

DALLAS COUNTY KEY COVID-19

RESPONSE METRICS/ INDICATORS

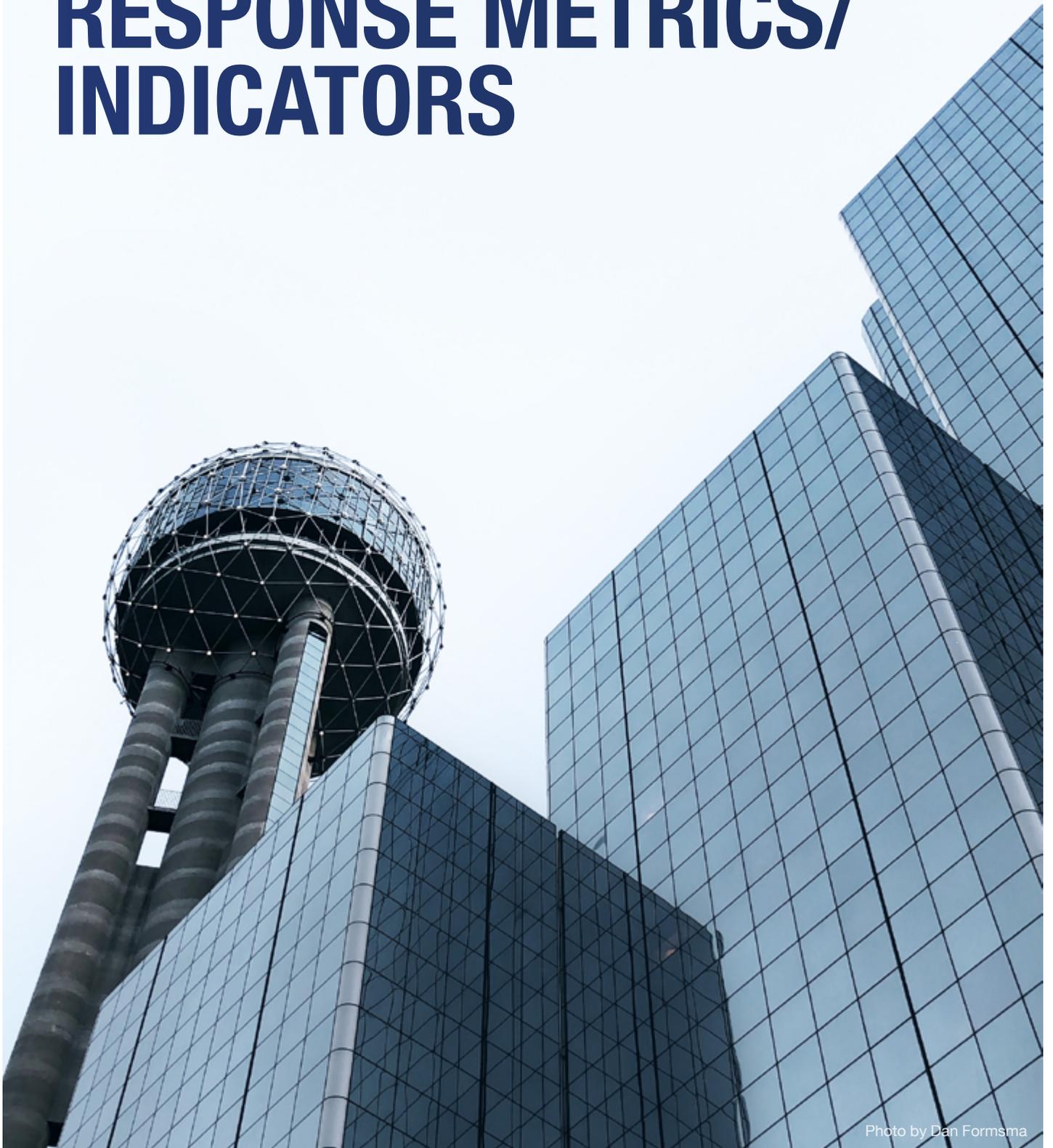


Photo by Dan Formsma

DALLAS COUNTY KEY COVID-19 RESPONSE METRICS/INDICATORS

The updated Dallas County metrics/indicators are based on new knowledge and information that continues to emerge and enhance our understanding of how to assess the Dallas County COVID-19 response. These metrics/indicators are based on information from Resolve to Save Lives, COVID Local, their collaborators, and numerous other sources and will provide the framework for determining how and when to relax or strengthen activities and interventions. Essentially, they will help assess the effectiveness of the Dallas County COVID-19 Response. The Public Health Committee utilizes the metrics/indicators to assist in determining the risk of COVID-19 transmission within the county. Each set of metrics/indicators builds on prior core metrics and continues to use the Dallas County “stoplight” guidance system which includes four phases/levels of COVID-19 transmission risk: **RED**, **ORANGE**, **YELLOW**, and **GREEN**.

