



# MISSOURI

STATE REPORT

01.17.2021

Issue 31

## SUMMARY

- Missouri is in the red zone for cases, indicating 101 or more new cases per 100,000 population, with the 43rd highest rate in the country. Missouri is in the red zone for test positivity, indicating a rate at or above 10.1%, with the 16th highest rate in the country.
- Missouri has seen a decrease in new cases and a decrease in test positivity.
- The following three counties had the highest number of new cases over the last 3 weeks: 1. St. Louis County, 2. Jackson County, and 3. St. Charles County. These counties represent 40.2% of new cases in Missouri.
- 83% of all counties in Missouri have moderate or high levels of community transmission (yellow, orange, or red zones), with 76% having high levels of community transmission (red zone).
- During the week of Jan 4 - Jan 10, 24% of nursing homes had at least one new resident COVID-19 case, 40% had at least one new staff COVID-19 case, and 10% had at least one new resident COVID-19 death.
- Missouri had 261 new cases per 100,000 population, compared to a national average of 478 per 100,000.
- Current staff deployed from the federal government as assets to support the state response are: 93 to support operations activities from FEMA and 5 to support operations activities from ASPR.
- Between Jan 9 - Jan 15, on average, 242 patients with confirmed COVID-19 and 215 patients with suspected COVID-19 were reported as newly admitted each day to hospitals in Missouri. This is a decrease of 8% in total new COVID-19 hospital admissions.
- As of Jan 15, 528,800 vaccine doses have been distributed to Missouri. 153,664 individuals have received at least the first dose and 36,525 have received a full course.

