *Limitations*: The study did not meet the target sample size of 200 and was terminated early for futility.

Implications for 4 studies (RECOVERY Collaborative Group, Huybrechts *et al.*, Gentry *et al.*, & Abella *et al.*): HCQ is not effective for treatment of COVID-19 or prevention of SARS-CoV-2 infection. The potential for congenital malformation may not be an acceptable level of risk for healthy women of childbearing age, especially as data to support HCQ use for treatment or prevention of COVID-19 are lacking. These additional data support previous data suggesting no role for HQC in the management of COVID-19 or prevention of SARS-CoV-2 infection.

Modeling & Transmission

PEER-REVIEWED

Seasonal coronavirus protective immunity is short-lasting. Edridge *et al.* Nature Medicine (September 14, 2020).

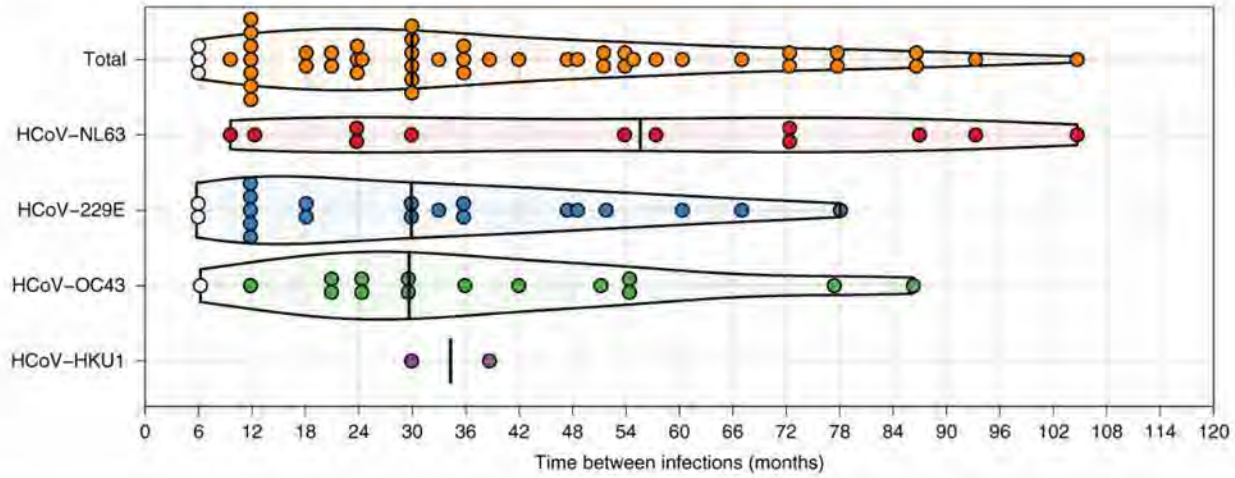
Key findings:

- Reinfections with seasonal coronaviruses (CoVs) frequently occurred at 12 months, and in a few cases as early as 6 months (Figure).

Methods: Testing for antibodies to seasonal CoV using stored serum from 10 healthy adult males who gave blood every 3 to 6 months for 12 to 35 years as part of the Amsterdam Cohort Studies on HIV-1 infection and AIDS. Increases in antibody levels to seasonal CoVs (HCoV-NL63, HCoV-229E, HCoV-OC43 and HCoV-HKU1) were used as a proxy for reinfection. *Limitations*: Ability to detect short-term reinfections was limited by the sampling interval; 1.4-fold increase in antibodies to CoV N antigen was used as a proxy for incident infection.

Implications: Natural reinfection occurred for 4 common seasonal endemic coronaviruses and may be a common feature of human coronaviruses including SARS-CoV-2. Calculations of herd-immunity and vaccine strategies may need to consider this and other studies when determining population-level protection and planning vaccination intervals.

Figure:



Note: Adapted from Edridge *et al*. Coronavirus reinfections for ten individuals. White dots represent reinfections without an intermediate decrease in antibody levels; black vertical lines represent median reinfection times. Reprinted by permission from Springer Nature Customer Service Centre GmbH: Springer Nature, Nature Medicine, Edridge *et al.*, Seasonal coronavirus protective immunity is short-lasting. DOI: https://doi.org/10.1038/s41591-020-1083-1, September 14, 2020, COPYRIGHT 2020.

Experimental infection of domestic dogs and cats with SARS-CoV-2: Pathogenesis, transmission, and response to reexposure in cats. Bosco-Lauth *et al.* Proceedings of the National Academy of Sciences (September 29, 2020).

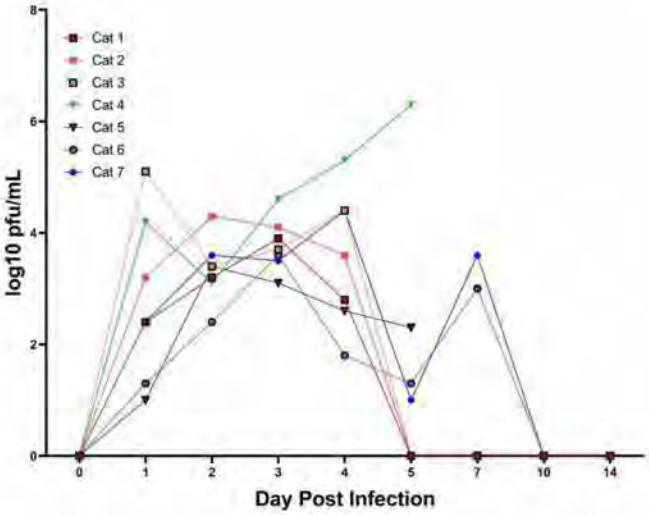
Key findings:

- Cats are highly susceptible to infection with SARS-CoV-2 and have oral and nasal viral shedding when experimentally or naturally infected (Figure).
    - Infected cats did not display overt clinical signs and were able to infect other cats.
    - Infected cats had mild pathologic changes of lungs, trachea, and nasal passages at different time points following inoculation.
- Cats rechallenged with virus after initial infection had a boosted immune response with high antibody titers but did not shed virus.
- Dogs mounted antibody responses but did not shed virus.

Methods: Animal infection and transmission study of seven cats and three dogs inoculated with SARS-CoV-2. Three cats were inoculated with SARS-CoV-2 and rechallenged on Day 28. Two cats were inoculated with SARS-CoV-2 and introduced to two uninfected cats 48 hours later. Viral shedding and antibody responses were assessed in all animals at multiple time points. *Limitations*: Animals were all from pathogen-free colonies and were in good health at time of infection; limited experimental study, replication with larger study size may be needed.

Implications: The high-titer viral shedding of cats along with the rapid transmission among cats may make them a good model for studies of kinetics of shedding and spread of SARS-CoV-2. Resistance to reinfection in cats may inform vaccine studies and strategies.

Figure:



Note: Adapted from Bosco-Lauth *et al*. Shedding of SARS-CoV-2 detected by plaque assay from nasal secretions of cats. Viral titers expressed as log_{10} plaque-forming units (pfu)/mL. Used by permission of the National Academy of Sciences.

Clinical Treatment & Management

PEER-REVIEWED

Clinical outcomes of in-hospital cardiac arrest in COVID-19. Thapa *et al.* JAMA Internal Medicine (September 28, 2020).

Key findings:

- Of 54 COVID-19 patients with in-hospital cardiac arrest (IHCA), none survived to discharge (95% CI 0-6.6).
  - Pre-COVID-19 survival to discharge for IHCA was 25%.
  - 42% had hypertension and 55.6% had diabetes.

Methods: A single institution, retrospective cohort study of hospitalized COVID-19 patients who underwent cardiopulmonary resuscitation (CPR) for IHCA, from March to April 2020. Primary outcomes were time to return of spontaneous circulation, overall survival and discharge. *Limitations*: Patient population had a high rate of comorbidities and although these constitute the vast majority of COVID-19 patients likely to suffer IHCA, may limit generalizability; observational data may be subject to unmeasured confounders.

Implications: CPR in hospitalized COVID-19 patients likely yields poor outcomes in patients with high rates of comorbidities.

Clinical sequalae of COVID-19 survivors in Wuhan, China: A single-centre longitudinal study. Xiong *et al.* Clinical Microbiology and Infection (September 23, 2020).

Key findings:

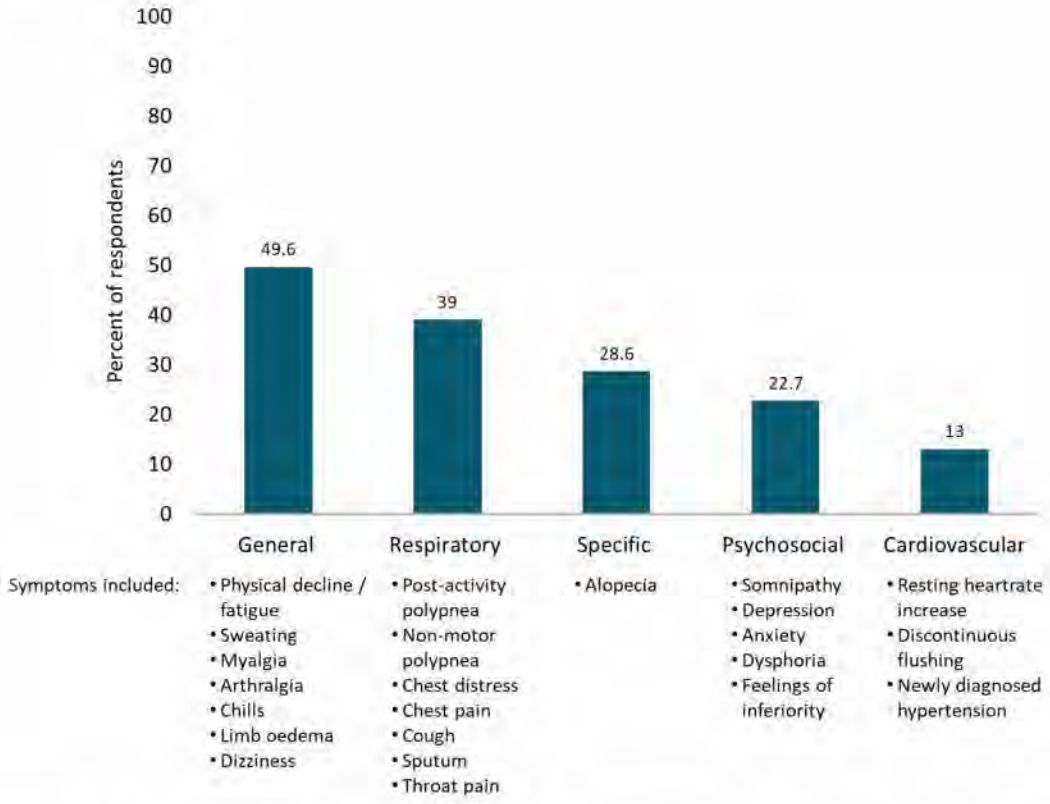
- Almost half (49.6%) of COVID-19 survivors reported general symptoms compared with 12.0% of control group members, p <0.01 (Figure).

- Additional reported clinical sequelae included respiratory symptoms (39%), alopecia (28.6%), psychosocial symptoms (22.7%) and cardiovascular symptoms (13%).
- Three symptoms were more common in women than in men: physical decline/fatigue (34.1% vs. 21.2%) p <0.01, rapid breathing after activity (24.6% vs 17.6%) p <0.05, and alopecia (48.5% vs 4.9%) p <0.01).

Methods: Phone survey of 538 individuals with COVID-19 discharged from Renmin Hospital, Wuhan at least three months prior to the survey. Incidence of symptoms from five categories—general, respiratory, cardiovascular, psychosocial, and specific— were compared with those from 184 controls. *Limitations*: Self-reported data from a single hospital; control group had not been recently hospitalized; not all responded to psychosocial questions.

Implications: Given the prevalence of symptoms among convalescent COVID-19 patients, targeted investigation into the etiology, time course, and treatment of clinical sequelae is warranted. This is especially true for unique sequelae such as sleep disorders and alopecia, a symptom that disproportionately affected women in this study.

Figure:



Note: Adapted from Xiong *et al*. Percent of COVID-19 patients reporting one or more symptom in each respective symptom category ≥3 months after hospital discharge. Polypnea = rapid breathing. Reprinted from Clinical Microbiology and Infection, Xiong *et al*., Clinical sequalae of COVID-19 survivors in Wuhan, China: A single-centre longitudinal study, DOI: https://doi.org/10.1016/j.cmi.2020.09.023, September 23, 2020. Copyright 2020, with permission from the European Society of Clinical Microbiology and Infectious Diseases.

Laboratory Science

PEER-REVIEWED

COVID-19 vaccine BNT162b1 elicits human antibody and T_H1 T-cell responses. Sahin *et al.* Nature (September 30, 2020).

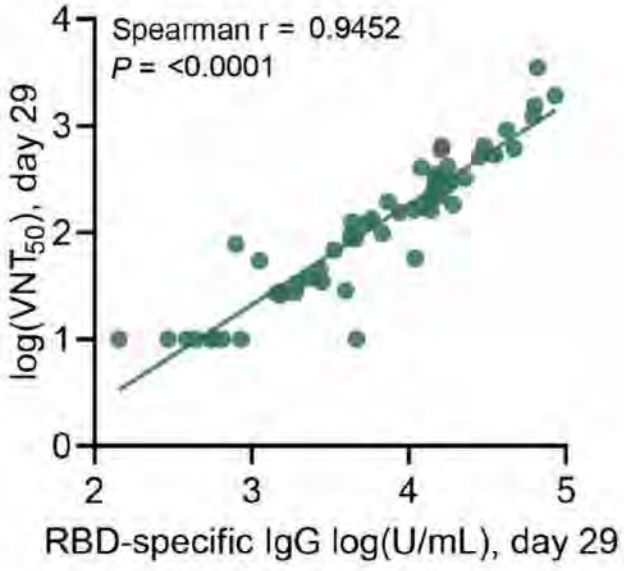
Key findings:

- Highest levels of neutralizing antibody were seen 29 days after initial dose (virus neutralization titers [VNT_{50}] 36–578) and were dose-dependent.
    - A booster at day 22 after the initial dose was necessary to see a robust immune response.
- Levels of IgG binding to the receptor binding domain (RBD) and neutralizing antibodies were highly correlated, r = 0.9452, p <0.0001 (Figure 1).
- BNT162b1 had robust neutralizing titers against the common RBD variants, including D614G (the dominant spike variant).
- A positive correlation between the frequency of RBD-specific $CD8^+$ T cells and $CD4^+$ T cells was seen (Figure 2).

Methods: Phase 1/2 clinical trial with 60 participants assigned to five 12-person groups and administered the BNT162b1 mRNA experimental vaccine at varying dose levels between April 23 and May 22, 2020. Groups were given the first dose on day one and boosted on day 22, except for one group that was administered only one dose. Antibody and T-cell immune responses were evaluated. *Limitations*: Small sample size and only included participants <55 years; short study did not allow testing persistence of immune response.

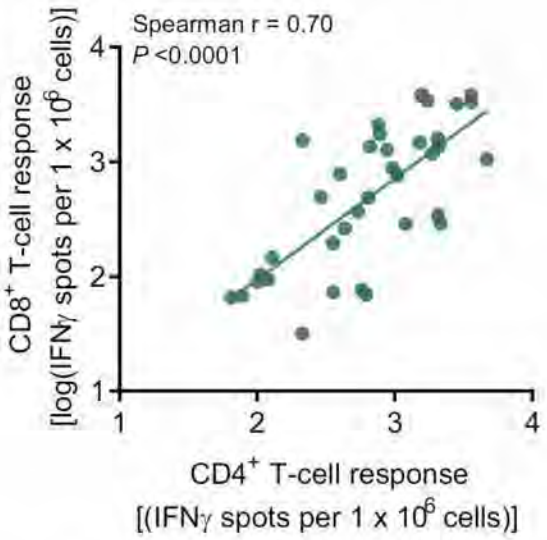
Implications: With a robust RBD-specific antibody and T-cell response, BNT162b1 mRNA vaccine is a promising SARS-CoV-2 vaccine candidate.

Figure 1



Note: From Sahin *et al.* Correlation of RBD-specific IgG titers versus VNT_{50} from day 29 sera of all immunized patients. Reprinted by permission from Springer Nature Customer Service Centre GmbH: Springer Nature, Nature, Sahin *et al.* COVID-19 vaccine BNT162b1 elicits human antibody and T_H1 T-cell responses. DOI: https://doi.org/10.1038/s41586-020-2814-7, September 30, 2020, COPYRIGHT 2020.

Figure 2



Note: From Sahin *et al*. Correlation of CD4+ with CD8+ T-cell responses from blood collected on day 29 in all immunized patients. Data shown as number of T cells secreting interferon-gamma (IFNγ) per 10^6 cells. Reprinted by permission from Springer Nature Customer Service Centre GmbH: Springer Nature, Nature, Sahin *et al.* COVID-19 vaccine BNT162b1 elicits human antibody and T_H1 T-cell responses. DOI: https://doi.org/10.1038/s41586-020-2814-7, September 30, 2020, COPYRIGHT 2020.

Epidemiological correlates of PCR cycle threshold values in detection of SARS-CoV-2. Salvatore *et al.* Clinical Infectious Diseases (September 28, 2020).

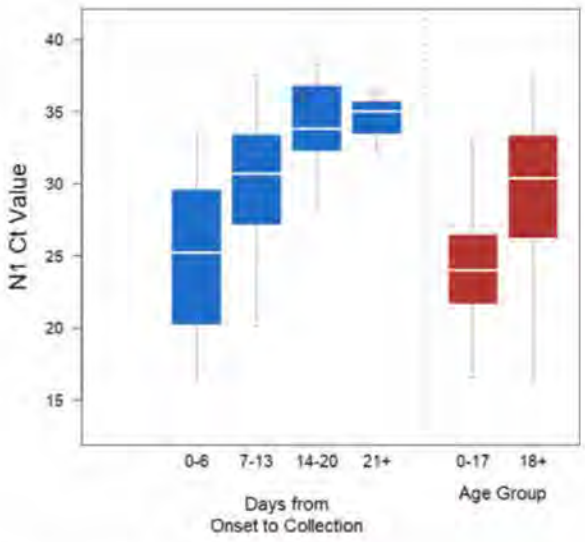
Key findings:

- Cycle threshold (Ct) values were positively correlated with time elapsed since symptom onset, p <0.001.
    - Ct values were lowest (indicating highest viral RNA concentration) among those who tested positive <7 days after symptom onset and highest among those who tested positive ≥21 days after onset (Figure 1).
- Ct values were lower among those ≤17 years old than among those ≥18 (Figure 1).
- Low Ct values were associated with a set of symptoms meeting the criteria of various respiratory syndromes (Figure 2) rather than individual symptoms, aside from runny nose.

Methods: Demographic and self-reported symptom data on 93 SARS-CoV-2-positive participants during a prospective household transmission investigation of mild COVID-19 cases between March 23 and May 13, 2020. Associations between demographic and clinical factors and RT-PCR Ct values were determined. *Limitations*: Study not powered to test relationship between Ct values and severe COVID-19 symptoms; small sample size.

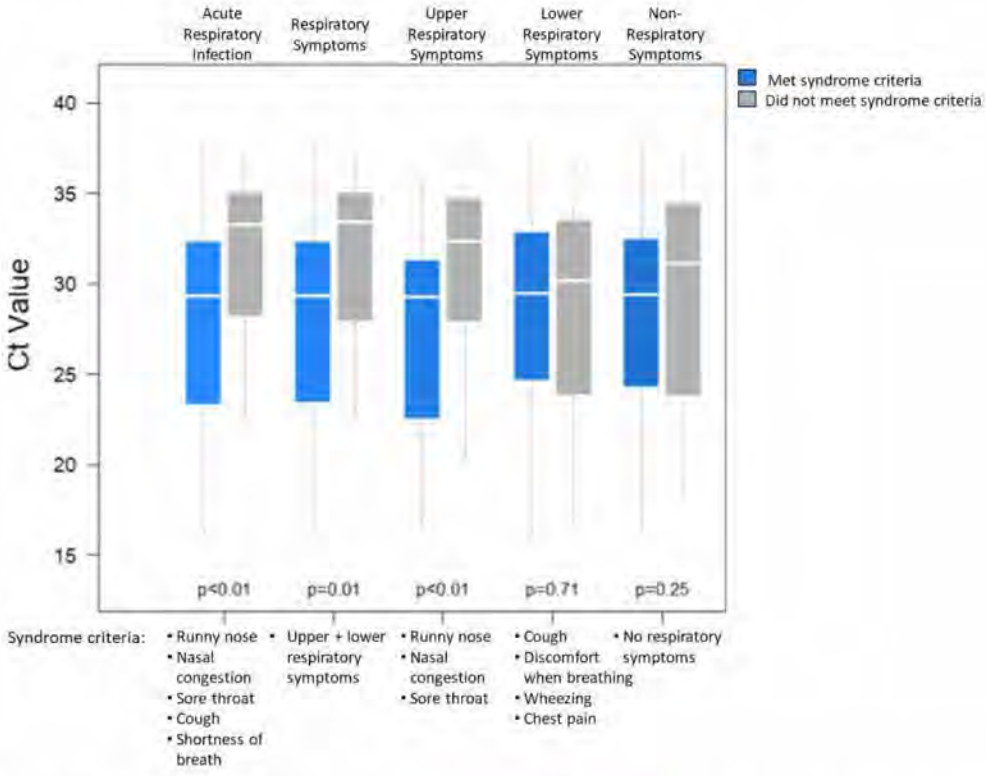
Implications: Testing for SARS-CoV-2 soon after symptom onset, particularly symptoms meeting respiratory syndrome definitions, will improve the chances of identifying and isolating individuals when they may be most infectious. Lower Ct values, reflecting higher viral loads, in symptomatic children suggests that children can contribute to SARS-CoV-2 transmission.