These metrics are used to guide decision making and are not exhaustive and do not replace the collective experience of the physicians, healthcare leaders, epidemiology, infectious diseases, and public health experts that make up the committee. These metrics contain both quantitative and qualitative measures, underscoring the ongoing importance of relying on local expertise, current data, and data trends to understand the dynamics of the COVID-19 epidemic. For qualitative

metrics at least two separate information sources are referenced. Meeting all metrics is not required for transitions from one phase to another, and the relative importance of some metrics may depend on the phase or stage of risk. Data are obtained from the most robust sources available, which continue to change. Sources include Dallas County Health and Human Services (DCHHS indicated by *), Texas Department of State Health Services (DSHS indicated by ^), and the Dallas Fort Worth Hospital Council and North Central Texas Trauma Resource Advisory Council (DFWHC/RAC indicated by **). For several metrics, data are obtained from both DCHHS and DFWHC indicated by (***)

The Committee strives for transparency in providing updates to the public. Making these metrics available to inform the public of key indicators is part of this process. As we continue to move through this unprecedented epidemic and response, the Committee will continue to assess new information as it becomes available to make the best recommendations to protect the health and safety of Dallas County residents. Impacting the course of this pandemic is a shared responsibility. Wearing facial coverings/masks and complying with other guidance and recommendations, such as quarantine and isolation, are important ways the public can reduce the impact of COVID-19.



Photo by Ramiro Olivares

DALLAS COUNTY KEY COVID-19 RESPONSE METRICS/INDICATORS: ASSESSMENT METHODOLOGY

The Dallas County metrics/indicators are assessed by the Public Health Committee weekly. The committee reviews 14 or 21 days of data as applicable for each metric. For example, some metrics require a lag to account for reporting delays. In these cases the committee reviews 21 days of data excluding the most recent 7 days, which do not represent complete data. Moves down on the risk scale will not occur more frequently than every 21 days to allow time to evaluate impact of any changes. Moving down a level requires 75% or more of all metrics meeting that level, AND these core hospitalization metrics must be met:

- A **decrease** in COVID-19 **hospitalizations per day** (census) reflected in a **7-day rolling average over 14 days**.
- Sustained **decline** in confirmed **COVID-19 hospital admissions** - trending down over **14 days as reflected in the 7-day rolling average**

In addition, metrics need to be met in at least 4 of 5 categories and 6 of 7 metrics in the infection rate categories to ensure that the spectrum of impact of COVID is accounted for and that vulnerable populations are accounted for in any considered change. We will include measures of the epidemic dynamics such as the doubling time or R0

or Rt as needed. Metrics that do not have a reliable data source will not be included until the data source is identified.

Decisions to move up a level, for example from **YELLOW** to **ORANGE**, will be made on no less than a 7-day period of time and will evaluate the trends with 7-21 days of data. Moving up a level requires 50% of the metrics meeting the higher level. Changes towards a higher level of risk must be considered on a shorter timeframe because rapid response and behavior change is critical to reducing the escalation of COVID-19 spread in communities.

As has been highlighted by DCHHS, DSHS, and other sources, from time to time, there may be reporting errors or other inconsistencies that require further data review to appropriately respond to the situation. This should become less frequent as federal, state, and local data management systems improve and are linked.

We strongly suggest that individuals, businesses, schools, and other entities move forward cautiously with the change in recommended activities in the lower risk levels. For example, upon a move to orange, organizations may wish to phase in increased capacity to allow staff and patrons time to adjust and ensure safe practices can be maintained.



Photo by Alex Hockett

High Community Risk for COVID-19 Transmission:
Phase 1

Moderate Community Risk for COVID-19 Transmission:
Thresholds to Enter Phase 2

Low Community Risk for COVID-19 Transmission:
Thresholds to Enter Phase 3

New Normal Risk for COVID-19 Transmission:
Thresholds to Enter Phase 4

COVID-19 Infection Rate

Stay at home - Stay safe; Maximum physical distancing; Universal masking; Frequent hand hygiene.