## RECOMMENDATIONS

- This is the last state report from the team of Birk, Zaidi, Vitek, Cavanaugh, and Crabtree. Each state was assigned to an individual throughout, and they were responsible for reviewing weekly state-level data, local news reports, and news conferences and writing state-specific recommendations. In addition, we had an amazing data team, including Wickwire, Gastfriend, and the DSEW, who worked every weekend to ensure quality data for this report.
- I personally am grateful, along with Zaidi, to the Governors, Mayors, State Legislators, County Commissioners, Tribal Leaders, state and local health leadership, and hospital and community leaders from the 44 states that met with us during our travels. These direct on-the-ground learnings from you changed policy and programs. You showed us the barriers that needed to be addressed, and many of you provided us with solutions that we could feature in the weekly Governor's call from the White House. For example, Chicago has an excellent hospital dashboard where all hospitals transparently share available capacity to better serve residents; the Broad Institute which, even as a research institution, massively scaled testing for the state and for colleges in the Northeast.
- For this week's report, we wanted to summarize what we have learned from you over the past 11 months and the gaps we still see.
- **Overall, this fall and winter surge is more aggressive**, with more rapid community spread that will need to be continuously met with aggressive and escalating mitigation. We should not be reassured that we don't yet have significant spread from imported, more transmissible variants as early evidence may underestimate the current spread; we are likely to have our own, more transmissible variants, and our mitigation actions should reflect this potential reality. We should act as though we have more transmissible strains circulating. This surge has also been significantly longer (currently 3x as long as the spring and summer surge) in the time it's taking to reach a plateau and significantly more deadly. Although case fatality rates have declined for Americans identified with COVID-19 infections in those over 70, nearly 20% are hospitalized and nearly 10% succumb to this virus. We do see evidence of early stabilization of community spread, albeit at very high rates of transmission, and plateauing rates of new COVID-19 admissions in many parts of the United States. However, aggressive mitigation must continue to prevent a resurgence and to accelerate declines.
- This virus can be mitigated and community spread can be curtailed, but action needs to be taken before an increase in hospitalizations is seen; it needs to be more comprehensive and longer than the summer mitigation actions. Due to the significant asymptomatic contribution to community spread, the degree of underlying community infection is extensive by the time hospitalizations occur.
- **Granular data matters.** Use your data (test positivity, cases, hospitalizations, and deaths) in real-time for immediate action. Finding the specific areas of active community spread and intensifying actions (mitigation and testing) in those locations works.
- **Mask mandates work.** Ensuring effective behavioral change of masking requires constant reminders that can be continuously reinforced by working with retailers to require masking.
- During increased community spread, any indoor space where masks cannot be continuously worn must be substantially curtailed or closed; this includes bars, indoor dining, gyms, etc. as any unmasking indoors creates viral spreading events. We witnessed amazing, safe, "winterized" outdoor dining approaches in Philadelphia and other urban settings.
- **Personal gatherings** across families and friends indoors are key viral spreading events; continuous messaging of this risk to change behavior and of the importance of indoor masking is essential. Miami was unable to control the summer surge without changing this behavior. Messaging must constantly be updated and delivered through different platforms to ensure continuous behavior change and vigilance.
- **Proactive testing works** by finding the asymptomatic, silent infections. As learned from many colleges and universities, IHEs that proactively tested individuals independent of symptoms (requiring weekly or greater testing of the entire student body on and off campus) in addition to masking and physical distancing had the lowest rates of infections, often under 1% for the entire fall semester. Universities that tested the way we do in this country, focused on symptomatic testing and contact tracing as well as low-level voluntary surveillance testing, resulted in 8-14% of the student body infected. The difference resulted from finding and isolating asymptomatic individuals. The creation of young adult testing sites (for those under 40) that utilize antigen tests with immediate results will decrease community spread when added to current state and local testing approaches.
- **Proactive treatment works.** Americans with underlying conditions and those over 65 must know to test with any symptoms or known exposure to ensure rapid access to monoclonal antibodies which, when implemented, are associated with a significant decline in the rate of hospitalization and fatalities. Every hospital and physician must directly provide infusion clinics or know where to link patients. Increased PSAs and community awareness of this important therapy must be accelerated.
- **Proactive vaccination of those most vulnerable is critical.** Strict tiering and traditional models of vaccination are hindering access to and the impact of vaccination. Ensuring rapid and equitable immunization of those most vulnerable, creating mass vaccination sites, and ensuring specific access to rural and urban vulnerable populations are critical, as we have seen in West Virginia. Aggressive immunization of Tribal Nations and multigenerational households across the United States is essential.
- Pandemic levels remain high with COVID-related hospitalizations and ICU at near-peak levels and 40% of LTCF having COVID-positive staff. To reduce community spread, focus on finding asymptomatic individuals through testing those under 40.
- At universities, early trends are similar to fall semester; conduct mandatory weekly testing to identify asymptomatic cases and prevent transmission into the community.
- Specific, detailed guidance on community mitigation measures can be found on the [CDC website](#).

*The purpose of this report is to develop a shared understanding of the current status of the pandemic at the national, regional, state, and local levels. We recognize that data at the state level may differ from that available at the federal level. Our objective is to use consistent data sources and methods that allow for comparisons to be made across localities. We appreciate your continued support in identifying data discrepancies and improving data completeness and sharing across systems. We look forward to your feedback.*