Figure 1



Note: Adapted from Salvatore *et al*. Ct values by days from **symptom onset** and **age group**. Medians are highlighted in white; boxes show the interquartile range and whiskers depict 95% CIs. US Government work not subject to copyright.

Figure 2

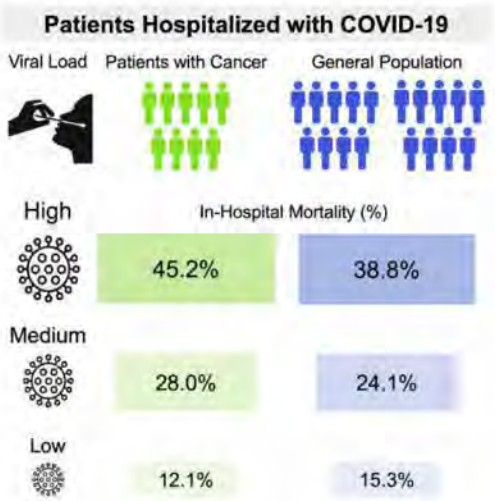


Note: Adapted from Salvatore *et al*. Ct values of patients **meeting syndrome criteria** or **not meeting syndrome criteria**. US Government work not subject to copyright.

In Brief

- Westblade *et al.* **SARS-CoV-2 viral load predicts mortality in patients with and without cancer who are hospitalized with COVID-19.** Cancer Cell. A retrospective analysis of over 3,000 individuals (100 with cancer) evaluating the relationship between viral load (represented by PCR cycle threshold [CT] value) and mortality.

Figure:



Note: From Westblade *et al.* In-hospital mortality of patients with COVID-19 with or without cancer. Reprinted from Cancer Cell, Westblade *et al.*, SARS-CoV-2 viral load predicts mortality in patients with and without cancer who are hospitalized with COVID-19., DOI: https://doi.org/10.1016/j.ccell.2020.09.007, September 15, 2020. Copyright 2020, with permission from Elsevier.

- Laxminarayan *et al.* **Epidemiology and transmission dynamics of COVID-19 in two Indian states**. Science. Identifies high prevalence of infection among children who were contacts of cases, suggesting that social interactions among children may be conducive to transmission of SARS-CoV-2.
- Rali *et al.* **Incidence of venous thromboembolism in coronavirus disease 2019: An experience from a single large academic center.** Journal of Vascular Surgery. Reports on the incidence rate of venous thromboembolism (VTE) in COVID-19 patients and notes a higher all-cause mortality for COVID-19 patients with VTE than in those without VTE.
- Webb *et al.* **Clinical criteria for COVID-19-associated hyperinflammatory syndrome: A cohort study.** Lancet Rheumatology. Proposes and validates criteria for hyperinflammatory syndrome in COVID-19 among adults (≥18 years old), which is commonly associated with progression to mechanical ventilation and death.
- Colaneri *et al.* **Severe acute respiratory syndrome coronavirus 2 RNA contamination of inanimate surfaces and virus viability in a health care emergency unit.** Clinical Microbiology and Infection. Environmental sampling of an emergency room unit showed little SARS-CoV-2 RNA on surfaces, suggesting environmental contamination might be less extensive than previously suggested.
- Zeberg *et al.* **The major genetic risk factor for severe COVID-19 is inherited from Neanderthals.** Nature. The only known genetic risk associated with severe COVID-19 is a region on chromosome 3; genetic analysis shows this risk haplotype came from Neanderthals and not from other hominins.
- Helfand *et al.* **The exclusion of older persons from vaccine and treatment trials for coronavirus disease 2019–Missing the target.** JAMA Internal Medicine. Exclusion of older age groups from clinical trials is common, which precludes the determination of an intervention's effectiveness, dosage or frequency, and adverse effects in the group most vulnerable to COVID-19.
- Mina *et al.* **Rethinking COVID-19 test sensitivity–A strategy for containment.** NEJM. Authors advocate that use of inexpensive point-of-care tests that can detect the infectious period, be used frequently and can have a larger public health impact than a sensitive lab-based test.

- Fan *et al.* **Effect of acid suppressants on the risk of COVID-19: A propensity score matched study using UK biobank acid suppressants and the risk of COVID-19.** Gastroenterology. No association of SARS-CoV-2 infection and mortality was seen in 1,516 users of acid suppressants compared to matched controls, and only patients with upper gastrointestinal diseases taking omeprazole were more susceptible to SARS-CoV-2 infection.
- Service, R. **One number could help reveal how infectious a COVID-19 patient is. Should test results include it?** Science. Ct values, which are proportional to viral loads, theoretically could be useful to guide patient care, but variations in Ct values due to assay design or instrument performance make standardization challenging.

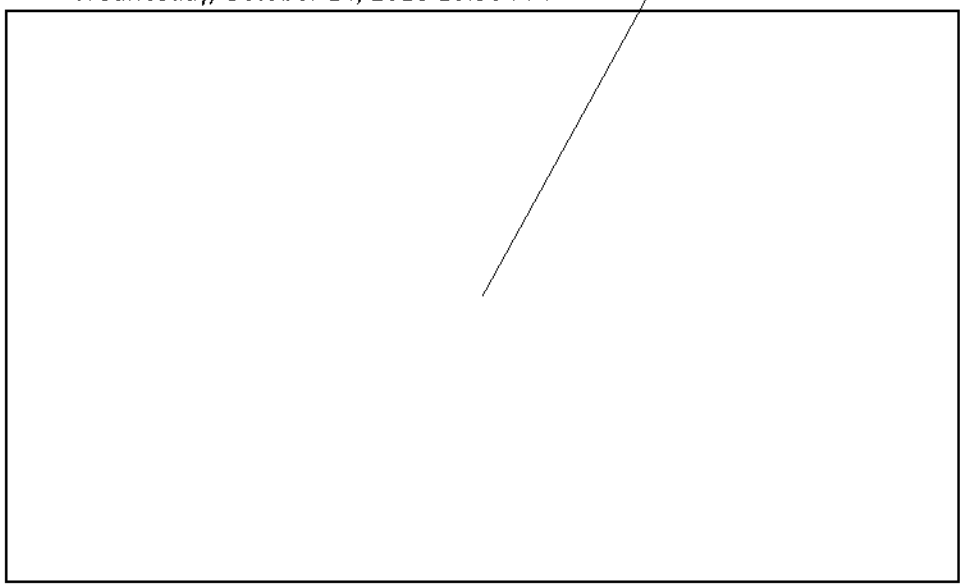
cdc.gov/coronavirus

From: (b)(3):50 USC 3024(i); (b)(6)

Sent: Wednesday, October 14, 2020 10:56 PM

To:

(b)(3):10 USC 424; (b)(6)



Cc:

Subject: CDC COVID-19 Update 14Oct2020 (For Internal USG only)

Attachments: (FOUO) CDC COVID-19 RESPONSE UPDATE 20201014.pdf

FOR OFFICIAL USE ONLY

Good Evening,

Please see attached CDC Report (actually attached this time)

Cases/deaths as of 14 Oct 2020:
- 7,835,007 confirmed and probable U.S. cases, +47,459 since yesterday
- 215,194 U.S. deaths reported to CDC, +758 since yesterday
- 38,002,699 confirmed cases worldwide (WHO dashboard data)

Highlights:
- **Case Counts and Deaths:** Month-long trend of increasing daily cases continues, but still 23% below 24-July peak. 7-day case average is up 17% from the previous 7-days; 7-day death average is up 2% from the previous 7-days. Case trajectory data: 38 (68%) states/jurisdictions in an upward/worsening trajectory; 4 (7%) in a plateau; and 14 (225%) in a downward/improving trajectory. Note: More than 2/3 of states/jurisdictions and counties are experiencing an upward case trajectory.
- **Travel Health Notices (THNs):** https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html; Cambodia de-escalated from Lv1 to No THN. No additional changes to individual country risk determinations. Significant updates are anticipated to CDC's Travel Health Notice website content in 2-3 weeks.

New/Updated Guidance:
- 10 Things Healthcare Professionals Need to Know about U.S. COVID-19 Vaccination Plans: https://www.cdc.gov/coronavirus/2019-ncov/hcp/vaccination.html
- Frequently Asked Questions about COVID-19 Vaccination: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html
- Interim Considerations for Testing for K-12 School Administrators and Public Health Officials: https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-testing.html#table1; Interesting considerations for possible testing strategies in school settings. Expect CDC recommendations regarding testing strategies to continue to evolve in the coming weeks/months.
- Laboratory Guidance for SARS-CoV-2 Point-of-Care Testing: https://www.cdc.gov/coronavirus/2019-ncov/lab/point-of-care-testing.html
- Halloween COVID Safety Guidance: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/holidays/halloween.html

MMWR Pubs:
- Three expected tomorrow or Friday.

Please regularly refer to CDC's COVID-19 webpage; information and guidance is updated daily: https://covid.cdc.gov/covid-data-tracker/

VR/

(b)(6)
Dept of Defense Liaison to the Centers for Disease Control and Prevention, Atlanta, GA
(b)(6)

(b)(3):50 USC 3024(i); (b)(6)

CDC COVID-19 Response Update Wednesday, 14 Oct, 2020
INTERNAL - NOT FOR FURTHER DISTRIBUTION

Table of Contents

Domestic Updates

Case Counts

The CDC numbers have been reviewed and approved by states and are suitable for use in all official communications.

Counts by Jurisdiction (Cumulative and New Cases and Deaths)[1]

Data Through 13 Oct 2020 *Last Updated: 14 Oct 2020 11:30*

57 Jurisdictions Reporting COVID-19 Cases[2]

50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands

Reporting Area[3]	Cases	New Cases[4]		Cases Per 100K			Deaths	New Deaths[4]		Deaths per 100K			CFR[5]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
AK	10,028	151	182.3	1359.8	20.5	24.7	60	-	0.3	8.1	-	0.0	0.6%
AL	167,193	1,117	959.4	3420.6	22.9	19.6	2,665	-	12.1	54.5	-	0.2	1.6%
AR	94,167	680	870.9	3124.5	22.6	28.9	1,611	25	20.3	53.5	0.8	0.7	1.7%
AZ	226,734	684	685.7	3161.5	9.5	9.6	5,767	8	7.7	80.4	0.1	0.1	2.5%
CA	852,406	2,378	3,420.7	2154.9	6.0	8.6	16,581	9	57.7	41.9	0.0	0.1	1.9%
CO	80,085	1,048	842.0	1406.1	18.4	14.8	2,153	37	10.3	37.8	0.6	0.2	2.7%
CT	61,697	320	350.9	1726.9	9.0	9.8	4,533	1	1.7	126.9	0.0	0.0	7.3%
DE[6]	22,394	0	132.6	2315.4	-	13.7	659	0	1.9	68.1	-	0.2	2.9%
FL	729,591	2,657	2,604.7	3425.4	12.5	12.2	15,531	119	109.1	72.9	0.6	0.5	2.1%
GA	333,304	993	1,236.3	3168.4	9.4	11.8	7,454	25	32.1	70.9	0.2	0.3	2.2%
HI	13,736	61	87.4	967.0	4.3	6.2	173	4	1.9	12.2	0.3	0.1	1.3%
IA	100,895	701	1,047.4	3196.8	22.2	33.2	1,486	14	12.3	47.1	0.4	0.4	1.5%
ID	49,247	584	595.0	2807.4	33.3	33.9	512	2	2.9	29.2	0.1	0.2	1.0%
IL	327,781	2,851	2,861.6	2572.6	22.4	22.5	9,272	29	26.7	72.8	0.2	0.2	2.8%
IN	138,104	1,549	1,594.0	2063.8	23.1	23.8	3,822	27	15.9	57.1	0.4	0.2	2.8%
KS[7]	67,862	-	736.3	2330.8	-	25.3	771	-	9.3	26.5	-	0.3	1.1%
KY	81,691	761	1,071.0	1828.2	17.0	24.0	1,269	14	7.3	28.4	0.3	0.2	1.6%
LA	175,329	682	694.3	3762.4	14.6	14.9	5,679	10	12.4	121.9	0.2	0.3	3.2%
MA	147,461	632	600.9	2136.5	9.2	8.7	9,621	12	12.9	139.4	0.2	0.2	6.5%
MD	132,918	575	610.6	2199.6	9.5	10.1	4,022	10	7.0	66.6	0.2	0.1	3.0%
ME	5,816	36	30.3	434.5	2.7	2.3	143	-	0.1	10.7	-	0.0	2.5%
MI	152,862	1,466	1,283.4	1529.2	14.7	12.8	7,255	30	13.4	72.6	0.3	0.1	4.7%
MN[7]	114,874	-	1,304.9	2047.2	-	23.3	2,204	-	9.1	39.3	-	0.2	1.9%
MO[7]	144,230	-	1,378.1	2354.2	-	22.5	2,422	-	31.7	39.5	-	0.5	1.7%
MS	106,817	876	734.1	3576.6	29.3	24.6	3,140	25	16.1	105.1	0.8	0.5	2.9%
MT	19,967	842	606.3	1879.6	79.3	57.1	228	16	5.1	21.5	1.5	0.5	1.1%
NC	234,481	1,734	1,889.0	2258.2	16.7	18.2	3,816	43	20.9	36.8	0.4	0.2	1.6%
ND	28,947	702	584.3	3808.4	92.4	76.9	365	8	8.7	48.0	1.1	1.1	1.3%
NE	53,543	704	683.7	2775.3	36.5	35.4	527	5	2.9	27.3	0.3	0.1	1.0%
NH	9,279	71	78.3	684.1	5.2	5.8	456	-	1.4	33.6	-	0.1	4.9%
NJ	215,085	988	820.4	2414.4	11.1	9.2	16,182	7	5.0	181.6	0.1	0.1	7.5%
NM	33,713	351	395.1	1608.9	16.8	18.9	918	3	3.4	43.8	0.1	0.2	2.7%
NV	86,926	487	560.1	2864.7	16.0	18.5	1,722	11	7.6	56.7	0.4	0.2	2.0%
NY City	252,613	544	532.6	3007.7	6.5	6.3	23,905	10	4.6	284.6	0.1	0.1	9.5%
NY State[8]	225,406	848	850.0	2022.8	7.6	7.6	9,117	4	5.7	81.8	0.0	0.1	4.0%
OH	171,626	1,447	1,475.3	1468.2	12.4	12.6	5,017	12	10.0	42.9	0.1	0.1	2.9%
OK	106,649	165	1,005.0	2704.7	4.2	25.5	1,124	14	7.4	28.5	0.4	0.2	1.1%
OR	37,780	313	348.6	901.5	7.5	8.3	605	6	3.4	14.4	0.1	0.1	1.6%
PA	174,646	1,342	1,343.3	1363.7	10.5	10.5	8,384	16	20.0	65.5	0.1	0.2	4.8%
RI	26,960	666	194.9	2549.9	63.0	18.4	1,139	9	2.0	107.7	0.9	0.2	4.2%
SC	158,883	828	844.7	3125.1	16.3	16.6	3,576	17	15.0	70.3	0.3	0.3	2.3%
SD	29,339	414	637.6	3325.5	46.9	72.3	293	5	6.4	33.2	0.6	0.7	1.0%

[1] Aggregated cases and deaths are reported voluntarily by each jurisdiction. Jurisdictions may update data reported on web pages which differ from information in the table above. If the number of cases or deaths on a jurisdictional webpage differ from what is reported above, the webpage should be considered the most up to date. See Technical Information about this data on the CDC Webpage.

[2] Darker shading in columns correspond to higher values.

[3] AS = American Samoa; DC = District of Columbia; FSM = Federated States of Micronesia; GU = Guam; CNMI = Commonwealth of the Northern Mariana Islands; PW = Palau; PR = Puerto Rico; RMI = Republic of the Marshall Islands; USVI = US Virgin Islands.

[4] These data represent new cases and deaths detected and tested in the US since the last update. Number of new cases and new deaths were included in total case numbers. Counts may have decreased from previous report due to case reclassification of cases to other jurisdictions or categories (e.g., probable to confirmed) by states.

[5] Percent change in cases, deaths and case fatality rates (CFR) are not calculated when the total number (denominator) was less than five.

[6] Jurisdiction reported zero new cases and zero new deaths.

[7] Jurisdiction did not provide an update.

[8] New York State excludes New York City.

57 Jurisdictions Reporting COVID-19 Cases[2]													
50 states + DC, NYC, Guam, Navajo Nation, Northern Mariana Islands, Puerto Rico, and US Virgin Islands													
Reporting Area[3]	Cases	New Cases[4]		Cases Per 100K			Deaths	New Deaths[4]		Deaths per 100K			CFR[5]
	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	Total	Today	7-Day Avg.	Overall	Today	7-Day Avg.	
TN	218,829	1,147	1,922.0	3232.3	16.9	28.4	2,797	23	25.1	41.3	0.3	0.4	1.3%
TX	800,415	5,289	3,854.3	2788.7	18.4	13.4	16,622	64	73.0	57.9	0.2	0.3	2.1%
UT	87,819	987	1,197.1	2778.1	31.2	37.9	522	-	4.9	16.5	-	0.2	0.6%
VA	161,610	805	1,131.3	1897.3	9.5	13.3	3,381	9	11.1	39.7	0.1	0.1	2.1%
VT	1,886	10	9.3	301.1	1.6	1.5	58	-	-	9.3	-	-	3.1%
WA	94,775	913	587.4	1257.7	12.1	7.8	2,211	21	6.6	29.3	0.3	0.1	2.3%
WI	163,759	3,428	2,861.3	2816.8	59.0	49.2	1,518	34	15.4	26.1	0.6	0.3	0.9%
WV	18,555	274	231.3	1027.5	15.2	12.8	387	2	3.3	21.4	0.1	0.2	2.1%
WY	7,964	162	170.6	1378.5	28.0	29.5	57	3	0.6	9.9	0.5	0.1	0.7%
AS	-	-	-	-	-	-	-	-	-	-	-	-	-
CNMI[6]	77	0	-	135.4	-	-	2	0	-	3.5	-	-	-
DC	16,068	46	59.4	2287.4	6.5	8.5	637	-	0.9	90.7	-	0.1	4.0%
FSM	-	-	-	-	-	-	-	-	-	-	-	-	-
GU	3,341	171	67.6	2015.5	103.2	40.8	61	1	0.9	36.8	0.6	0.5	1.8%
PR	55,516	976	535.4	1737.5	30.5	16.8	742	4	5.3	23.2	0.1	0.2	1.3%
PW	-	-	-	-	-	-	-	-	-	-	-	-	-
RMI	-	-	-	-	-	-	-	-	-	-	-	-	-
USVI	1,328	3	-	1268.6	2.9	-	20	-	-	19.1	-	-	1.5%
Total	**7,835,007**	**47,459**	**51,392.1**	**2367.6**	**14.3**	**15.5**	**215,194**	**748**	**708.9**	**65.0**	**0.2**	**0.2**	**2.7%**
Navajo[9]	10,737	9	33.7	3008.5	2.5	9.4	571	-	1.6	160.0	-	0.4	5.3%

Compilations of US Case Counts

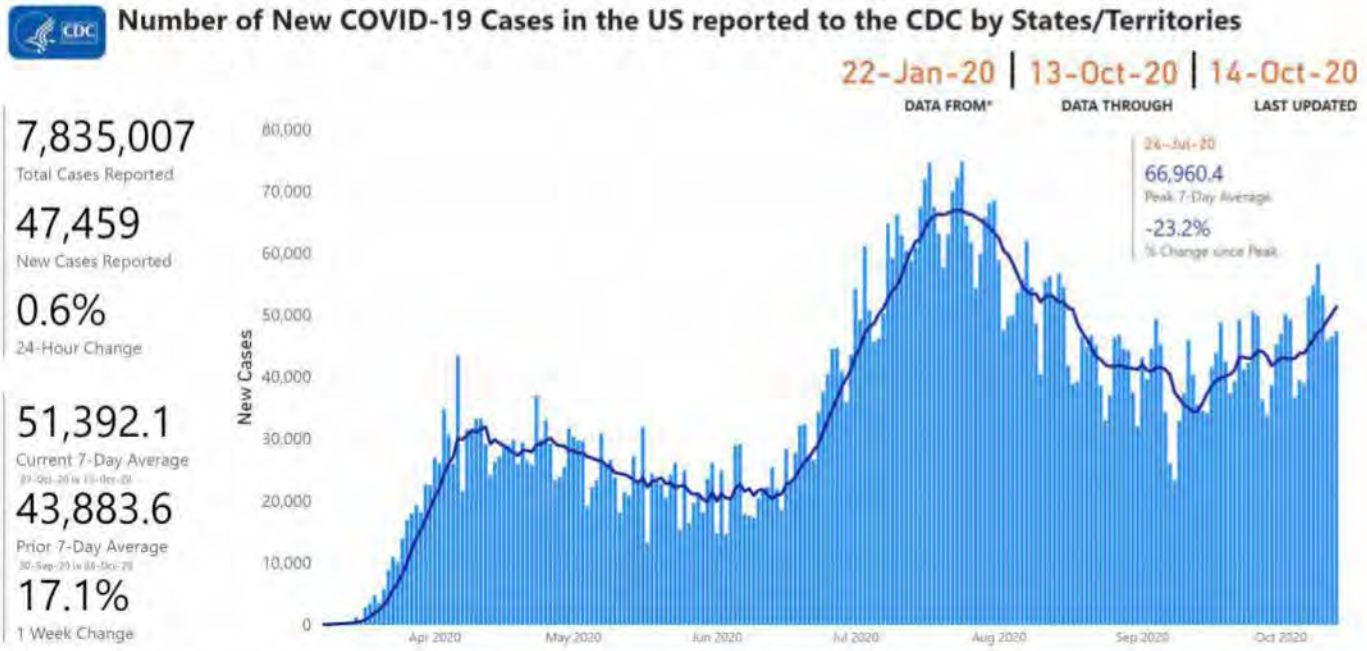
Reporting Source[10]	Data as of (all times are ET)	Cases	New Cases	Deaths	New Deaths
Official Sources (see table above)	14 Oct, 11:30	7,835,007	47,459	215,194	748
1Point3Acres	14 Oct, 10:00	8,021,010	55,195	220,163	842
Johns Hopkins	14 Oct, 10:24	7,860,452	54,266	215,971	870
USAFacts	13 Oct, NA	7,738,657	43,261	213,084	276
New York Times	14 Oct, 08:20	7,894,994	54,512	215,781	826
WorldoMeter	14 Oct, 10:47	8,100,550	56,493	221,038	864
COVID Tracking Project	13 Oct, 16:00	7,817,857	47,184	207,557	676

[9] Cases in the Navajo Nation are likely also reported by AZ, NM, and UT and were therefore already included in the grand total above. Counts reported separately here from Navajo Department of Health COVID-19 and Navajo Epidemiology Center Coronavirus Response Hub

[10] Data from other organizations are not reviewed or validated by CDC and may include data derived from open media sources not represented on official state public health department web pages.