Metrics/indicators here are higher than those listed in the subsequent phases and represent situations where there is uncontrolled transmission within the community, inadequate adoption of necessary public health measures, or inadequate resources to manage the response.

Sustained decline in daily confirmed and probable COVID-19 cases for 14 consecutive days, as reflected in the 7-day rolling average with a 7-day lag*

Confirmed and probable cases less than 10 cases per 100,000 population or 270 cases per day over 14 consecutive days with a 7-day lag*

Less than 10% of tests conducted over 14 days are positive for COVID-19⁰

Sustained decline in suspected and confirmed COVID-19 illness seen in the emergency department-trending down over 14 days as reflected in the 7-day rolling average**

Decrease in confirmed COVID-19 hospitalizations per day (census) reflected in a 7-day rolling average over 14 days**

Sustained decline in confirmed COVID-19 hospital admissions - trending down over 14 days as reflected in the 7-day rolling average**

Sustained decrease in COVID-19 confirmed and probable deaths per capita rates; 7-day rolling average over 14 days with a 7-day lag&*

Continued decline in daily confirmed and probable COVID-19 cases over 14 days as reflected in the 7-day rolling average with a 7-day lag*

Confirmed and probable cases less than 5 cases per 100,000 population or 135 cases per day over 14 consecutive days with a 7-day lag*

Less than 5% of tests conducted over 14 days are positive for COVID-19⁰

Sustained decline in suspected and confirmed COVID-19 illness seen in the emergency department-trending down over 14 days as reflected in the 7-day rolling average**

Decrease in confirmed COVID-19 hospitalizations per day (census) reflected in a 7-day rolling average over 14 days**

Sustained decline in confirmed COVID-19 hospital admissions - trending down over 14 days as reflected in the 7-day rolling average**

Sustained decrease in COVID-19 confirmed and probable deaths per capita rates; 7-day rolling average over 14 days with a 7-day lag&*

Continued decline in daily confirmed and probable COVID-19 cases over 14 days as reflected in the 7-day rolling average with a 7-day lag*

Confirmed and probable cases less than 1 case per 100,000 population or 27 cases per day over 14 consecutive days with a 7-day lag*

Less than 1% of tests conducted over 14 days are positive for COVID-19⁰

Sustained decline in suspected and confirmed COVID-19 illness seen in the emergency department-trending down over 14 days as reflected in the 7-day rolling average**

Decrease in confirmed COVID-19 hospitalizations per day (census) reflected in a 7-day rolling average over 14 days**

Sustained decline in confirmed COVID-19 hospital admissions - trending down over 14 days as reflected in the 7-day rolling average**

Sustained decrease in COVID-19 confirmed and probable deaths per capita rates; 7-day rolling average over 14 days with a 7-day lag&*

Case & Contact Investigations

Stay at home - Stay safe; Maximum physical distancing; Universal masking; Frequent hand hygiene.

At least 40% of new cases are from identified contacts*

At least 60% of new cases are from identified contacts*

At least 80% of new cases are from identified contacts*

High Community Risk for COVID-19 Transmission:
Phase 1

Moderate Community Risk for COVID-19 Transmission:
Thresholds to Enter Phase 2

Low Community Risk for COVID-19 Transmission:
Thresholds to Enter Phase 3

New Normal Risk for COVID-19 Transmission:
Thresholds to Enter Phase 4

Diagnostic Testing & Surveillance

Stay at home - Stay safe; Maximum physical distancing; Universal masking; Frequent hand hygiene.

Metrics/indicators here are higher than those listed in the subsequent phases and represent situations where there is uncontrolled transmission within the community, inadequate adoption of necessary public health measures, or inadequate resources to manage the response.

All symptomatic, asymptomatic, and high-risk individuals or contacts can access testing (qualitative)***

Tests are readily available for all essential personnel (qualitative)***

Adequate supply of equipment, reagents, and testing supplies (qualitative)***

Health Department receives 80% of test results within 48 hours (hospital and commercial labs)*

All symptomatic, asymptomatic, and high-risk individuals or contacts can access testing (qualitative)***

Tests are readily available for all essential personnel (qualitative)***

Adequate supply of equipment, reagents, and testing supplies (qualitative)***

Health Department receives 90% of test results within 48 hours (hospital and commercial labs)*

All symptomatic, asymptomatic, and high-risk individuals or contacts can access testing(qualitative)***

Tests are readily available for all essential personnel (qualitative)***

Adequate supply of equipment, reagents, and testing supplies (qualitative)***

Health Department receives the majority of test results within 24 hours and 95% of tests within 48 hours (hospital and commercial labs)*

Healthcare Readiness

Stay at home - Stay safe; Maximum physical distancing; Universal masking; Frequent hand hygiene.