Number of New COVID-19 Cases in the US Reported to the CDC by States/Territories

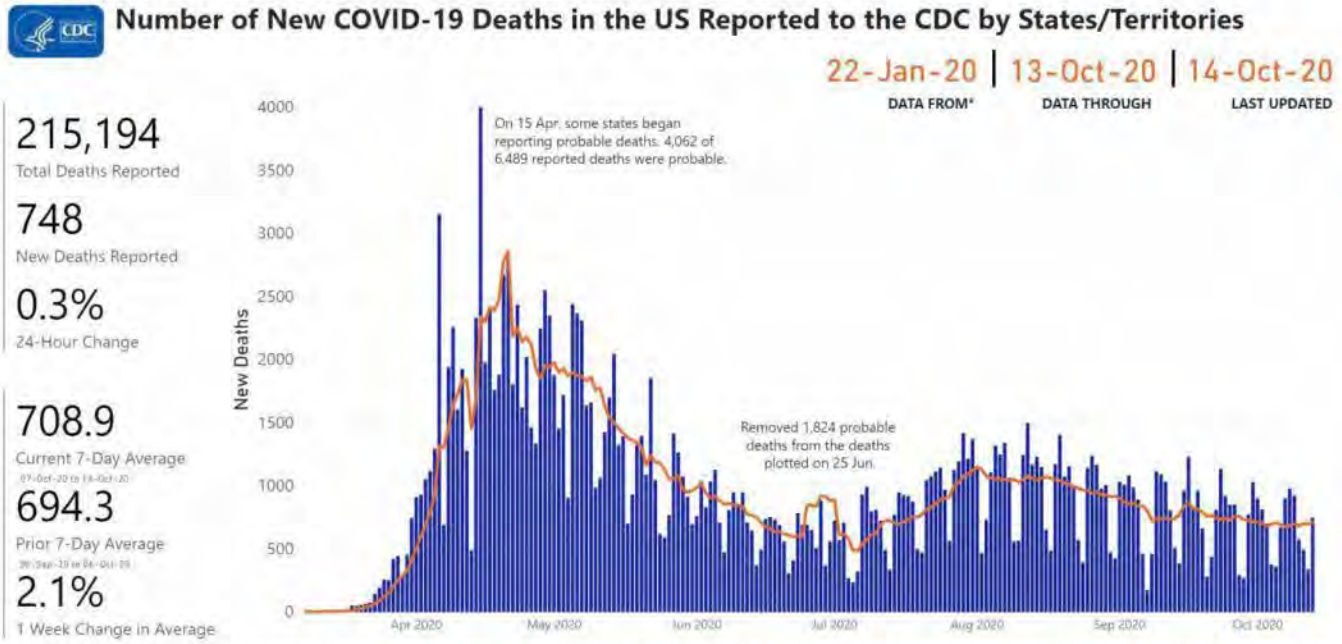
Data: 22 Jan 2020 – 13 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER[11])



Data Sources, References & Notes: Total cases are based on aggregate counts of COVID-19 cases reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 22 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Numbers include confirmed and probable COVID-19 cases as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as cases/100,000 people. The 7-day moving average of new cases (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall case numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC, may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER; US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

Number of New COVID-19 Deaths in the US Reported to the CDC by States/Territories

Data: 22 Jan 2020 – 13 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)

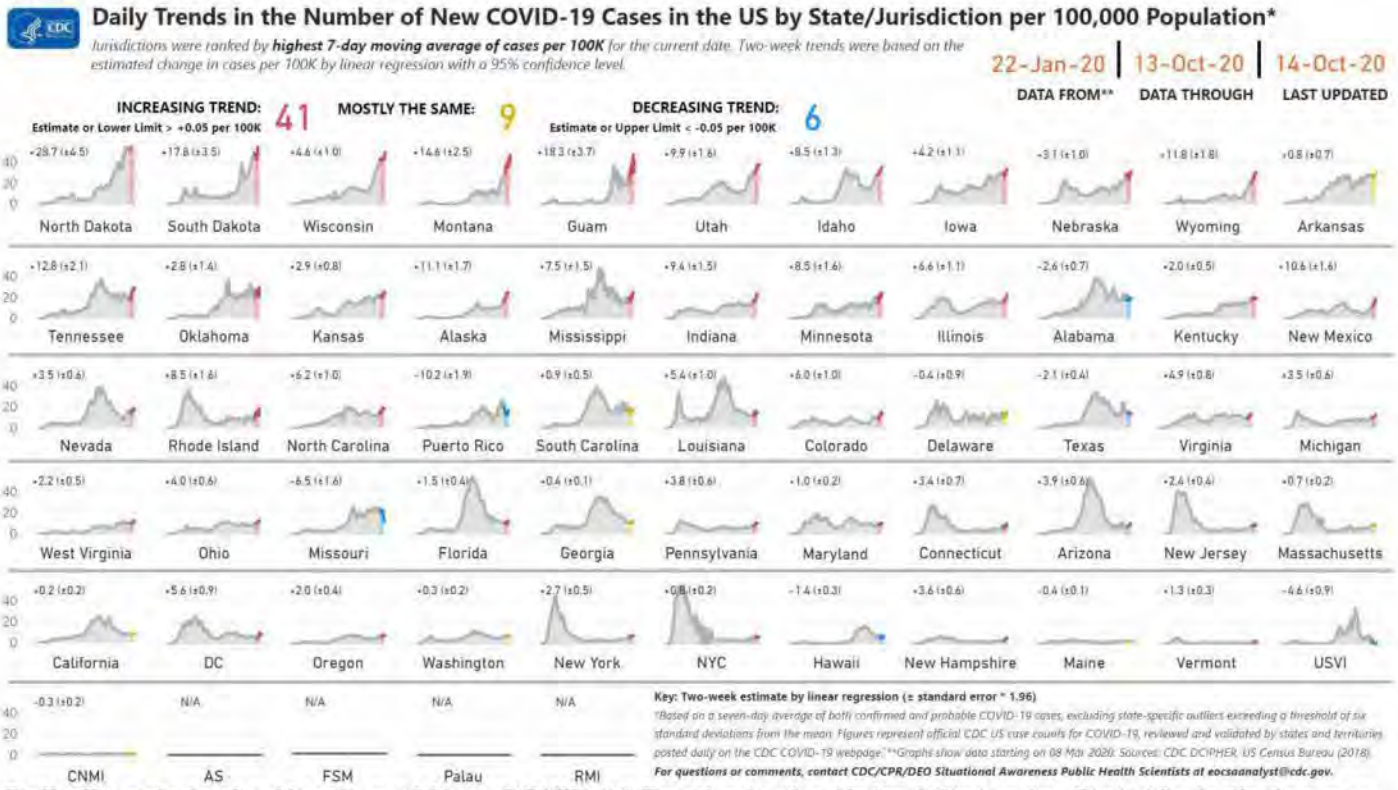


Data Sources, References & Notes: Total deaths are based on aggregate counts of COVID-19 deaths reported by state and territorial jurisdictions to the Centers for Disease Control and Prevention (CDC) since 21 Jan 2020, with the exception of persons repatriated to the United States from Wuhan, China, and Japan. Number include confirmed and probable COVID-19 deaths as reported by U.S. states, U.S. territories, New York City, and the District of Columbia from the previous day. Rates are calculated using U.S. Census Bureau, 2018 (Dec 2018) estimates and are shown as deaths/100,000 people. The 7-day moving average of new deaths (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts. CDC's overall death numbers are validated through a confirmation process with each jurisdiction. Differences between reporting jurisdictions and CDC may occur due to the timing of reporting and website updates.
Graph shows data starting on 08 Mar 2020. Sources: CDC DCIPHER; US Census Bureau (2018).* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.*

[11] Data Collation and Integration for Public Health Event Response.

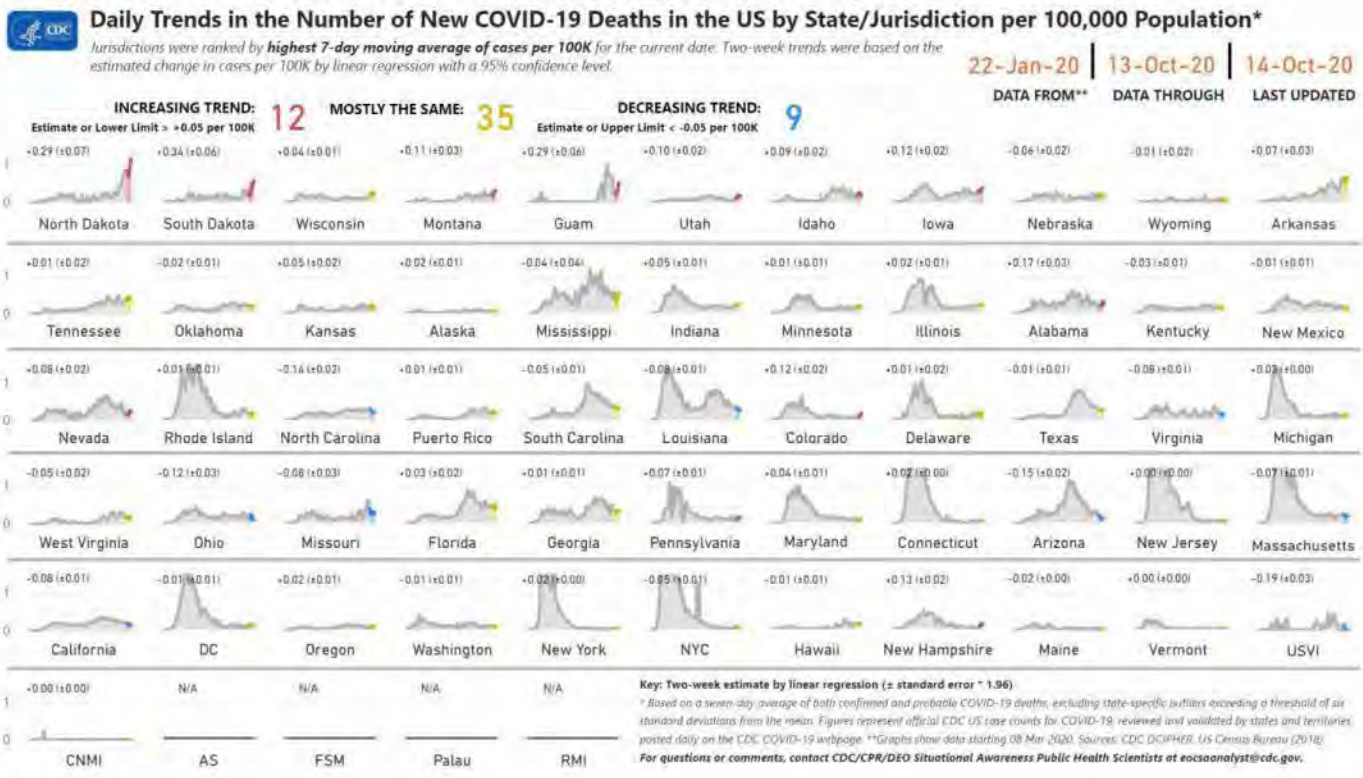
Daily Trends in the Number of New COVID-19 Cases in the United States by State/Jurisdiction per 100,000 Population

Data: 22 Jan 2020 – 13 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)



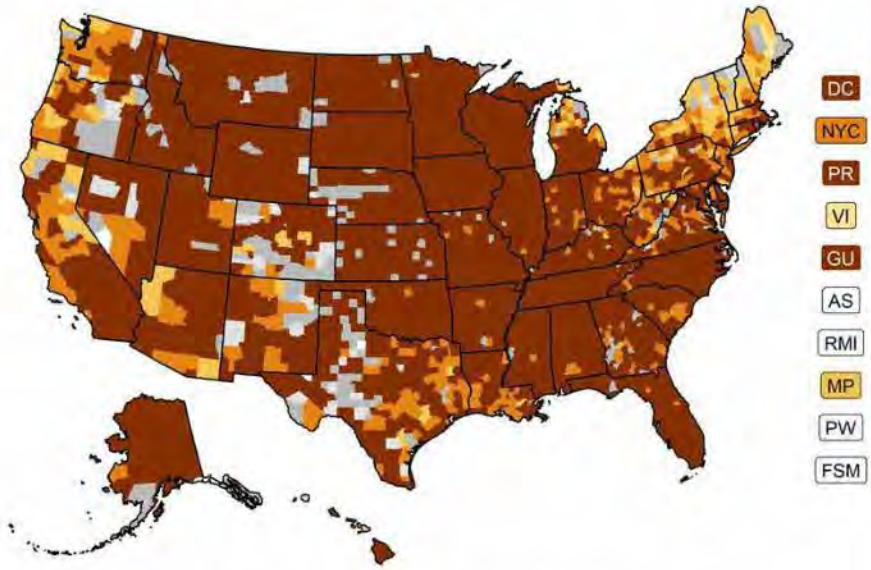
Daily Trends in the Number of New COVID-19 Deaths in the United States by State/Jurisdiction per 100,000 Population

Data: 22 Jan 2020 – 13 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)



Cases by County[12]

Coronavirus Disease 2019 (COVID-19)
Number of New Cases per 100,000 in the past 2 weeks, by U.S. County, 29 September–12 October, 2020



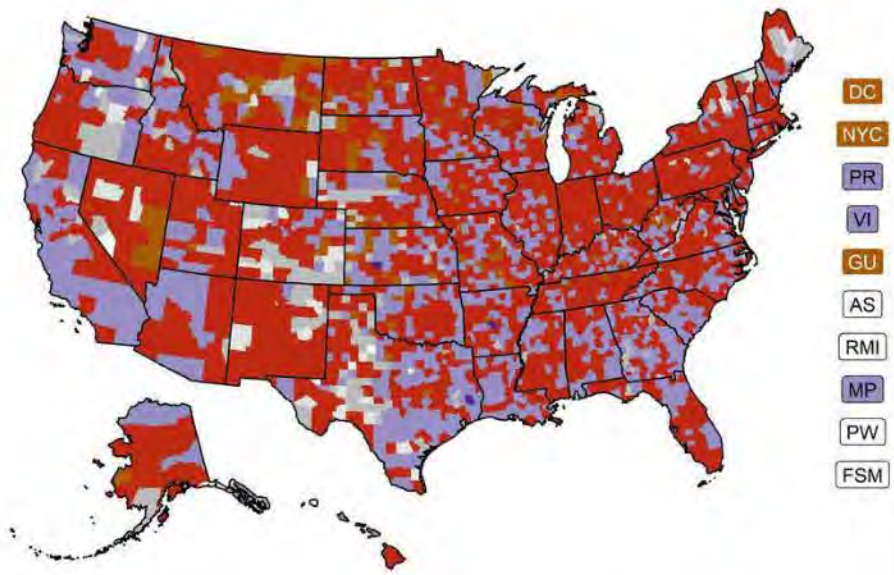
Incidence
- Low
- Moderate
- Moderately high
- High
- 1-5 cases in the past 2 weeks
- 0 cases in the past 2 weeks
- No reported cases

Purpose of this map
Describes recent incidence of COVID-19 infection to capture the potential burden of currently ill people who may be infectious and/or accessing healthcare.

Main Findings
- COVID-19 infection remains prevalent throughout the country.
- Elevated incidence of disease during the past 2 weeks remains widespread, including in the Southeast, the Midwest, and the West.

Notes: Defined using the number of new cases per 100,000 in the past 2 weeks. Low is >0 to 10, moderate is >10 to 50, moderately high is >50 to 100, and high is >100. Jurisdictions denoted as 0 cases in the past 2 weeks have had at least 1 case previously.
Sources: HHS Protect, US Census

Coronavirus Disease 2019 (COVID-19)
Current epidemic curve status*, by U.S. County, October 12, 2020



Current status
- Low incidence growth
- Elevated incidence growth
- Elevated incidence plateau
- Sustained decline
- Low incidence plateau
- Rebound
- 1-5 cases in the past two weeks
- 0 cases in the past two weeks
- No reported cases

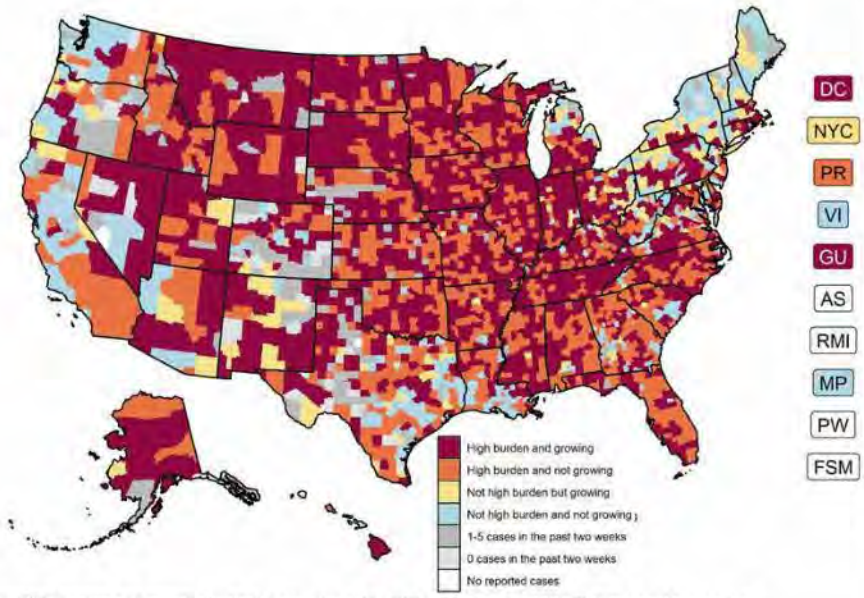
Purpose of this map
Provides the most detailed view into both the burden of illness and the trajectory of new illnesses.

Main Findings
- There are many counties throughout the States whose incidence are in rebound.
- Many counties in California, Arizona, Texas, Georgia, South Carolina and Florida have burden in sustained decline.
- The goal is to have all communities be represented in the lighter colors, demonstrating little to no disease burden and no increase in trajectory.

*Categorized according to the slope of a spline fit to the 7-day moving average of daily incidence and the number of new cases (per 100,000) in the past 2 weeks. Elevated incidence is defined as >10 new cases per 100,000 in the past two weeks.
Sources: HHS Protect, US Census

[12] See CDC COVID-19 Data Tracker for the latest visualizations on cases and deaths trends by state and county.

Coronavirus Disease 2019 (COVID-19)
Burden and growing of new cases per 100,000 in the past 2 weeks, by U.S. county, 29 September–12 October, 2020



Notes: High burden and growing indicates counties with >100 new cases per 100,000 in the past two weeks and a slope of at least 0.1 per 100,000 per day.
Sources: HHS Protect, US Census

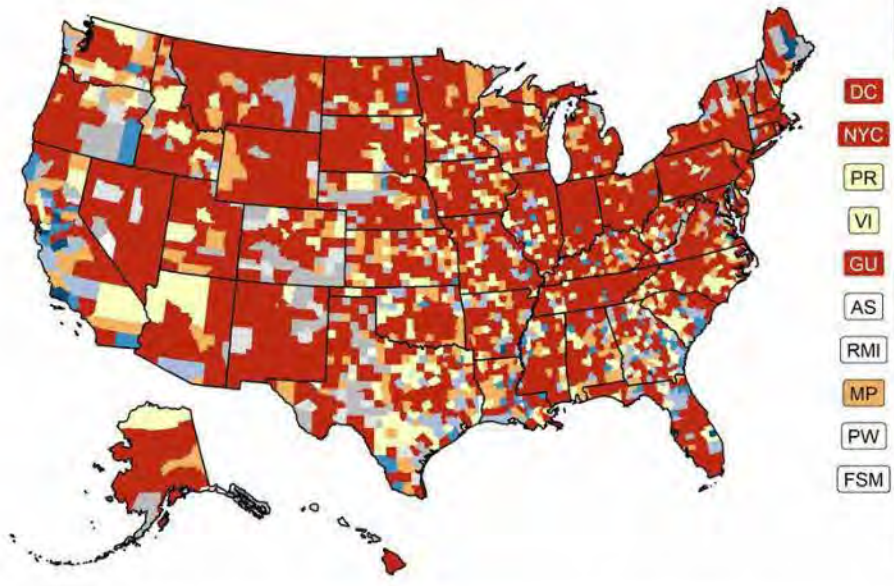
Purpose of this map
Identifies "areas of concern" where a county's disease burden is high and still growing.