Metrics/indicators here are higher than those listed in the subsequent phases and represent situations where there is uncontrolled transmission within the community, inadequate adoption of necessary public health measures, or inadequate resources to manage the response.

COVID-19 patients occupy <20% med/surg (ward) beds and <30% of ICU beds with a 7-day rolling average over 14 days**

Sufficient PPE for majority of healthcare facilities, at-risk facilities, and essential personnel for 4 weeks (qualitative)***#

80% of acute-care hospitals with more than 250 beds have adequate staffing without RAC/ state support for care (qualitative)***

COVID-19 patients occupy <15% med/surg (ward) beds and <25% of ICU beds with a 7-day rolling average over 14 days**

Sufficient PPE for majority of healthcare facilities, at-risk facilities, and essential personnel for at least 6 weeks (qualitative)***#

80% of acute-care hospitals with more than 250 beds have adequate staffing without RAC support for care (qualitative)***

COVID-19 patients occupy <10% med/surg (ward) beds and <20% of ICU beds with a 7-day rolling average over 14 days**

Sufficient PPE for majority of healthcare facilities, at-risk facilities, and essential personnel for at least 90 days (qualitative)***#

80% of acute-care hospitals with more than 250 beds have adequate staffing without RAC support for care (qualitative)***

High Community Risk for COVID-19 Transmission:

Phase 1

Moderate Community Risk for COVID-19 Transmission:

Thresholds to Enter Phase 2

Low Community Risk for COVID-19 Transmission:

Thresholds to Enter Phase 3

New Normal Risk for COVID-19 Transmission:

Thresholds to Enter Phase 4

Protecting at-Risk Populations

Stay at home - Stay safe; Maximum physical distancing; Universal masking; Frequent hand hygiene.

Metrics/indicators here are higher than those listed in the subsequent phases and represent situations where there is uncontrolled transmission within the community, inadequate adoption of necessary public health measures, or inadequate resources to manage the response.

Sufficient testing, quarantine, and isolation in long-term care facilities (qualitative)***

Decreasing long-term care, schools, and other congregate facilities (homeless shelters, correctional facilities), and essential workplace (e.g. meatpacking) outbreaks with COVID-19 cases and deaths in residents and staff—report aggregated numbers*

Sufficient PPE for majority long-term care facilities and essential personnel for 2 weeks (qualitative)***

80% of long-term care facilities have adequate staffing without RAC/ state support for care (qualitative)**

>80% of people wearing masks correctly in public indoor settings (e.g., mass transit, shopping), based on direct observation by a standard, consistent method, by week

Sufficient testing, quarantine, and isolation in long-term care facilities (qualitative)***

Decreasing long-term care, schools, and other congregate facilities outbreaks with COVID-19 cases and deaths in residents and staff—report aggregated numbers*

Sufficient PPE for majority healthcare facilities, at-risk facilities, and essential personnel for at least 3 weeks (qualitative)***

80% of long-term care facilities have adequate staffing without RAC/ state support for care (qualitative)**

>80% people wearing masks correctly in public indoor settings (e.g., mass transit, shopping), based on direct observation by a standard, consistent method, by week

Sufficient testing, quarantine, and isolation in long-term care facilities (qualitative)***

Decreasing long-term care, schools, and other congregate facilities outbreaks with COVID-19 cases and deaths in residents and staff—report aggregated numbers*

Sufficient PPE for long-term care facilities, and essential personnel for at least 45 days (qualitative)**

>80% people wearing masks correctly in public indoor settings (e.g., mass transit, shopping), based on direct observation by a standard, consistent method, by week

COVID-19 RESPONSE METRICS/INDICATORS FOR PHASE LEVEL: COMMENTS

^oTests that are included are those used for diagnosis of acute or active infection such as PCR and antigen tests.

[&]Deaths are reported by date of death.

[#]Including supplies on hand and projected for delivery.