Main Findings
- Counties with the greatest burden and which are still demonstrating growth are listed in the table below

Counties in the high burden, growing category (Top 10 with the highest number of cases per 100,000 in the past 2 weeks)

County name, State	No. of new cases in past 2 weeks	2-week incidence (per 100,000)	Change in daily incidence (per 100,000 per day)
Toole, MT	166	3,420.6	15.3
Jerauld, SD	65	3,181.6	19.2
Aurora, SD	80	2,856.1	21.9
Glacier, MT	354	2,575.1	8.0
Norton, KS	138	2,541.4	22.1
Golden Valley, ND	44	2,487.3	10.1
Nelson, ND	69	2,405.0	4.7
Faulk, SD	56	2,403.4	20.8
Roosevelt, MT	251	2,269.6	4.7
Prairie, MT	24	2,207.9	10.4

Coronavirus Disease 2019 (COVID-19)
Current consecutive days of downward trajectory, by U.S. County, October 12, 2020



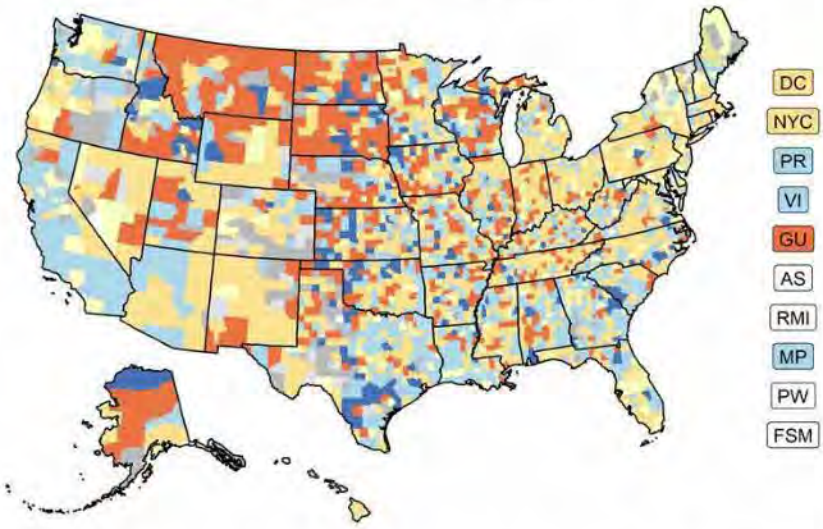
Days in downward trajectory*
- 1-6 days
- 7-13 days
- 14-20 days
- 21-41 days
- ≥42 days
- Not in downward trajectory
- 1-5 cases in the past 2 weeks
- 0 cases in the past 2 weeks
- No reported cases

Purpose of this map
Identifies progress in counties towards achieving a downward trajectory in case incidence over a 14-day period.

Main Findings
- 261 counties have been identified as having 14 or more consecutive days of improvement and are indicated in the blue colors (excludes counties with 0-5 cases in the past 2 weeks); median population size: 30,444 with a range of 749 – 4,698,619
- This method is still being refined to best characterize progress towards achieving a downward trajectory in daily case incidence over a 14-day period, and the results provided should be interpreted with caution when determining mitigation strategies to use.

*The number of days in a downward trajectory represents the number of consecutive days for which the jurisdiction experienced either a negative slope or a low incidence plateau (two-week incidence ≤10 cases per 100,000 and slope >-0.1 and ≤0.1).
Sources: HHS Protect, US Census

Coronavirus Disease 2019 (COVID-19) Change in Daily Incidence*, by U.S. County, October 12, 2020



Change in incidence per 100,000 per day

- Greater decline
- Moderate decline
- Plateau
- Moderate increase
- Greater increase
- 1-5 cases in the past 2 weeks
- 0 cases in the past 2 weeks
- No reported cases

*Measured as the change in slope of a spline fit to smoothed daily incidence. Incidence was smoothed using a 7-day moving average. These values therefore represent the change in 7-day average number of new cases per 100,000 per day. Greater declines are ≤-1, moderate declines are >-1 to -0.1, plateaus are >-0.1 to ≤0.1, moderate increases are >0.1 to 1, greater increases are >1. Counties denoted as 0 cases in the past 2 weeks have had at least 1 case previously.

Sources: HHS Protect, US Census

Purpose of this map

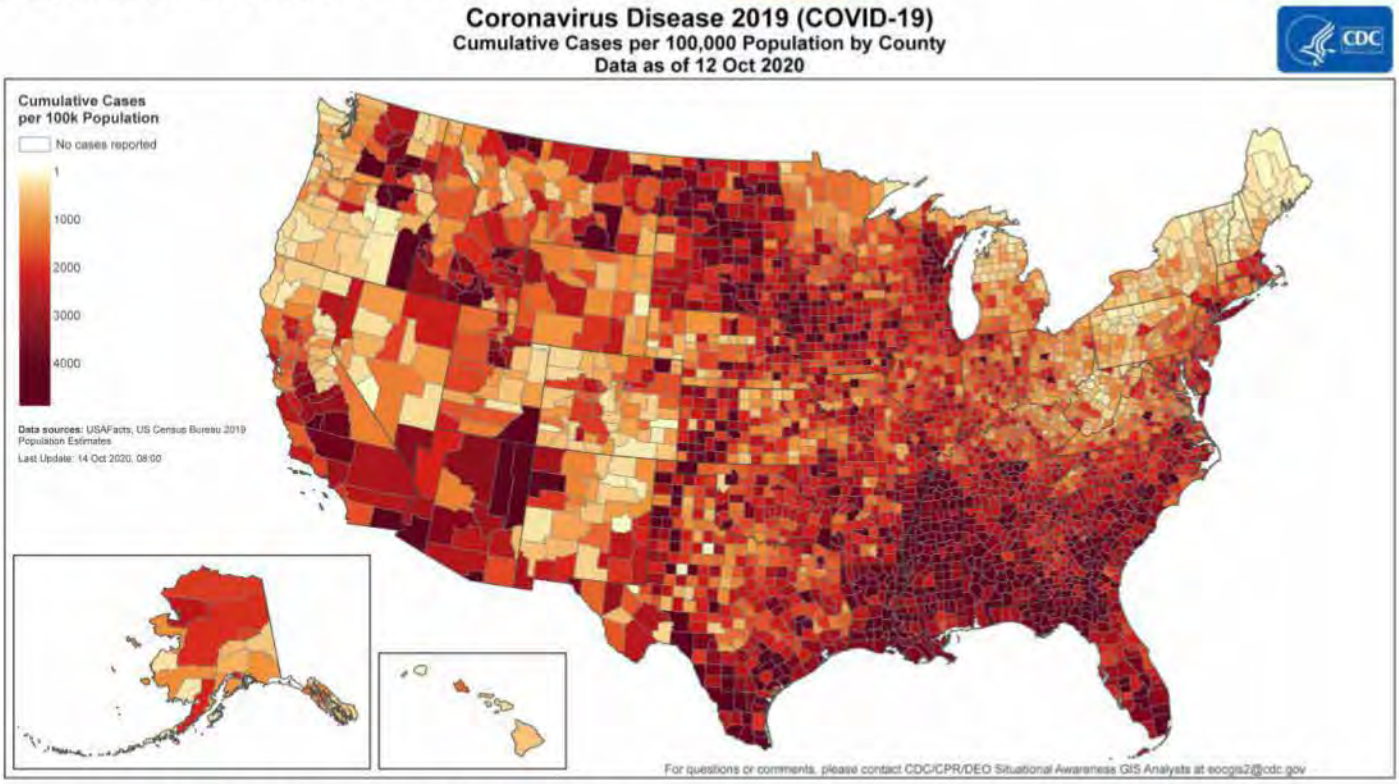
Describes the trajectory of new illnesses as recently increasing, being stable, or decreasing in number.

Main Findings

- Daily county-level incidence rates continue to decrease in much of the East Coast and the West Coast.
- However, county-level incidence is increasing throughout much of the Midwest and Great Plains, including Minnesota, Wisconsin, North Dakota, South Dakota, Nebraska, Kansas, Wyoming, Montana, Idaho, Utah, and Oklahoma.

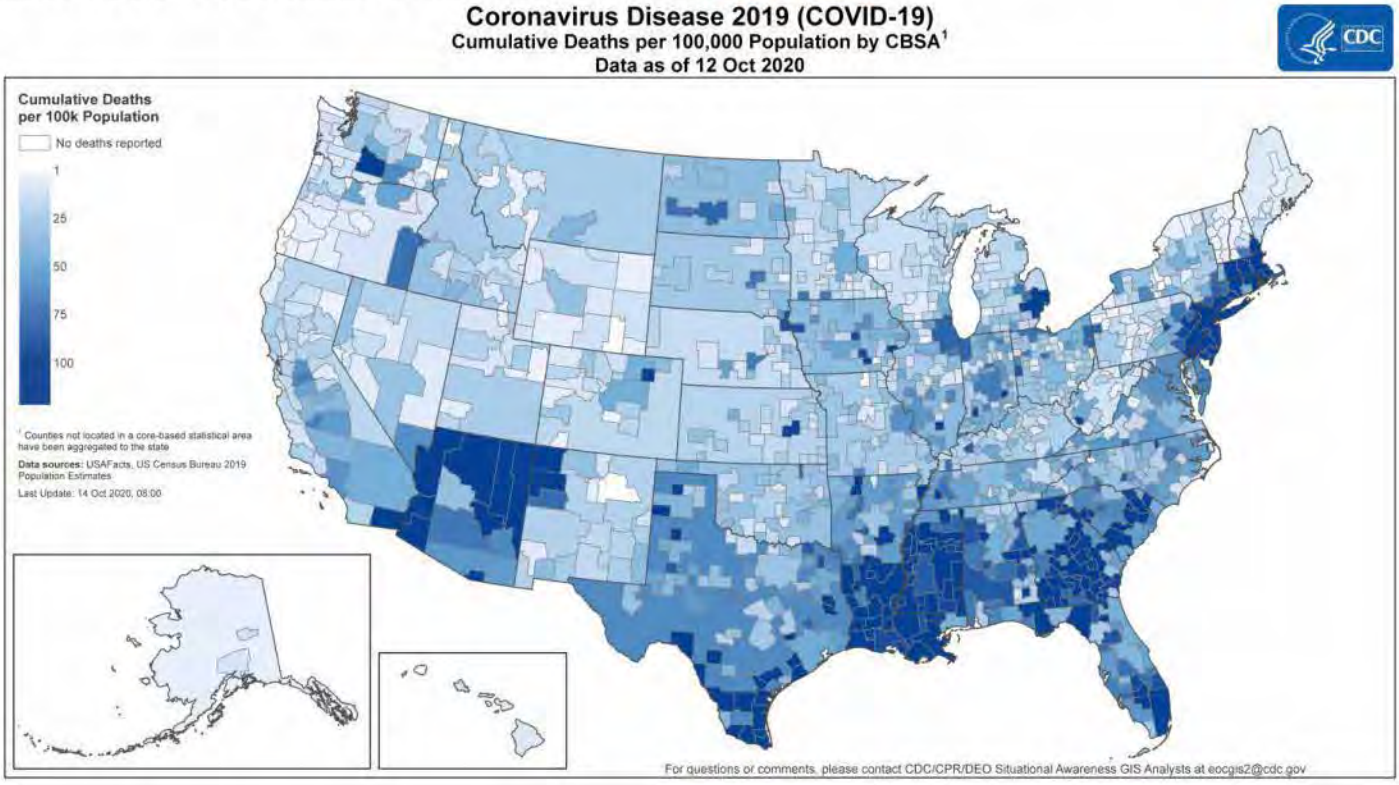
Cumulative Number of COVID-19 Cases in the United States by County per 100,000 Population

Data Through: 12 Oct 2020 *Last Updated: 14 Oct 2020, 08:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: USAFACTS)



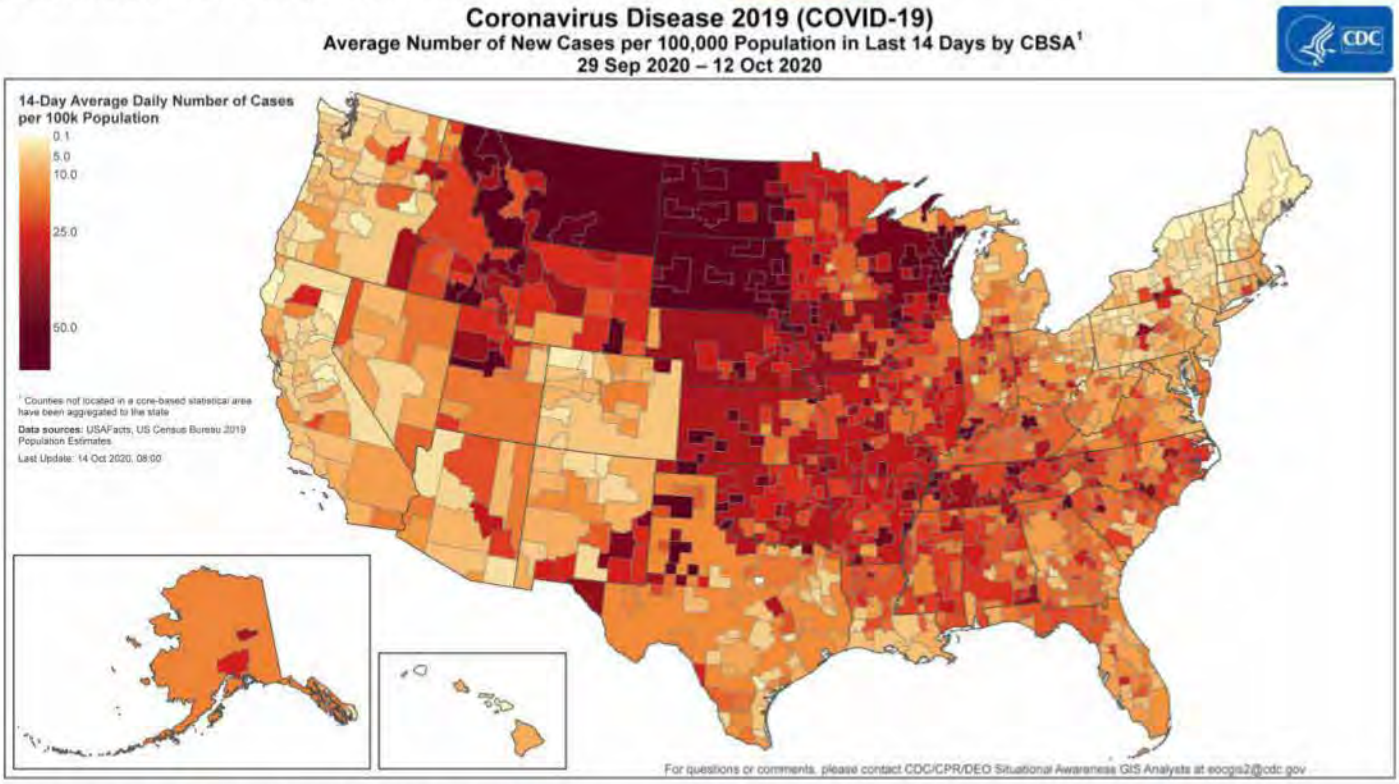
Cumulative Number of COVID-19 Deaths in the United States by County per 100,000 Population

Data Through: 12 Oct 2020 *Last Updated: 14 Oct 2020, 08:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: USAFACTS)



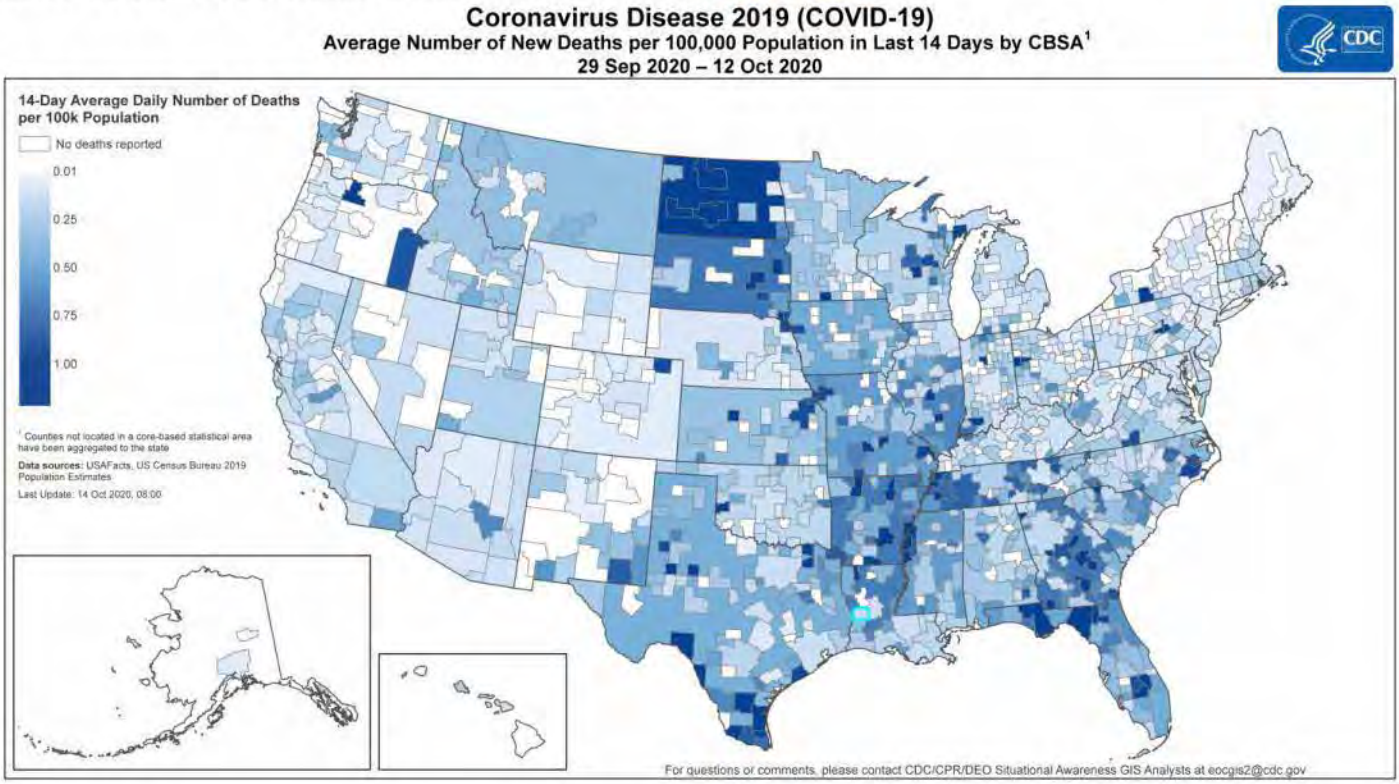
Average Number of New COVID-19 Cases per 100,000 Population by CBSA, Last 14 Days

Data: 29 Sep 2020 - 12 Oct 2020 *Last Updated: 14 Oct 2020, 08:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: USAFACTS)



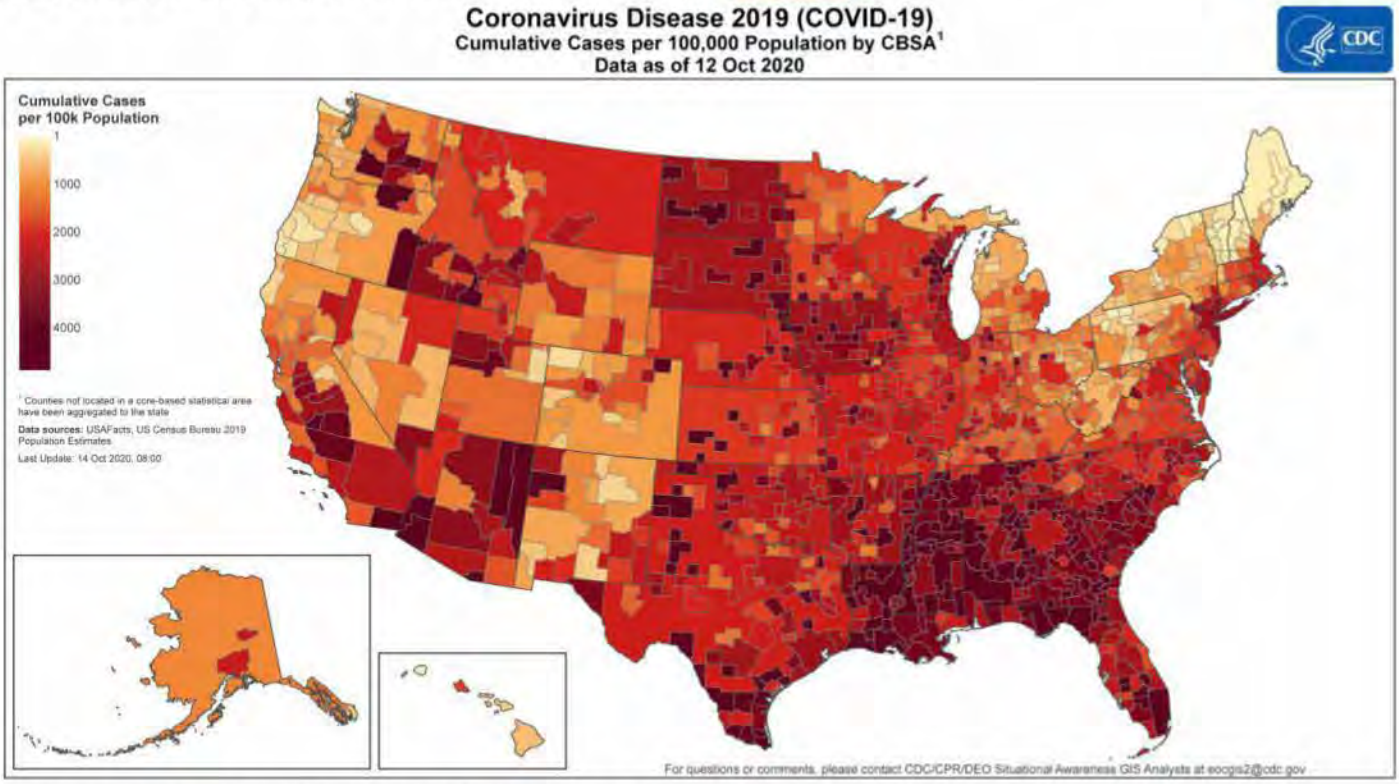
Average Number of New COVID-19 Deaths per 100,000 Population by CBSA, Last 14 Days

Data: 29 Sep 2020 - 12 Oct 2020 *Last Updated: 14 Oct 2020, 08:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: USAFACTS)



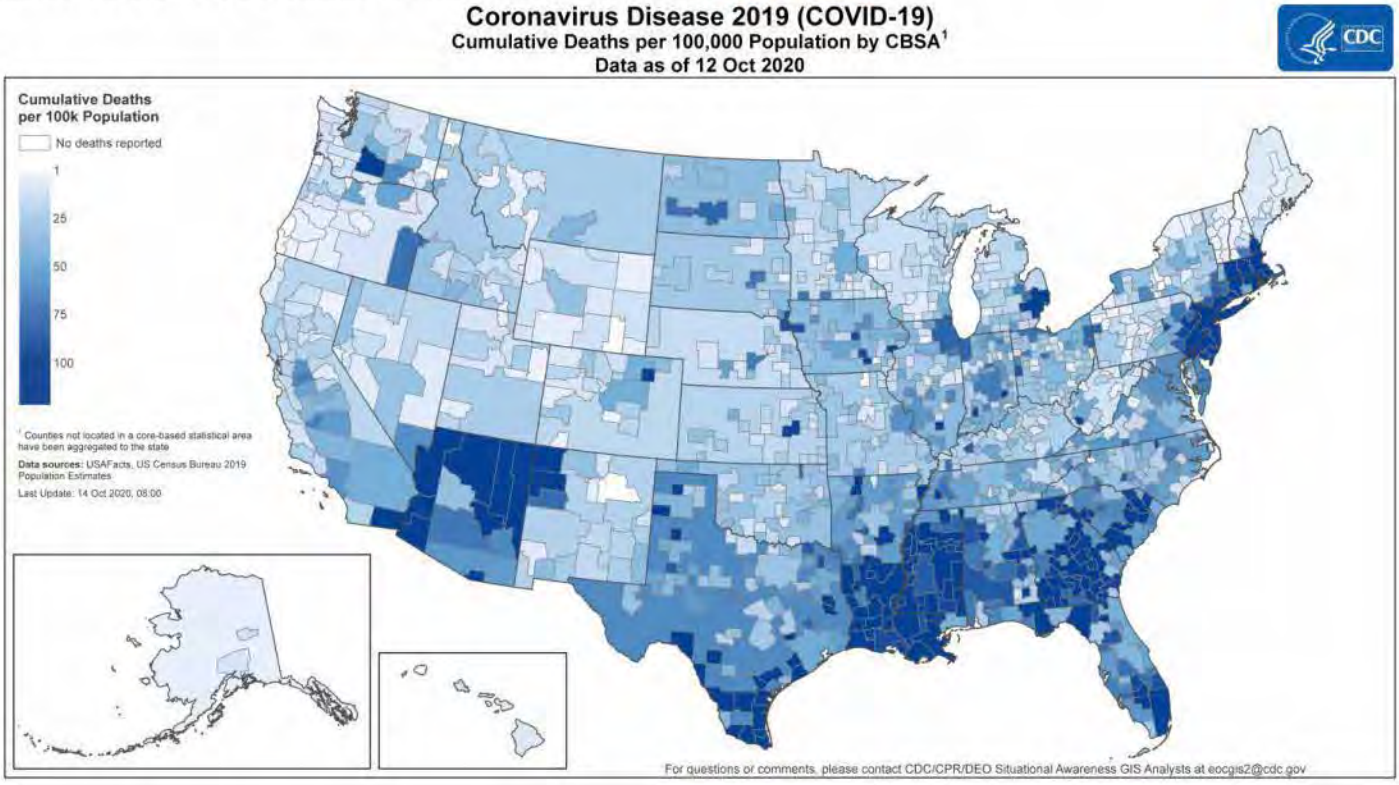
Cumulative Number of COVID-19 Cases per 100,000 Population by CBSA

Data Through: 12 Oct 2020 *Last Updated: 14 Oct 2020, 08:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: USAFACTS)



Cumulative Number of COVID-19 Deaths per 100,000 Population by CBSA

Data Through: 12 Oct 2020 *Last Updated: 14 Oct 2020, 08:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: USAFACTS)



Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC[13]

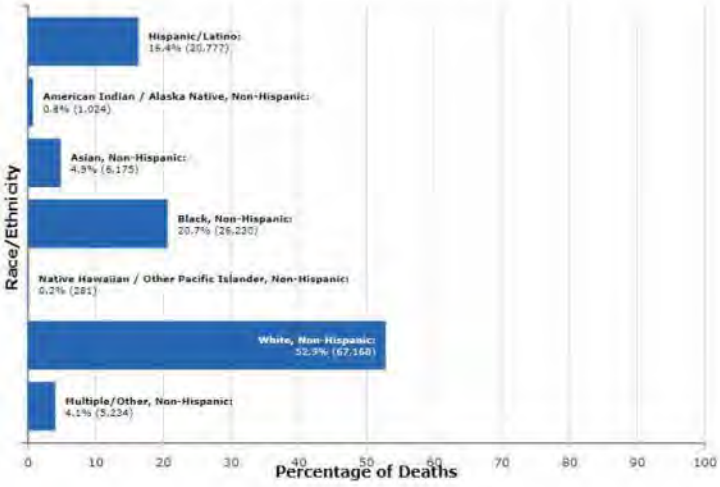
Data through 11 Oct 2020 Last Updated: 12 Oct 2020 12:29
Source: Data Reported to CDC from States/Jurisdictions on CDC COVID Data Tracker

Cases and Deaths by Race/Ethnicity

Cases by Race/Ethnicity
Data from 5,805,176 cases.
Race/Ethnicity was available for 3,038,200 (52%) cases.

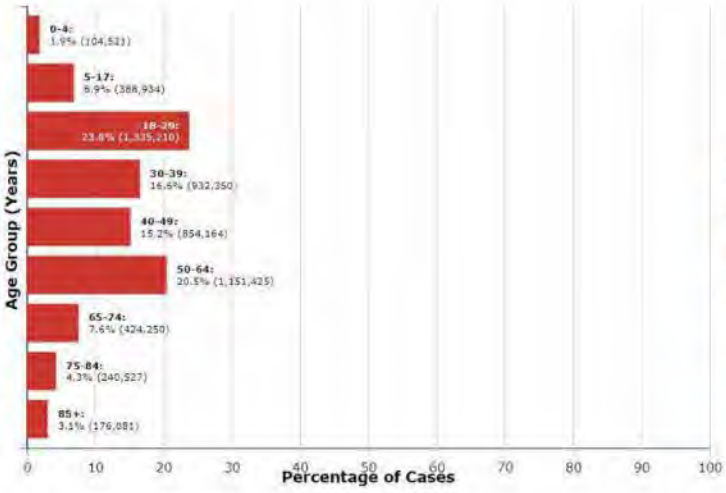
CDC | Updated: Oct 13 2020 3:00PM

Deaths by Race/Ethnicity
Data from 154,244 deaths.
Race/Ethnicity was available for 126,889 (82%) deaths.



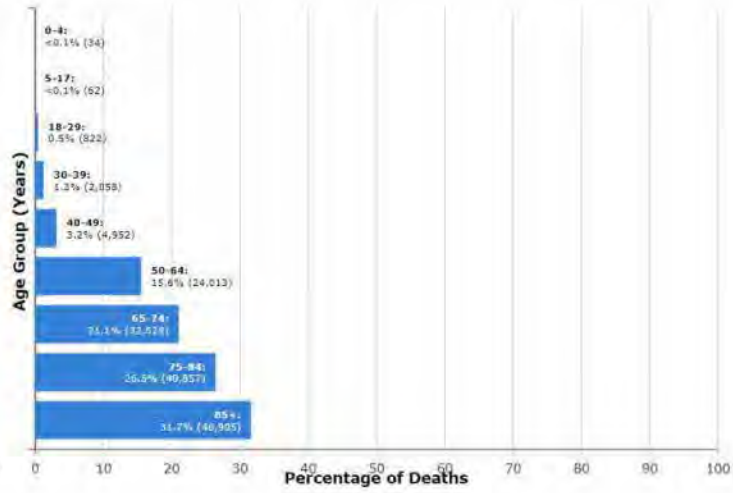
Cases and Deaths by Age Group

Cases by Age Group
Data from 5,805,176 cases. Age group was available for 5,607,462 (96%) cases.



CDC | Updated: Oct 13 2020 3:00PM

Deaths by Age Group
Data from 154,244 deaths. Age group was available for 154,232 (99%) deaths.

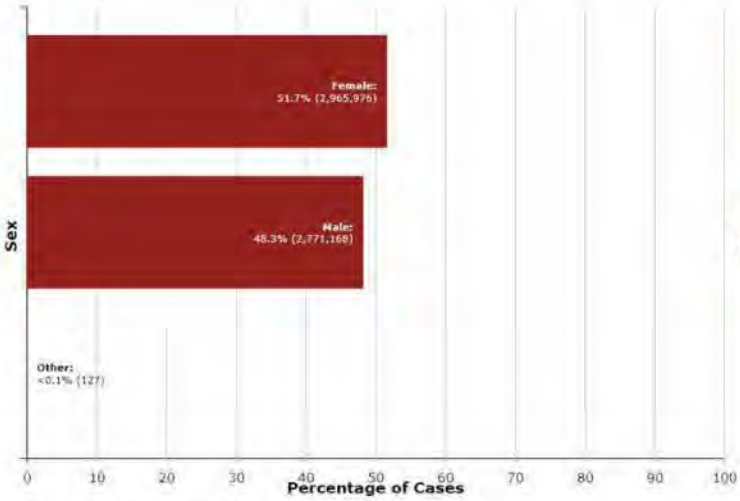


[13] The demographic data by age, race/ethnicity and sex is derived from information jurisdictions submit to CDC through a standardized COVID-19 case reporting form. More information can be found on the FAQ site on Data and Surveillance, under the section "National COVID-19 Case Surveillance: How is COVID-19 case information collected and reported?"

Cases and Deaths by Sex

Cases by Sex

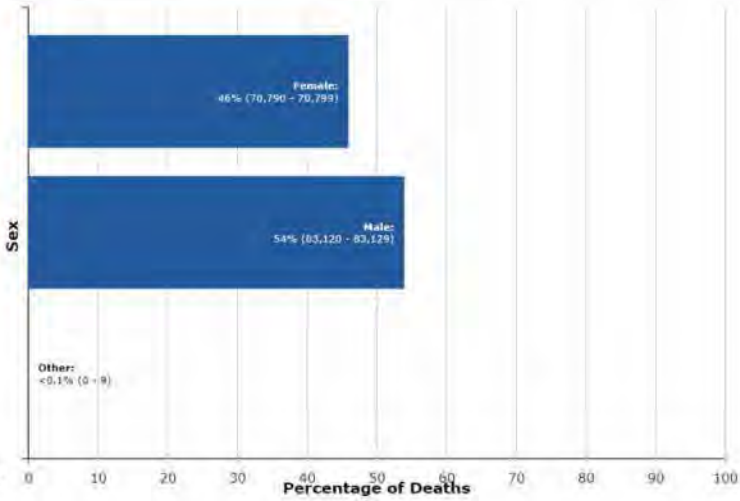
Data from 5,805,176 cases. Sex was available for 5,737,271 (98%) cases.



CDC | Updated: Oct 13 2020 3:00PM

Deaths by Age Group

Data from 154,244 deaths. Sex was available for 153,924 (99%) deaths.

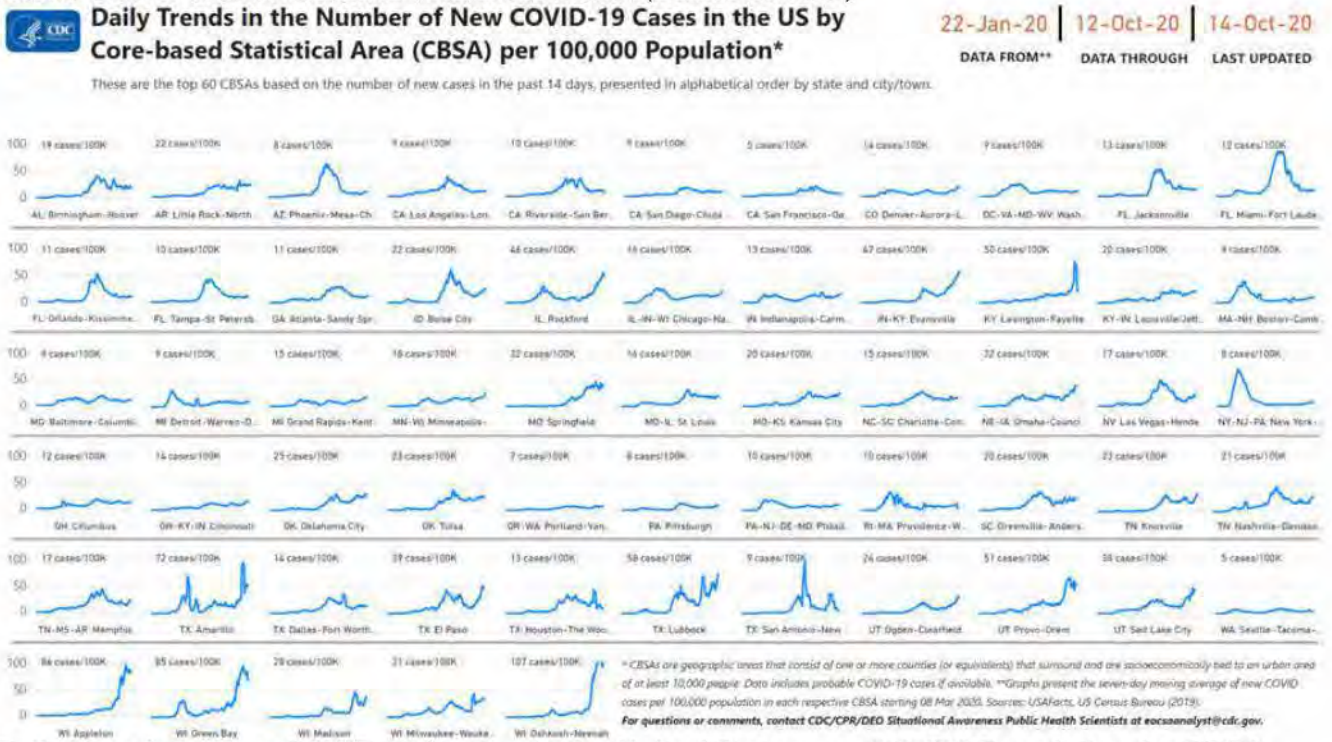


Cases/Deaths by CBSA [14,15]

Daily Trends in New COVID-19 Cases in the United States per 100,000 Population by CBSA

Data: 22 Jan 2020 – 12 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*

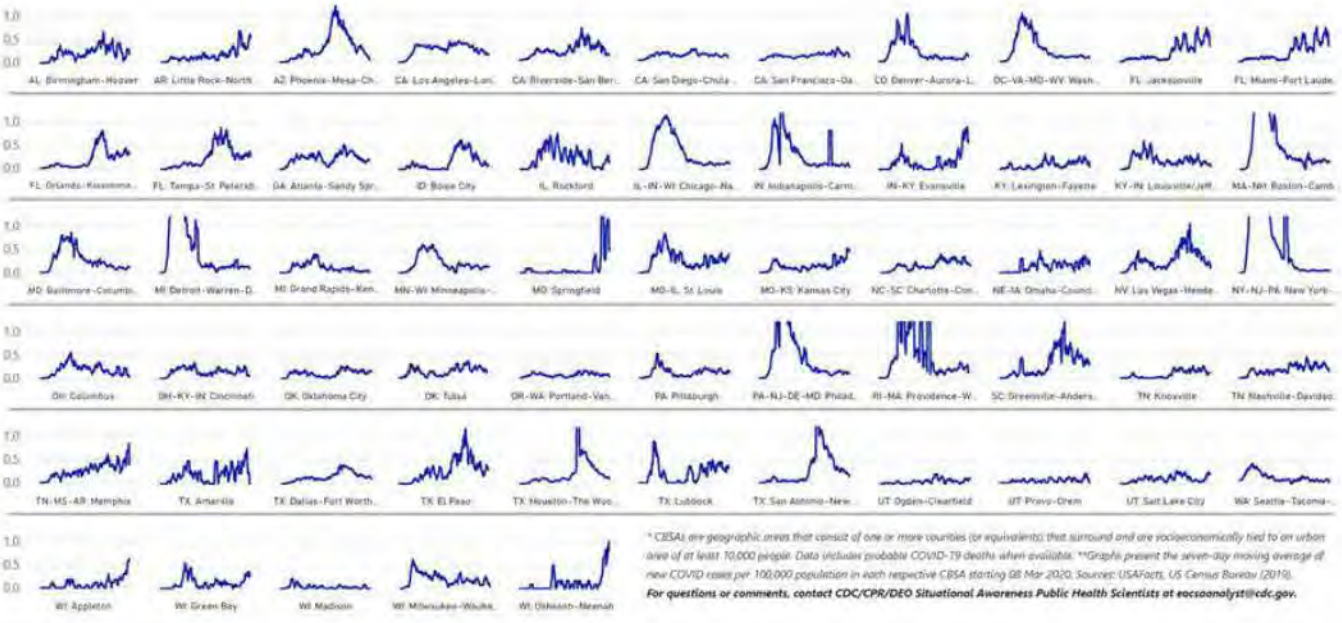
Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)



Daily Trends in New COVID-19 Deaths in the United States per 100,000 Population by CBSA

Data: 22 Jan 2020 – 12 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*

Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER)



[14] See methodology and sources for data reported by *USAFACTS*.

[15] See information on Core-Based Statistical Area (CBSA) from the US Census Bureau.

COVID-19 Among Specific Populations

US Healthcare Workers

Healthcare Workers in US - Case Count Reported in Case-Based Surveillance

Data as of 13 Oct 2020

N = 179,059 (+791)

- 752 Deaths (-2)[16]
  - 192 in CA
  - 189 in IL
  - 65 in OH
  - 46 in MA
  - 31 in MI
  - 31 in NV
  - 27 in TN
  - 25 in NY
  - 23 in NC
  - 20 in PA
  - 18 in WA
  - 16 in AR
  - 12 in IA
  - 12 in MN
  - 11 in LA
  - 8 in KS
  - 8 in NH
  - 7 in NJ
  - 4 in CO
  - 3 in DC
  - 2 in PR
  - 1 in UT
  - 1 in VI

Laboratory Testing[17,18]

Status of Laboratory Testing[19]

Data Through: 08 Oct 2020 *Last Updated: 13 Oct 2020, 23:56*

Source: HHS Protect

Report	Total New Orders	Cumulative Orders	New With Results	Cumulative Results	New Positives	Cumulative Positives	Total % Positive	% Positive Last 7 Days
Hospital[20]	135,297	20,801,860	141,001	20,825,390	7,874	1,433,318	6.88%	4.57%
Commercial labs[21]	244,771	45,282,360	312,987	44,195,063	15,102	3,613,042	8.18%	4.85%
State/Local PHL[22]	55,486	7,152,237	60,727	7,062,276	3,319	511,905	7.25%	5.28%
Total	435,554	73,236,457	514,715	72,082,729	26,295	5,558,265		

	Cumulative Results		Cumulative Positives	Total % Positive	% Positive Last 7 Days[18]
Total Incl. State HD's[23]	128,863,968		9,649,419	7.49%	5.81%

[16] The number of HCP deaths decreased by 4 for OH due to data validation and cleaning.

[17] Data from unified dataset which includes a combination of CELR line-level, CELR aggregate, commercial/reference, state public health, and hospital laboratories.

[18] Due to CA correcting historical data, there is a significant spike in positive tests on October 5 which affects national and CA state 7-day % positivity and test volume.

[19] Not all jurisdictions report data up through the day of reporting. In order to report data for all jurisdictions along a consistent time window, this report uses data up through the most recent day for which all jurisdictions have reported. There may be data available for more recent days for several jurisdictions that is not included in this report.

[20] Hospital laboratory data are reported directly to HHS via an online form, beginning 11 Apr. Respondents are asked to report all tests run in the hospital laboratory and not sent out to commercial laboratories.