Cases and % positivity results are reported by date collected (not date reported).

Metrics include confirmed and probable cases as defined by DCHHS.

REFERENCES:

<https://www.covidlocal.org/metrics/>

<https://preventepidemics.org/covid19/resources/indicators/>

GLOSSARY:

PPE = Personal Protective Equipment

RAC = North Central Texas Trauma Regional Advisory Council



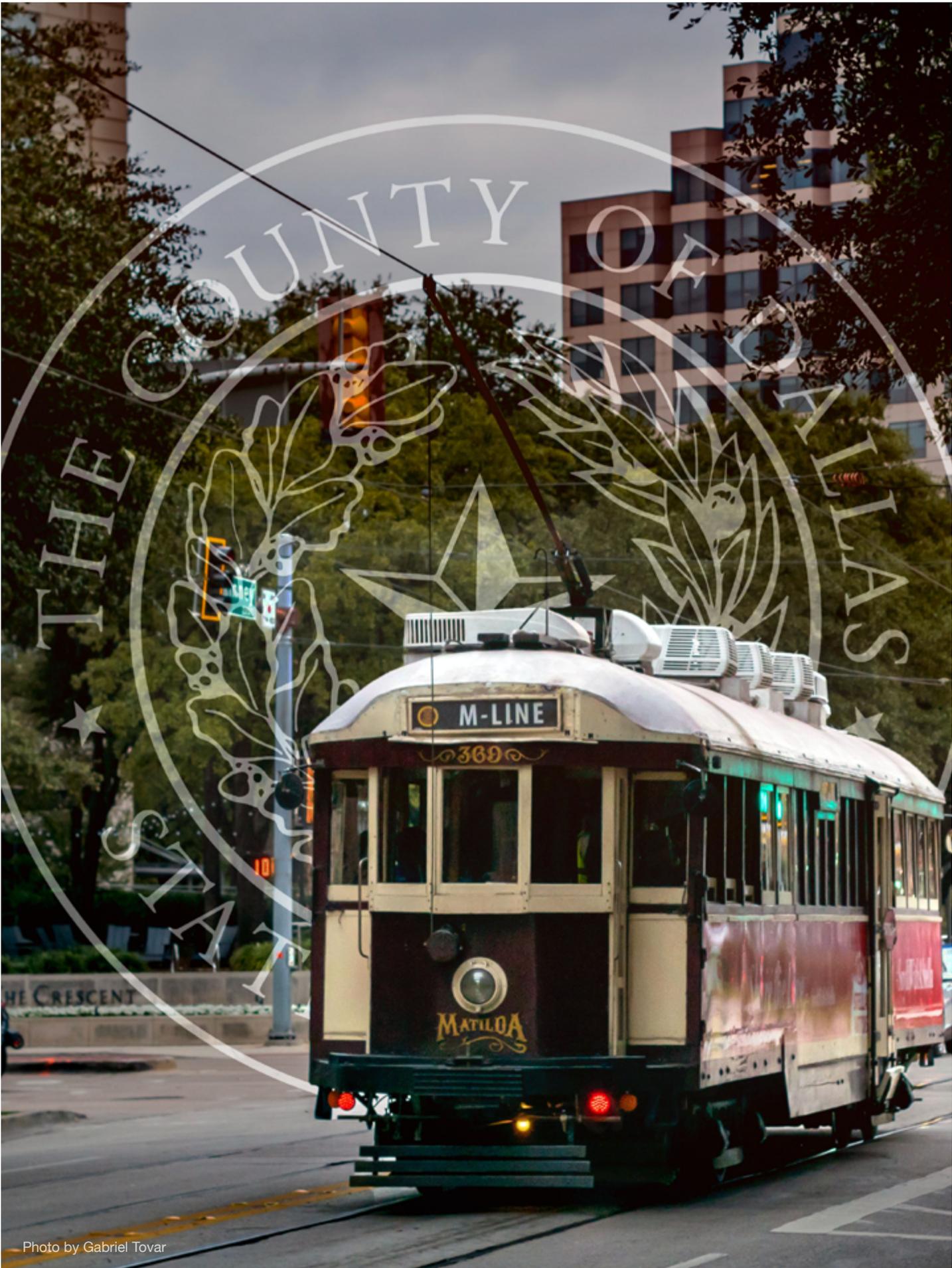


Photo by Gabriel Tovar