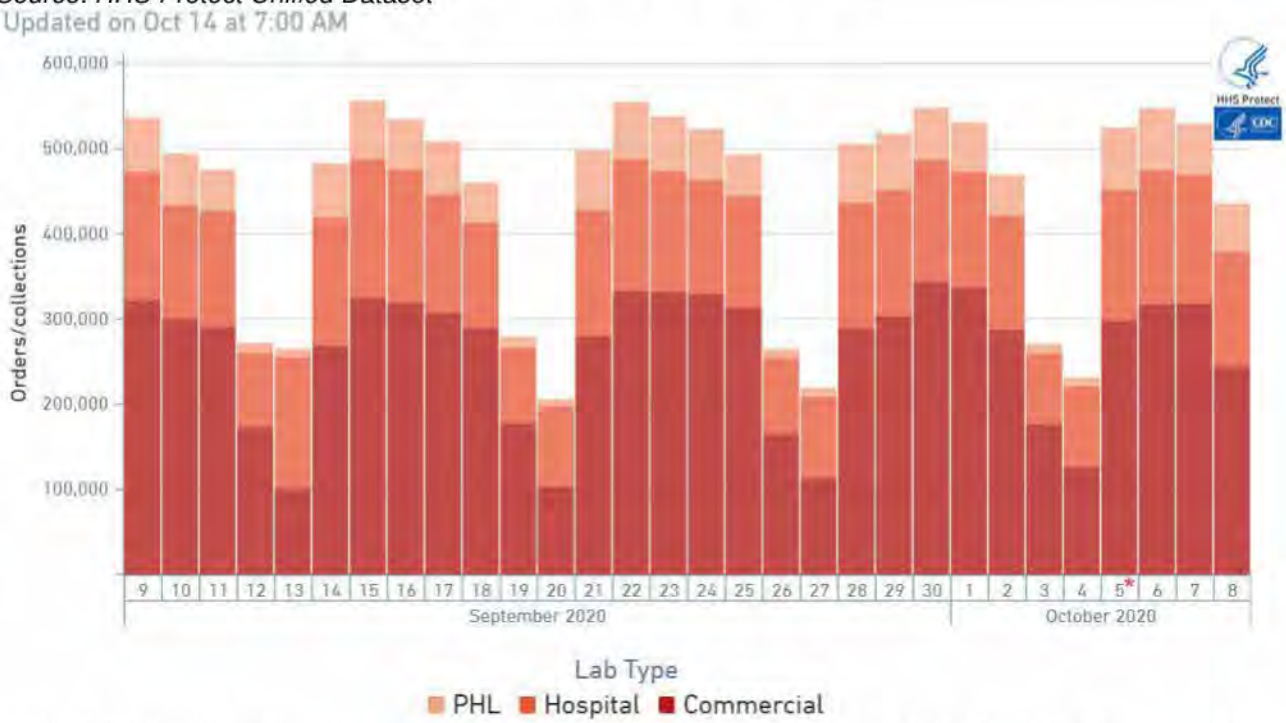
[21] Includes 6 commercial labs: LabCorp, Quest Diagnostics, BioReference, ARUP, Mayo Clinic, and Sonic Healthcare.

[22] Reporting public health labs are all 50 state public health labs, the District of Columbia, New York City, Puerto Rico, USAF, and 17 California counties.

[23] Includes laboratory results reported to CDC from state health departments not reported through HHS Protect including additional lab orders received prior to 23 Apr not included in HHS Protect.

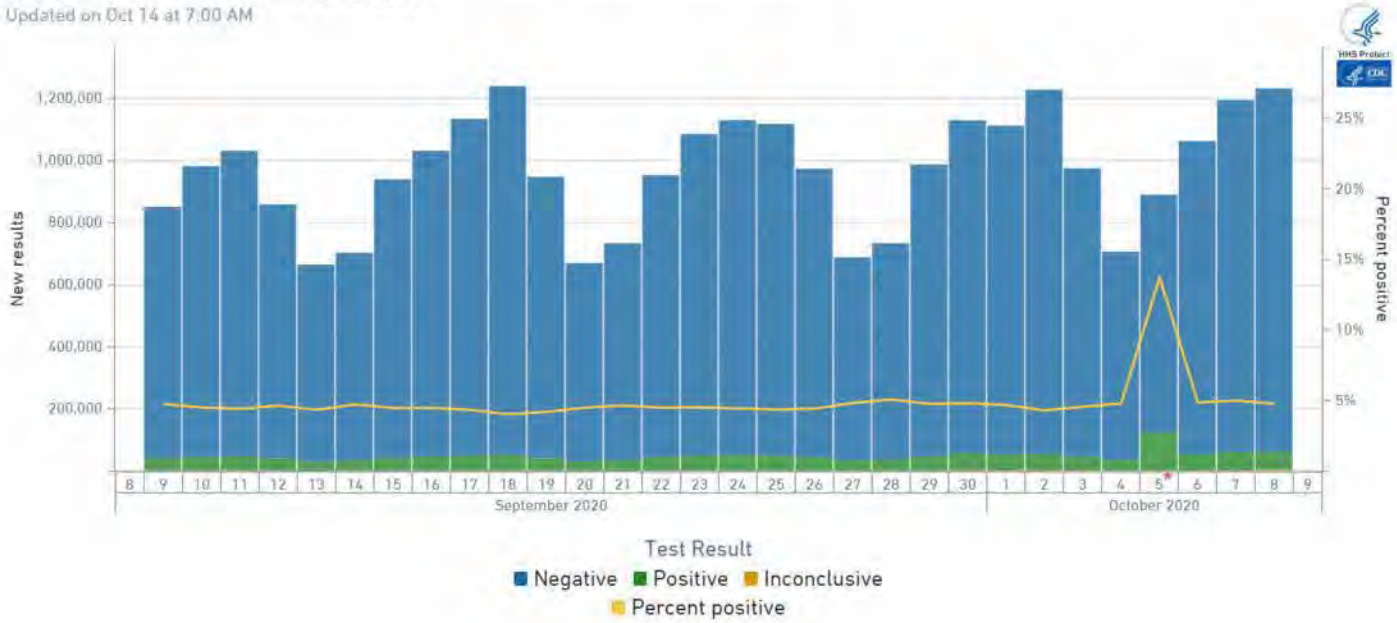
Laboratory Orders/Collections per Day by Lab Type [18, 24]

Data: 09 Sep 2020 - 08 Oct 2020 *Last Updated: 14 Oct 2020, 07:00*
Source: HHS Protect Unified Dataset



COVID-19 Positive/Negative Results and Percent Positive from Public Health, Commercial, and Hospital Laboratories [25]

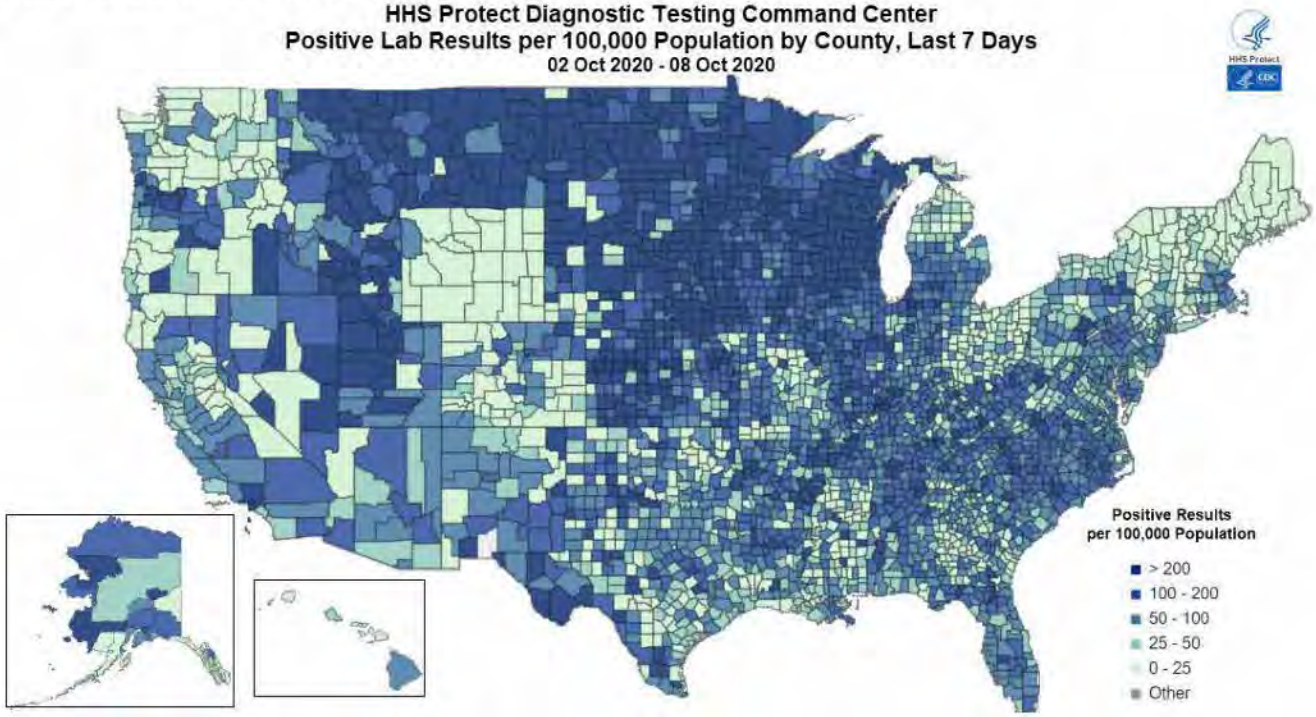
Data: 09 Sep 2020 - 08 Oct 2020 *Last Updated: 14 Oct 2020, 07:00*
Source: HHS Protect Unified Dataset



[24] Reported by test order date if available, otherwise the date the specimen was collected. Due to reporting lags, data for the most recent three days may be underrepresented.
[25] Reported by test result date. Due to reporting lags, data for the most recent three days may be underrepresented.

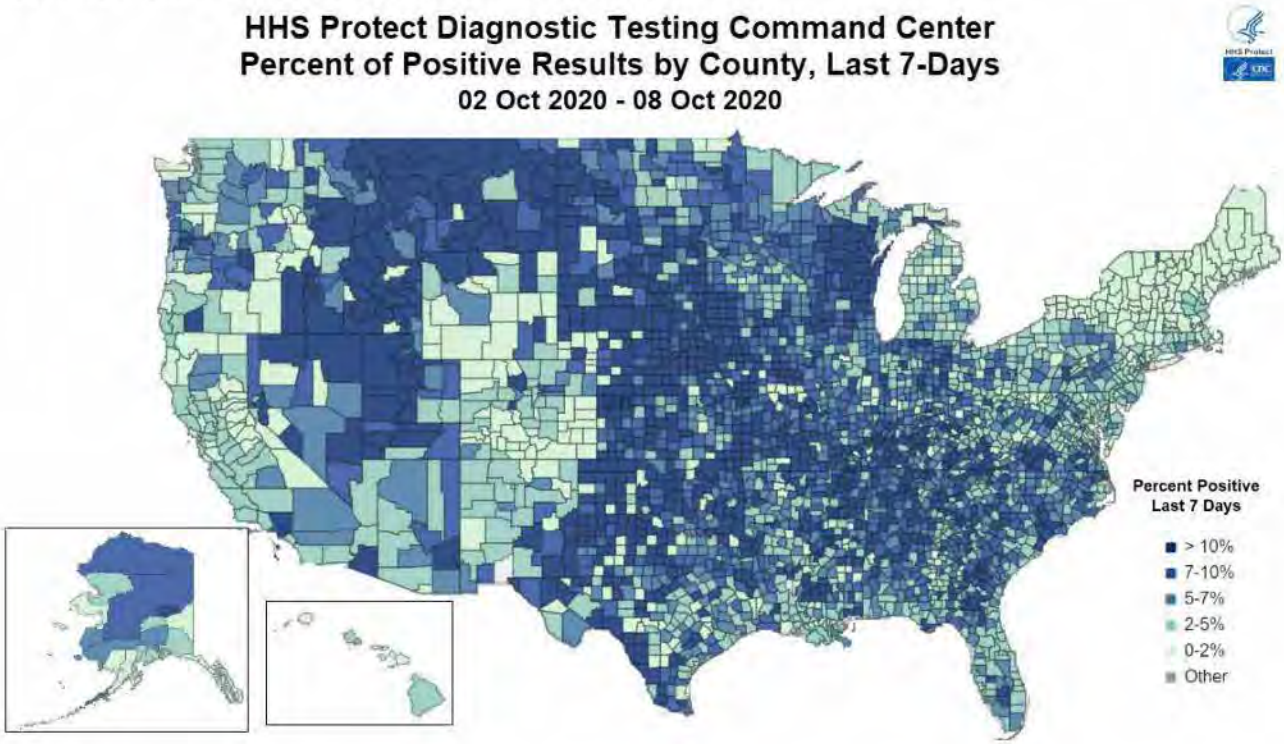
Positive Results per 100,000 Population Last 7-Days by County [26, 27]

Data: 02 Oct 2020 - 08 Oct 2020 Last Updated: 17 Oct 2020, 07:00
Source: HHS Protect: Diagnostic Testing Command Center



Percent Positive Results Last 7-Days by County [27]

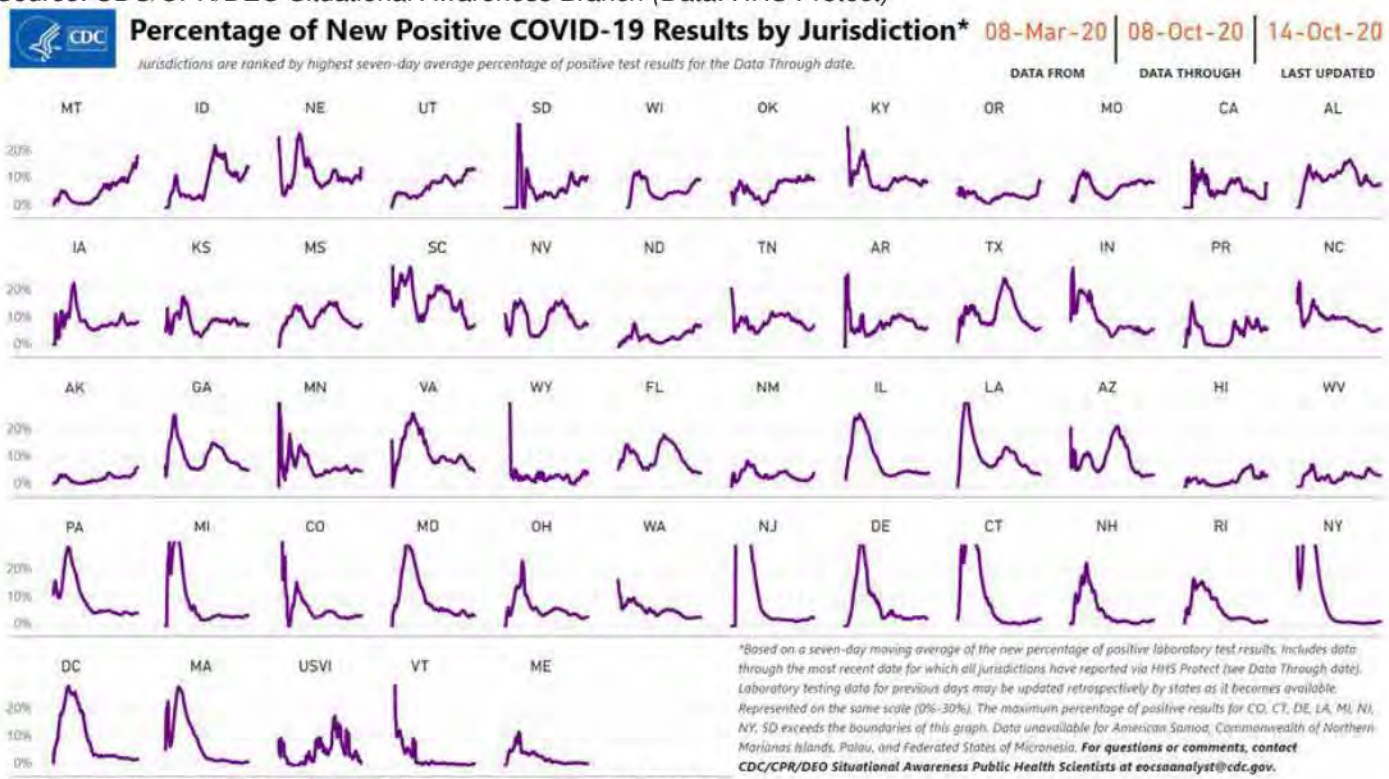
Data: 02 Oct 2020 - 08 Oct 2020 Last Updated: 14 Oct 2020, 07:00
Source: HHS Protect: Diagnostic Testing Command Center



[26] Data represent (total number of positive results/total population) * 100.One person may have multiple tests and positive results.
[27] See CDC COVID-19 Data Tracker for the latest visualizations on US laboratory testing by state.

Percentage of New Positive COVID-19 Test Results by Jurisdiction 18

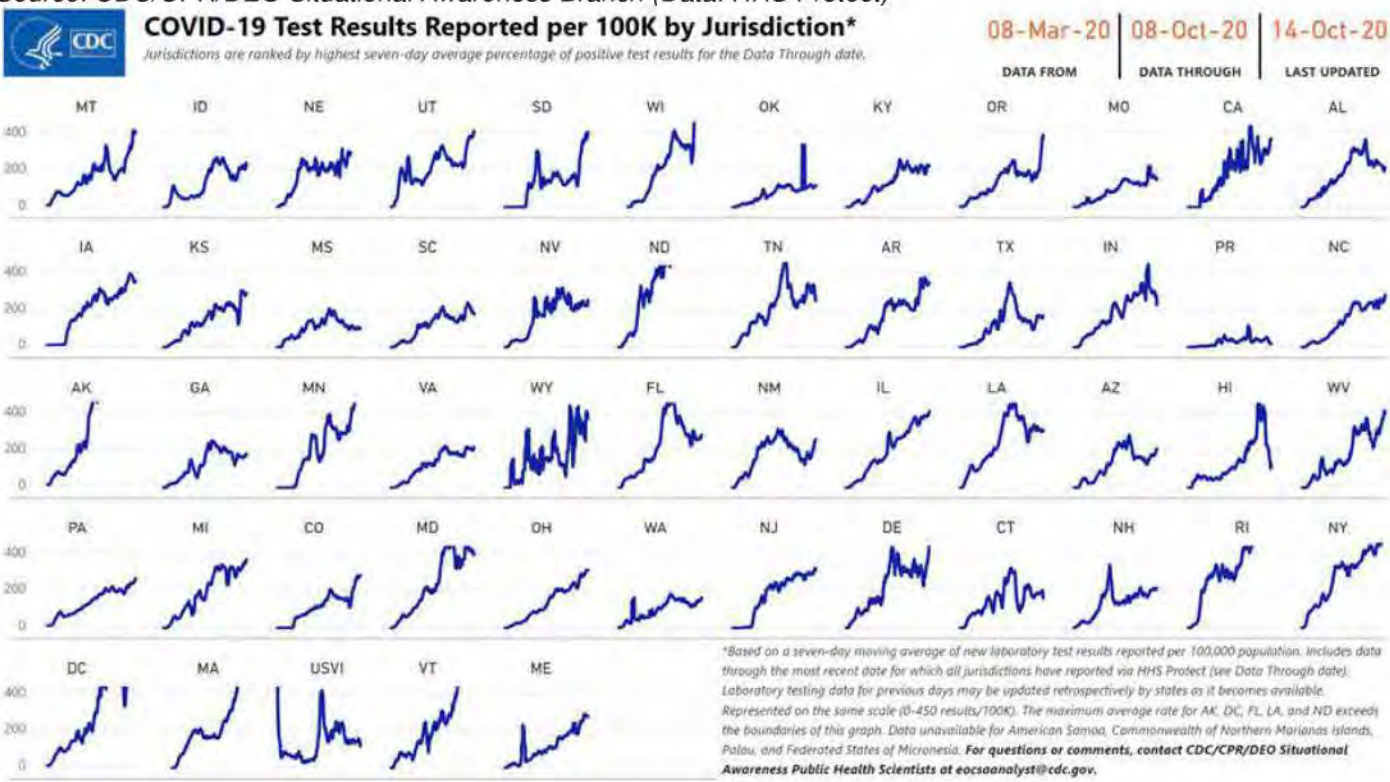
Data: 08 Mar 2020 – 08 Oct 2020 *Last Updated: 14 Oct 2020, 07:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: HHS Protect)



Based on a seven-day moving average of the new percentage of positive laboratory test results. Includes data through the most recent date for which all jurisdictions have reported via HHS Protect (see Data Through date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Represented on the same scale (0%-30%). The maximum percentage of positive results for CO, CT, DE, LA, MI, NJ, NY, SD exceeds the boundaries of this graph. Data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Palau, and Federated States of Micronesia. ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.***

New Positive COVID-19 Test Results per 100,000 Population by Jurisdiction 18

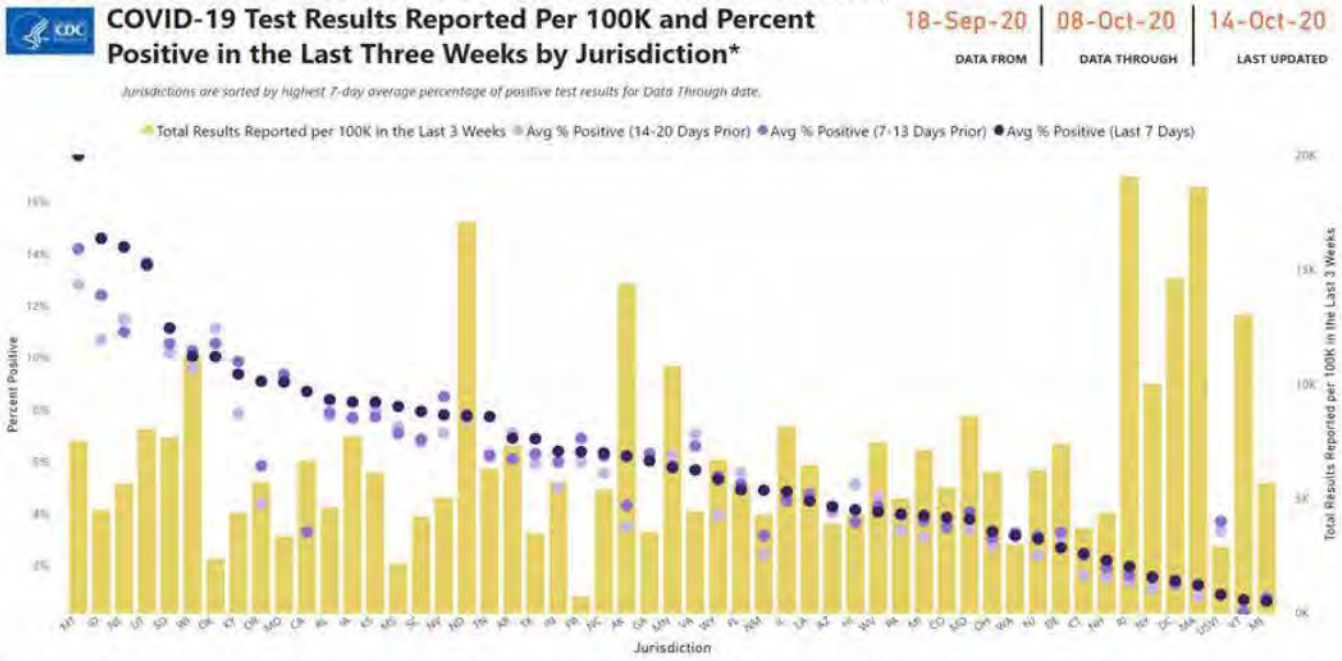
Data: 08 Mar 2020 – 08 Oct 2020 *Last Updated: 14 Oct 2020, 07:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: HHS Protect)



Based on a seven-day moving average of new laboratory test results reported per 100,000 population. Includes data through the most recent date for which all jurisdictions have reported via HHS Protect (see Data Through date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Represented on the same scale (0-450 results/100K). The maximum average rate for AK, DC, FL, LA, and ND exceeds the boundaries of this graph. Data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Palau, and Federated States of Micronesia. ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.***

COVID-19 Test Results per 100,000 and Percent Positive in the Last 3 Weeks by Jurisdiction [18, 28, 29, 30]

Data: 18 Sep 2020 – 08 Oct 2020 *Last Updated: 14 Oct 2020, 07:00*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: HHS Protect)



*Based on total laboratory test results reported per 100,000 population in the last 21 days. Includes data through the most recent date for which all jurisdictions have reported via HHS Protect (see Data Through date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Guam, US Virgin Islands, Palau, and Federated States of Micronesia.
For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

COVID-19 Test Results per 100,000 and Percent Positive in the Last 3 Weeks by CBSA [29, 30]

Data: 18 Sep 2020 – 08 Oct 2020 *Last Updated: 14 Oct 2020, 10:30*
Source: CDC/CPR/DEO Situational Awareness Branch (Data: HHS Protect)

*Metropolitan and Micropolitan Statistical Areas are collectively referred to as Core-Based Statistical Areas (CBSA); new definitions were announced by OMB on 06 Jun 2003, based on application of the 2000 standards with Census 2000 data. Figure based on total laboratory test results reported per 100,000 population in the last 21 days. Includes data through the most recent date for which all jurisdictions have reported via HHS Protect (see Data Through date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Guam, US Virgin Islands, Palau, and Federated States of Micronesia.
For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.

[28] Data from state health departments, state public health labs, commercial labs, and hospitals.
[29] Metropolitan and Micropolitan Statistical Areas are collectively referred to as Core-Based Statistical Areas (CBSA). Due to reporting lags, data for the most recent three days may be underrepresented.
[30] Line level laboratory data for the most recent three days may be incomplete and the latest 7-day average should be interpreted with caution.

Comparison of U.S. Case Counts with Laboratory Testing Data 18

COVID-19 Cases, Deaths and Lab Comparison by Jurisdiction

Data Through: 08 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*

Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER & HHS Protect)

COVID-19 Epi/Lab Overview -- US States, Territories & DC

Data for case and laboratory data includes data through the most recent date for which most jurisdictions have reported via HHS protect. *Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Lab data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Palau, and Federated States of Micronesia.*

** Calculation omitted where the number of total new tests was less than five.*

08-Oct-20 DATA THROUGH | 14-Oct-20 LAST UPDATED

State/ Territory	Cases/ 100K	Deaths/ 100K	Total Tests	New Tests	Tot. Tests/ 100K	New Tests/ 100K	New Pos Tests	Total Pos Tests	% Total Pos Tests	% New Pos Tests*
AK	1221.1	9.1	656,049	6,095	89,679.9	833.2	379	17,912	2.7%	6.2%
AL	[illegible]	53.9	1,871,867	16,759	38,176.6	341.8	1,131	212,499	[illegible]	6.7%
AR	[illegible]	50.0	1,121,469	15,298	37,161.8	506.9	966	92,366	8.2%	6.3%
AZ	[illegible]	80.1	2,064,797	16,719	28,367.6	257.2	815	225,720	10.9%	4.4%
CA	2130.4	41.4	15,967,520	145,109	40,411.6	367.3	5,049	1,043,605	6.5%	3.5%
CO	1330.8	36.8	1,381,676	18,939	23,992.7	328.9	762	61,140	4.4%	4.0%
CT	1672.4	126.7	1,148,075	1,462	32,201.5	41.0	27	67,922	5.9%	1.8%
DE	2241.8	67.3	474,974	8,548	48,377.1	857.3	185	24,495	5.2%	2.2%
FL	[illegible]	70.7	10,444,792	70,995	48,650.8	330.6	3,218	1,174,116	11.2%	4.5%
GA	[illegible]	69.3	3,019,526	19,862	28,439.3	187.1	1,239	302,255	10.0%	6.2%
HI	936.1	11.5	427,374	3,752	30,184.5	265.0	180	15,630	3.7%	4.8%
IA	[illegible]	45.0	1,336,942	13,659	42,374.8	432.9	1,156	109,878	8.2%	8.5%
ID	[illegible]	28.7	512,955	4,489	28,703.5	251.2	615	66,937	13.0%	13.7%
IL	[illegible]	71.9	5,653,094	60,285	44,617.5	475.7	3,129	357,722	6.3%	5.2%
IN	1337.8	55.9	2,677,116	7,015	39,765.7	104.2	441	190,800	7.1%	6.3%
KS	2196.5	24.8	913,550	10,830	31,357.8	371.7	889	79,317	8.7%	8.2%
KY	1253.4	27.6	1,250,170	13,568	27,982.6	303.7	1,141	114,717	9.2%	8.4%
LA	[illegible]	123.4	2,487,958	16,249	53,518.4	349.5	617	247,073	9.9%	3.8%
MA	2084.8	160.1	4,494,728	68,492	65,211.0	993.7	849	177,962	4.0%	1.2%
MD	2154.8	66.0	3,142,269	32,705	51,975.4	541.0	912	213,680	6.8%	2.8%
ME	423.3	10.7	354,280	3,402	26,356.0	253.1	21	6,018	1.7%	0.6%
MI	1465.3	72.0	4,241,962	41,738	42,475.4	417.9	1,829	201,879	4.8%	4.4%
MN	1121.3	38.5	2,619,578	38,994	46,449.4	691.4	2,265	160,544	6.1%	5.8%
MO	1238.8	36.9	1,225,527	12,936	19,968.1	210.8	1,235	95,020	7.8%	9.5%
MS	1081.1	103.1	676,081	3,880	22,716.6	130.4	358	76,225	11.3%	9.2%
MT	1569.5	18.5	372,815	5,024	34,882.4	470.1	703	27,142	7.3%	14.0%
NC	2130.8	35.8	3,167,031	39,855	30,196.7	380.0	2,036	262,501	8.3%	5.1%
ND	[illegible]	42.2	685,014	9,672	89,899.5	1,269.2	697	28,940	4.2%	7.2%
NE	[illegible]	26.6	746,693	6,122	38,600.6	316.5	786	90,189	[illegible]	[illegible]
NH	654.5	33.0	404,497	3,177	29,748.7	233.7	95	14,002	3.5%	3.0%
NJ	[illegible]	[illegible]	3,400,081	24,265	38,279.8	273.2	654	118,730	3.5%	2.7%
NM	1515.5	42.9	821,981	5,535	39,201.1	264.0	381	34,027	4.1%	6.9%
NV	[illegible]	55.8	1,135,305	12,784	36,658.7	415.0	815	114,222	10.1%	6.4%
NY	1733.0	146.5	11,921,632	126,556	67,282.5	650.6	1,853	581,961	4.9%	1.5%
OH	1405.2	42.6	3,482,878	33,521	29,795.9	286.8	1,333	175,430	5.0%	4.0%
OK	[illegible]	27.8	675,185	6,151	17,063.2	155.4	672	56,763	8.4%	10.9%
OR	861.8	14.2	1,279,004	20,287	30,324.4	481.0	1,353	38,150	4.5%	6.7%
PA	1311.2	64.3	3,650,635	43,677	28,516.2	341.2	1,680	224,116	6.1%	3.8%
RI	2461.3	106.5	669,717	15,124	62,980.3	1,422.7	262	36,421	4.2%	1.7%
SC	[illegible]	59.1	1,336,977	9,308	25,967.2	180.8	715	194,977	14.6%	7.7%
SD	[illegible]	31.1	253,159	5,100	28,616.6	576.5	550	18,940	7.5%	10.8%
TN	[illegible]	40.0	3,095,546	25,970	45,328.3	380.3	1,843	281,935	9.1%	7.1%
TX	1218.1	56.9	7,836,155	64,958	27,025.1	224.0	4,011	1,095,918	14.0%	6.2%
UT	2005.8	15.8	1,491,091	15,233	46,510.0	475.1	1,988	136,450	9.2%	13.1%
VA	1693.1	39.3	2,372,203	23,112	27,792.1	270.8	1,350	261,451	11.9%	5.8%
VT	293.5	9.3	337,338	5,747	54,041.5	921.0	14	2,905	0.9%	0.2%
WA	1219.6	29.0	1,678,149	17,392	22,037.7	228.4	509	83,892	5.0%	2.9%
WI	[illegible]	24.7	2,962,170	42,446	50,875.1	729.0	4,442	194,611	6.6%	10.5%
WV	959.4	20.5	701,220	9,445	39,127.4	527.0	397	27,794	4.0%	4.2%
WY	1227.5	9.3	202,722	0	35,027.0	0.0	0	6,616	3.3%	
CNMI	131.9	3.5								
DC	2,264.8	90.8	467,476	7,504	68,238.3	1,095.3	88	20,885	4.5%	1.2%
PR	1455.4	22.5	202,164	334	6,330.1	10.5	24	8,669	4.3%	7.2%
USVI	1264.8	19.1	24,302	150	23,215.5	143.3	2	1,254	5.2%	1.3%

This table also summarizes official CDC US case counts for COVID-19, reviewed and validated by states and territories, posted daily on the CDC COVID-19 webpage (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html). Sources: CDC DCIPHER, HHS Protect, US Census Bureau. ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.***

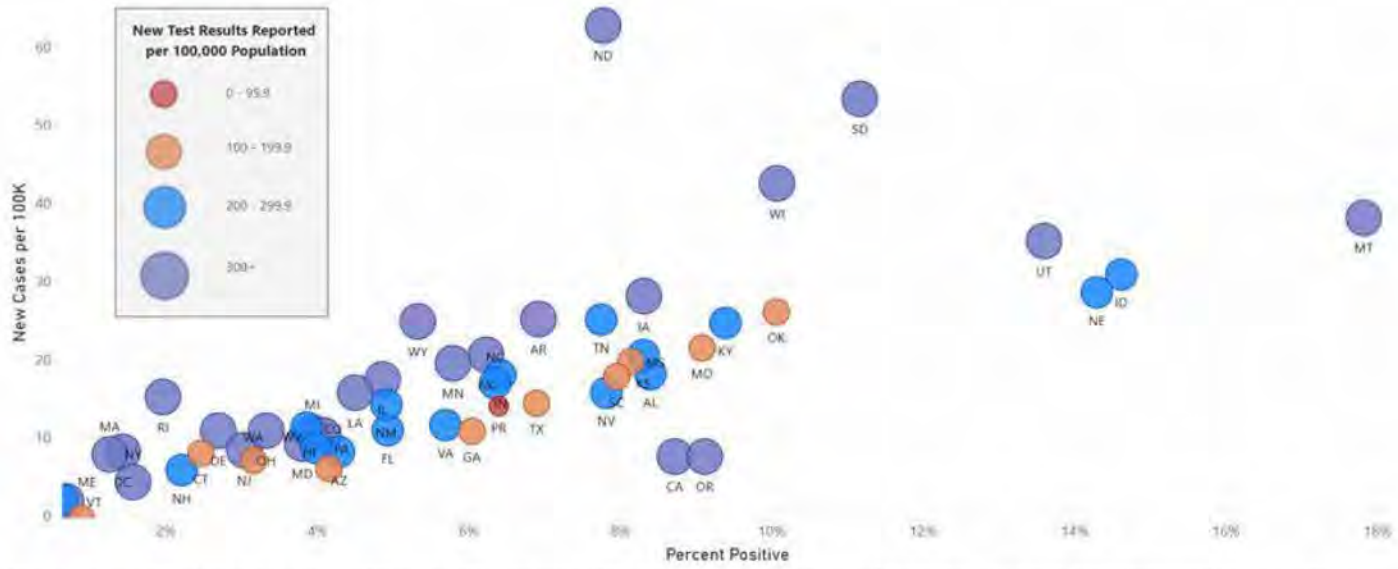
Comparison New Cases per 100,000 Population and Percent Positive Test Results, Last 7-Days 18

Data: 02 Oct 2020 – 08 Oct 2020 *Last Updated: 14 Oct 2020, 11:30*

Source: CDC/CPR/DEO Situational Awareness Branch (Data: DCIPHER & HHS Protect)

Seven-Day Average of New COVID-19 Cases Per 100K by Seven-Day Average of New Percentage of Positive Test Results* -- US States, Territories, & DC

02-Oct-20 DATA FROM | 08-Oct-20 DATA AS OF | 14-Oct-20 LAST UPDATED

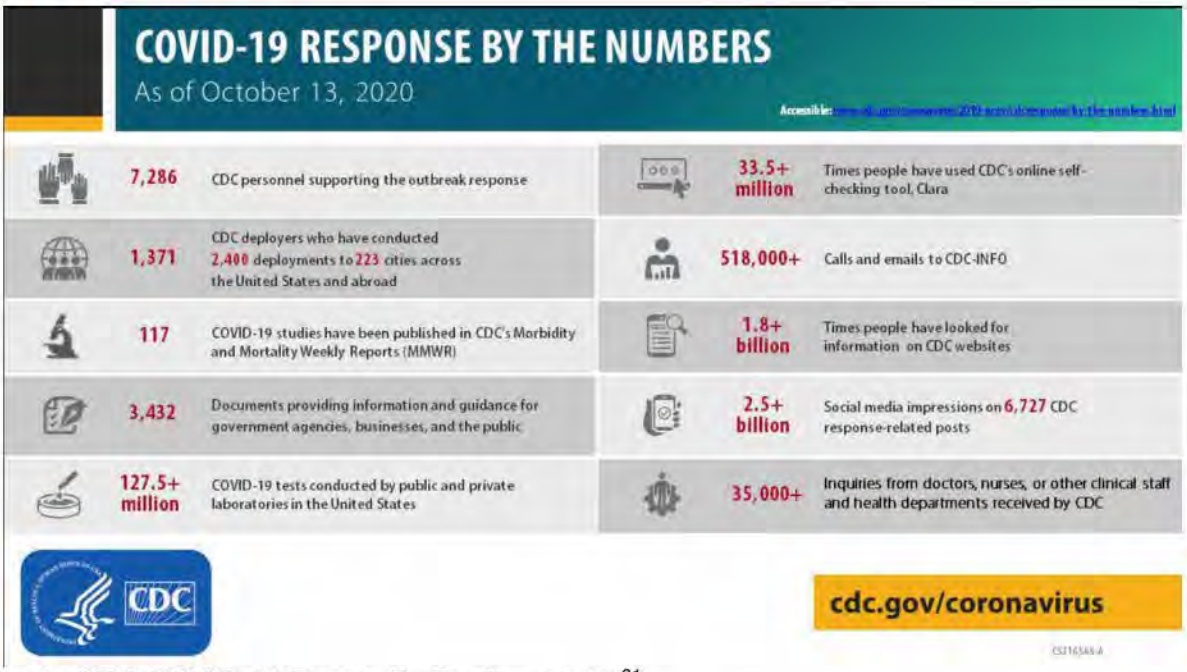


** Includes data through the most recent date for which all jurisdictions have reported laboratory data via HHS Protect (see Data As Of date). Laboratory testing data for previous days may be updated retrospectively by states as it becomes available. Figure represents official CDC US case counts for COVID-19, including both confirmed and probable cases, reviewed and validated by states and territories and posted daily on the CDC COVID-19 webpage (https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html). New test results reported per 100,000 population is based on a seven-day moving average. Laboratory Data unavailable for American Samoa, Commonwealth of Northern Marianas Islands, Palau, and Federated States of Micronesia.* ***For questions or comments, contact CDC/CPR/DEO Situational Awareness Public Health Scientists at eocsaanalyst@cdc.gov.***

CDC Response Statistics

CDC COVID-19 Response Activities by the Numbers

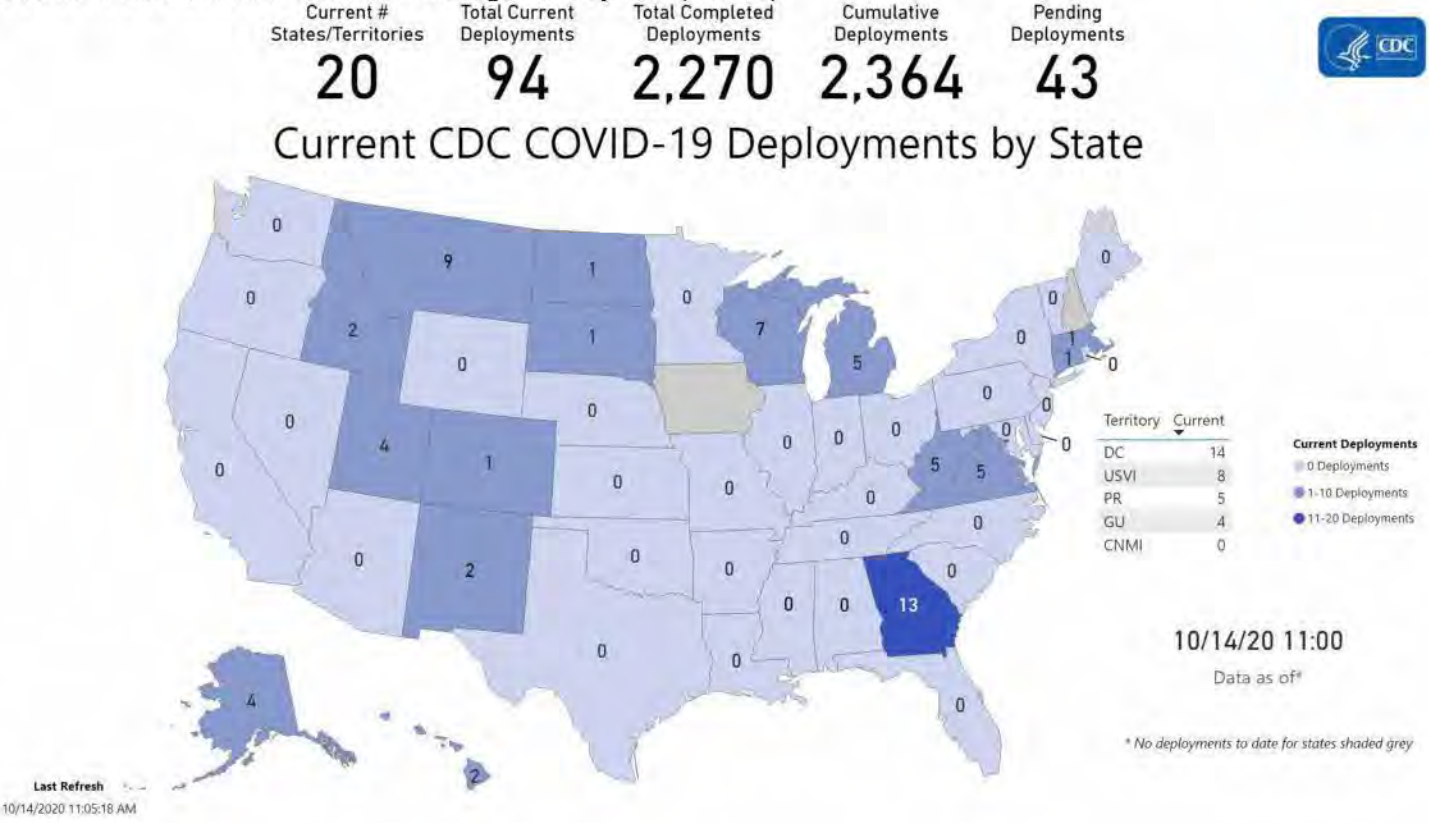
Data as of 13 Oct 2020
Source: COVID-19 By The Numbers



Deployments CDC COVID-19 Domestic Deployments [31]

Data as of 14 Oct 2020 *Last Updated: 14 Oct 2020, 11:05*
Source: CDC Personnel Workforce Management System (PWMS)

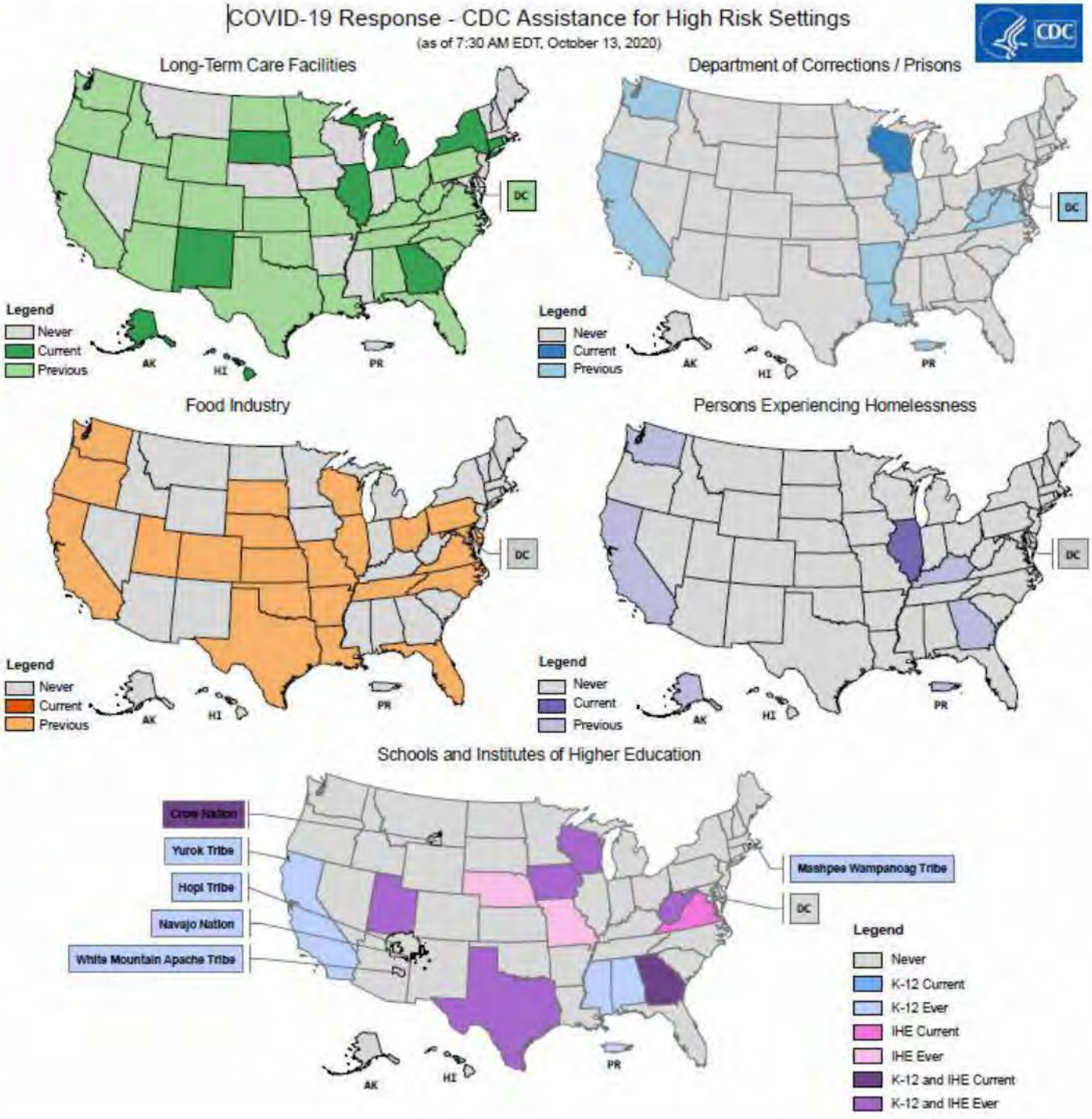
Current # States/Territories	Total Current Deployments	Total Completed Deployments	Cumulative Deployments	Pending Deployments
20	94	2,270	2,364	43



[31] A single person may have multiple deployments over time.

Health Department and High-Risk Setting Deployments[32, 33]

As of 14 Oct 2020, 09:00 unless otherwise indicated
Teams: 39 update teams Deployers: 101 deployers



[32] Field Staff and Remote Staff counts are current number of deployed staff of each type.

[33] These data represent deployed CDC field teams focusing on supporting health departments in state, tribal, local, and territorial jurisdictions. These health department deployments are a subset of the deployments represented in the graphic above. Each team aligns to a specific mission. The number of deployed staff per team may fluctuate throughout each mission. These data come from CDC Health Department Task Force records of teams deployed since 03 Apr 2020.

Summary of Health Department Support Teams [34]

Team Description	No. Teams	No. Staff
Currently Deployed	39	101
Field[35]	36	89
Remote	3	12
Returned[36]	308	1,397
Field	272	1,222
Remote	97	239
Cumulative[37]	345	1,498
Field	308	1,311
Remote	113	251

Subset of Deployment Teams with Work in High Risk Settings [38]

	Number of Teams		
	Currently Deployed	Returned	Total
Department of Corrections / Prisons	1	15	16
Early Childhood Education	0	1	1
Food Industry	0	27	27
Homeless Pop	3	12	15
Institutes of Higher Education	2	17	19
K-12 Schools	9	63	72
Long-Term Care Facilities	1	12	13
Total	**13**	**125**	**138**

Team and Staff Counts by Team Category

	No. Teams	No Staff
Currently Deployed	39	101
Outbreak Response	7	18
State Support	18	43
Study/Trial	8	27
Tribal Support	6	13

Health Department Support Deployments by Mission

Team ID	HHS Region	County	Start Date	End Date[39]	Current Staff	HHS CRAFT Team	Mission
AK-2	10	Anchorage	04/02/20	12/31/20	2	No	Provide case and contact investigation support to the Alaska state Department of Health for outbreak investigation in a long-term care facility.
AK-5	10	Anchorage	09/16/20	10/15/20	1	No	Characterize various COVID-19 outbreaks occurring in the state of Alaska.
Blackfeet-1	8	TBD	10/14/20	10/28/20	2	No	Tribal Support Section (TSS) Tribal Rapid Assessment Team (TRAT): Provide support and evaluate opportunities for CDC potential support.
CO-5	8	Adams; Arapahoe; Denver	09/15/20	11/27/20	2	No	Provide oversight and coordination to evaluate the sensitivity, utility, and acceptability of self-collected vs healthcare-professional-collected nasopharyngeal and saliva specimens for SARS-CoV-2 testing during community universal testing events.

[34] Field and remote staff may not sum to total because some teams or individuals could provide both field and remote support.
[35] Includes 2 teams with both field and remote staff.
[36] Includes 61 teams with both field and remote staff.
[37] Includes 74 teams with both field and remote staff.
[38] Total may differ from calculated sum in table due to some teams working in multiple high-risk settings.
[39] Represents projected date the deployment will end.

Team ID	HHS Region	County	Start Date	End Date[39]	Current Staff	HHS CRAFT Team	Mission
Crow-1	8	Yellowstone ; Treasure; Big Horn	08/10/20	11/03/20	4	No	Provide technical assistance and training in the following workstreams:1. ICS Structure 2. Messaging and Health Communications 3. Contact Tracing Support and Guidance 4. Epidemiology and Surveillance Support/Data Coordination and Analysis 5. Community Mitigation Plan 6. IPC for Traditional Practices
CT-2	1	TBD	10/13/20	10/15/20	1	No	Support work related to collection, collation, and management of data from long term care facilities (LTCFs).
DC-5	3	District of Columbia	08/27/20	10/25/20	1	No	Collect employee data on COVID-19 cases from healthcare facility employers including hospitals, nursing homes, outpatient facilities, group homes, ambulatory surgical centers, dentists, and others. Establish systems for data collection and analysis for automated reporting.
DC-7	3	TBD	10/05/20	10/19/20	7	No	Provide contact tracing and case investigation activities in the Washington, DC area.
GA-8	4	DeKalb; Fulton	08/04/20	12/15/20	5	No	Identify patients with COVID-19 among dialysis facilities in the state of Georgia and enroll consenting patients in the COVID-R dialysis project. Follow up with these patients with questionnaires and obtain specimens. Follow up will occur over a period of 42 days, every 3 days during the first 21 days after enrollment, and weekly after the first 21 days.
GA-10	4	Fulton	08/11/20	11/17/20	8	No	Evaluate the performance of healthcare personnel in diagnosis of SARS-CoV-2 via self-collected specimens with nasopharyngeal swabs.
GA-12	4	Fulton	09/10/20	10/31/20	2	No	Implement phone-based school surveys to collect and analyze aggregated data on school-associated COVID-19 cases and clusters weekly. Plan and conduct investigations in schools with and without COVID-19 cases among students, teachers and staff, to assess level of adherence to and impact of mitigation measures.
GA-14	4	TBD	09/28/20	10/28/20	2	No	CADENCE: COVID-19 Antigen Detection Efficacy in Nursing Homes and Caretakers. Conduct evaluation to assess performance of Point-of-Care antigen testing via repeat point prevalence surveys during ongoing outbreaks in nursing homes in GA. PPSs will confirm identification of patients and healthcare personnel with COVID-19 and identify any new cases among patients and HCP. PPSs will be conducted in nursing homes that have identified >3 positive cases in HCP or >1 nursing home onset resident case in the past 7-10 days. PPSs will be conducted every 3-7 days for a maximum of 3 times.
GU-1	9	TBD	10/07/20	11/17/20	4	No	Provide case investigation, contact tracing and support to Guam's lab and epidemiology unit.
HI-1	9	Hawaii; Kauai; Maui; Honolulu	08/24/20	11/13/20	1	No	Provide infection prevention and control support to the Hawaii Department of Health (HDOH).
IHS ABQ-1	TBD	Cibola	08/16/20	11/11/20	2	No	Incident Command (ICS) Support: IHS Albuquerque Area Office is requesting a 30-day deployment of a staff member who may serve in the IHS Albuquerque Area's Incident Command System (ICS) Team under the Command Staff position's "Safety/Infection Prevention Officer".
IHS SBT-1	10	Bingham; Bannock	08/13/20	10/28/20	2	No	Response Coordination and ICS Structure. CDC will provide onsite technical assistance and recommendations to stand up an incident command center for the Fort Hall IHS Service Center/Shoshone-Bannock Tribe's response to COVID-19. This assistance will help identify necessary agreements, duties, protocols, procedures, and coordinate relationships with county, state, and health care providers.
IL-1	5	Sangamon	04/05/20	10/17/21	0	No	Provide a wide range of epidemiological support to state health department for the COVID-19 response.
IL-4	5	Cook	05/18/20	01/17/21	0	No	Team is supporting development of a serologic surveillance testing plan, epidemiology, data management, and data analysis of COVID-19 data, including LTCFs and homeless shelters.
MI-5	5	TBD	10/13/20	10/15/20	1	No	Support work related to collection, collation, and management of data from long term care facilities (LTCFs).

Team ID	HHS Region	County	Start Date	End Date[39]	Current Staff	HHS CRAFT Team	Mission
MI-6	5	TBD	10/11/20	10/24/20	4	No	Support One Health (OHWG) efforts to investigate COVID-19 on farms with multiple animal species; train state public health and animal health partners to conduct One Health investigations on mink farms, and conduct training for farmers on worker safety.
MO-5	7	Cass; Platte; Clay; Jackson	08/12/20	10/16/20	1	No	Conduct case investigations, perform and systematize surveillance data entry, provide CDC and health department guidance to community via call center. Partner with and provide direct support to the Kansas City Health Department.
NM-5	6	Santa Fe	05/19/20	10/31/20	1	No	Support work related to data collection, collation, and management with respect to data from long term care facilities (LTCFs).
Northern Cheyenne-1	8	TBD	09/04/20	10/15/20	2	No	Provide technical assistance to Northern Cheyenne to support their COVID activity as it relates to Emergency Response and preparedness, case investigation and contact tracing, and epidemiology and surveillance. Technical assistance on communications, community mitigations and non-healthcare IPC related to worker safety will also be provided.
NY-3	2	New York	05/11/20	10/31/20	2	No	Support the city by working with academic institutions, commercial labs, and the two public labs, by doing validation of lab-derived tests for massive scale-up of testing.
NY-6	2	TBD	10/13/20	10/15/20	1	No	Support work related to collection, collation, and management of data from long term care facilities (LTCFs).
PR-4	2	San Juan	07/15/20	02/06/21	7	No	Establish a COVID-19 community cohort study with the CDC Dengue Branch laboratory in Puerto Rico.
SD-7	8	TBD	10/13/20	10/15/20	1	No	Support work related to collection, collation, and management of data from long term care facilities (LTCFs).
Spirit Lake-1	8	TBD	09/13/20	10/31/20	1	No	Assist the Spirit Lake Tribe COVID-19 response and mitigate the impact of SARS-CoV2.
TX-4	6	Harris	07/14/20	12/10/20	1	No	Support data analytics, forecasting, and surveillance to better characterize recent transmission and inform response decisions.
USVI-4	2	St. Croix; St. Johns; St. Croix; St. Thomas	08/31/20	10/23/20	1	No	Provide Spanish and French/creole speaking contact tracers to support the COVID efforts in USVI through a remote location for 30 days.
USVI-5	2	TBD	09/24/20	11/22/20	7	No	Support the epi/surveillance mission, enhance the capacity of the laboratory mission, and increase capacity to support the emergency management of the COVID-19 response.
UT-5	8	Salt Lake	08/28/20	10/31/20	1	No	Identify gaps is protective policies/procedures that relate to risk of COVID outbreaks.
UT-6	8	TBD	10/12/20	10/30/20	2	No	Evaluate the sensitivity and specificity of queries for coronavirus-like illness (CLI) or influenza-like illness (ILI) from healthcare records in two facilities; identify methodologies to improve the queries of chief complaint text to better differentiate COVID-19 from influenza.
UT-7	8	TBD	09/30/20	10/16/20	2	No	OHWG: Support an ongoing public health investigation for the One Health aspects of COVID-19 on multiple farm premises with multiple animal species.
VA-12	3	TBD	10/05/20	11/01/20	5	No	Support state in conducting contact tracing.
WI-10	5	TBD	10/14/20	11/13/20	1	No	Conduct a study on the effectiveness of the city's mask mandate and determine the mandate's contribution to the decline in positivity rate from ~10% when the mandate was implemented to ~5% currently.
WI-13	5	TBD	10/06/20	10/20/20	5	No	Investigate outbreak at the Kettle Moraine Correctional Institution and investigate the source of the outbreak (single introduction or multiple). Determine how to prevent similar outbreaks in other correctional facilities in WI. Provide guidance to the WI Department of Corrections on infection prevention and control in the context of a correctional facility.
WI-14	5	TBD	10/11/20	10/24/20	3	No	Support One Health (OHWG) efforts to investigate COVID-19 on farms with multiple animal species; train state public health and animal health partners to conduct One Health investigations on mink farms, and conduct training for farmers on worker safety.

Team ID	HHS Region	County	Start Date	End Date[39]	Current Staff	HHS CRAFT Team	Mission
WV-2	3	Monongalia County	07/23/20	12/30/20	6	No	Identify conditions that would propagate disease transmission leading to cluster or outbreak in the community and conduct case investigation and contact tracing to detect any evidence of human-to-human COVID-19 transmission among contacts. Reduce human-to-human transmission, prevent outbreaks, and delay the spread of disease.

CDC Website Updates – COVID-19 Response[40]

As of 14 Oct 2020, 08:00

New/Updated Guidance, Recommendations, Considerations

- 8 Things to Know about Vaccine Planning
- Additional Tools and Resources
- Cases & Deaths by County
- Cases in the U.S.
- Frequently Asked Questions about COVID-19 Vaccination
- Vaccines
- Your Health

New/Updated Webpages

- COVID-19 Travel Recommendations by Country
- Elastomeric Respirators: Strategies During Conventional and Surge Demand Situations
- Ensuring the Safety of COVID-19 Vaccines in the United States
- Holiday Celebrations
- How CDC Is Making COVID-19 Vaccine Recommendations
- Interim Considerations for K-12 School Administrators for SARS-CoV-2 Testing
- Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists

New MMWR Publications

- Characteristics Associated with Adults Remembering to Wash Hands in Multiple Situations Before and During the COVID-19 Pandemic — United States, October 2019 and June 2020
- Trends in COVID-19 Incidence After Implementation of Mitigation Measures — Arizona, January 22–August 7, 2020
- Adolescent with COVID-19 as the Source of an Outbreak at a 3-Week Family Gathering — Four States, June–July 2020
- Case Series of Multisystem Inflammatory Syndrome in Adults Associated with SARS-CoV-2 Infection — United Kingdom and United States, March–August 2020
- COVID-19 Science Update released: October 13, 2020

[40]Updates since last report. See additional resources at CDC COVID-19 What's New, Morbidity and Mortality Weekly Report Publications, Emerging Infectious Disease Publications, Preventing Chronic Disease Publications, CDC COVID-19 Science Updates, Guidance Documents, Health Alert Network (HAN) and Communication Resources.

International Updates

WHO Epidemiological Update

WHO Global Cases and Deaths

Data: 23 Jan 2020 – 14 Oct 2020 *Last Updated: 14 Oct 2020 11:07 CEST*
Source: WHO Coronavirus Disease (COVID-19) Dashboard

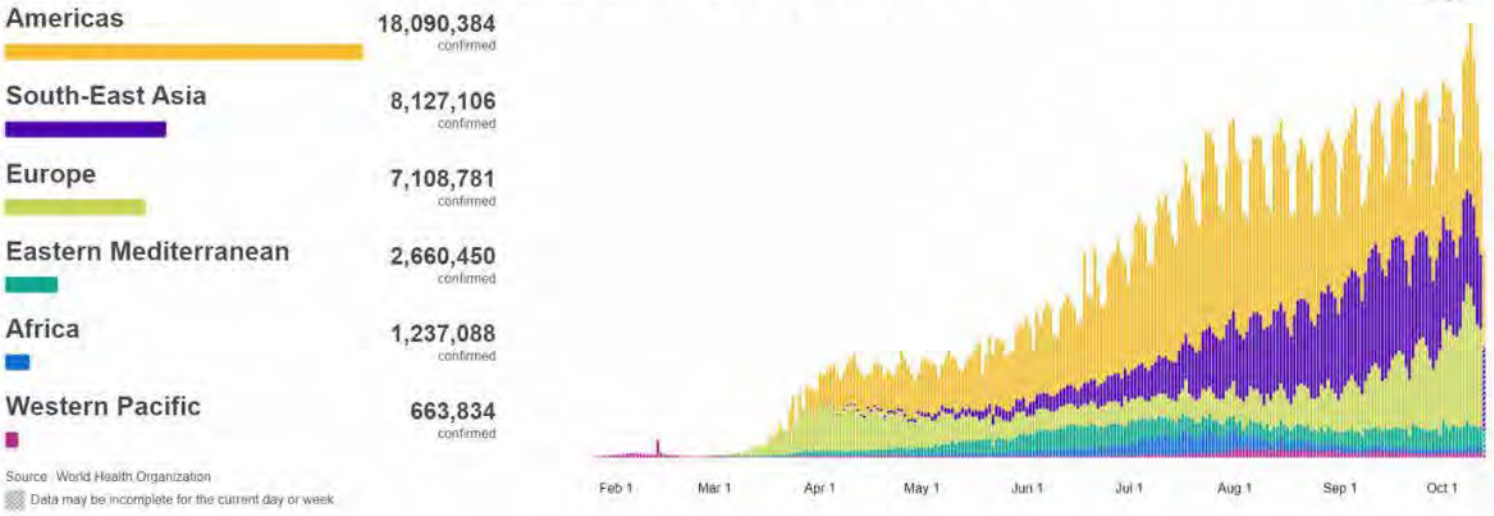
WHO Coronavirus Disease (COVID-19) Dashboard
Global Cases and Deaths
Data Last Updated: 14 Oct 2020 11:07 CEST

Cases		Deaths	
Cumulative Total	**Newly Reported Last 24 Hours**	**Cumulative Total**	**Newly Reported Last 24 Hours**
37,888,384	274,967	1,081,868	3,915

Global Epidemic Curve of Confirmed COVID-19 Cases by Date of Report and WHO Region

Data: 23 Jan 2020 – 14 Oct 2020 *Last Updated: 14 Oct 2020 11:07 CEST*
Source: WHO Coronavirus Disease (COVID-19) Dashboard

WHO Coronavirus Disease (COVID-19) Cases by WHO Region
Data last updated: 2020/10/14, 11:07am CEST



Global Epidemic Curve of Confirmed COVID-19 Deaths by Date of Report and WHO Region

Data: 23 Jan 2020 – 14 Oct 2020 *Last Updated: 14 Oct 2020 11:07 CEST*

Source: WHO Coronavirus Disease (COVID-19) Dashboard