COVID-19



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	STATE	STATE, % CHANGE FROM PREVIOUS WEEK	FEMA/HHS REGION	UNITED STATES		
NEW COVID-19 CASES (RATE PER 100,000)	16,006 (261)	-29%	45,235 (320)	1,568,368 (478)		
VIRAL (RT-PCR) LAB TEST POSITIVITY RATE	14.9%	-3.5%*	13.5%	12.2%		
TOTAL VIRAL (RT-PCR) LAB TESTS (TESTS PER 100,000)	62,101** (1,012**)	+4%**	272,190** (1,925**)	10,993,342** (3,349**)		
COVID-19 DEATHS (RATE PER 100,000)	339 (5.5)	-18%	949 (6.7)	22,402 (6.8)		
SNFs WITH ≥1 NEW RESIDENT COVID-19 CASE	24%	-5%*†	20%	29%		
SNFs WITH ≥1 NEW STAFF COVID-19 CASE	40%	-7%*†	38%	50%		
SNFs WITH ≥1 NEW RESIDENT COVID-19 DEATH	10%	-3%*†	11%	16%		
TOTAL NEW COVID-19 HOSPITAL ADMISSIONS (RATE PER 100 BEDS)	3,198 (21)	-8% (-6%)	6,043 (17)	156,174 (22)		
NUMBER OF HOSPITALS WITH SUPPLY SHORTAGES (PERCENT)	31 (27%)	+4% (+15%*)	123 (27%)	1,086 (21%)		
NUMBER OF HOSPITALS WITH STAFF SHORTAGES (PERCENT)	34 (30%)	+3% (+10%*)	75 (17%)	1,169 (23%)		
COVID-19 VACCINE SUMMARY	DOSES DISTRIBUTED		1ST DOSE ADMINISTERED		FULL COURSE ADMINISTERED	
	TOTAL	RATE PER 100,000	TOTAL	PERCENT OF ADULTS	TOTAL	PERCENT OF ADULTS
	528,800	8,615	153,664	3.2%	36,525	0.8%

\* Indicates absolute change in percentage points.

\*\* Due to delayed reporting, this figure may underestimate total diagnostic tests and week-on-week changes in diagnostic tests.

† 93% of facilities reported during the most current week.

**DATA SOURCES** – Additional data details available under METHODS

**Note:** Some dates may have incomplete data due to delays in reporting. Data may be backfilled over time, resulting in week-to-week changes.

**Cases and Deaths:** State values are calculated by aggregating county-level data from a CDC-managed dataset compiled from state and local health departments; therefore, the values may not match those reported directly by the state. Data is through 1/15/2021; previous week is 1/2 - 1/8.

**Testing:** CELR (COVID-19 Electronic Lab Reporting) state health department-reported data through 1/13/2021. Previous week is 12/31 - 1/6.

**SNFs:** Skilled nursing facilities. National Healthcare Safety Network. Data is through 1/10/2020, previous week is 12/28-1/3.

**Admissions:** Unified hospitalization dataset in HHS Protect. Totals include confirmed and suspected COVID-19 admissions.

**Shortages:** Unified hospital dataset in HHS Protect. Values presented show the latest reports from hospitals in the week ending 1/15/2021.

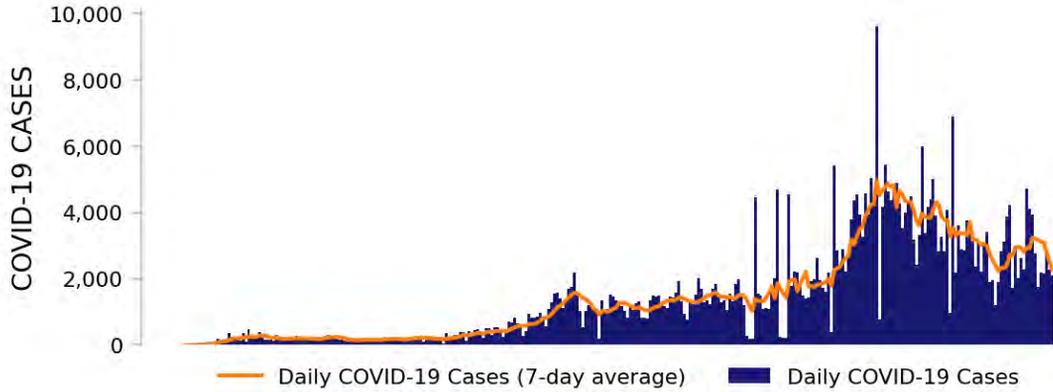
**Vaccinations:** [CDC COVID Data Tracker](#). Data includes both the Moderna and Pfizer BioNTech COVID-19 vaccines and reflects current data available as of 16:01 EST on 01/17/2021. Data last updated 06:00 EST on 01/15/2021. Adults is defined as the population 18 years old and older.



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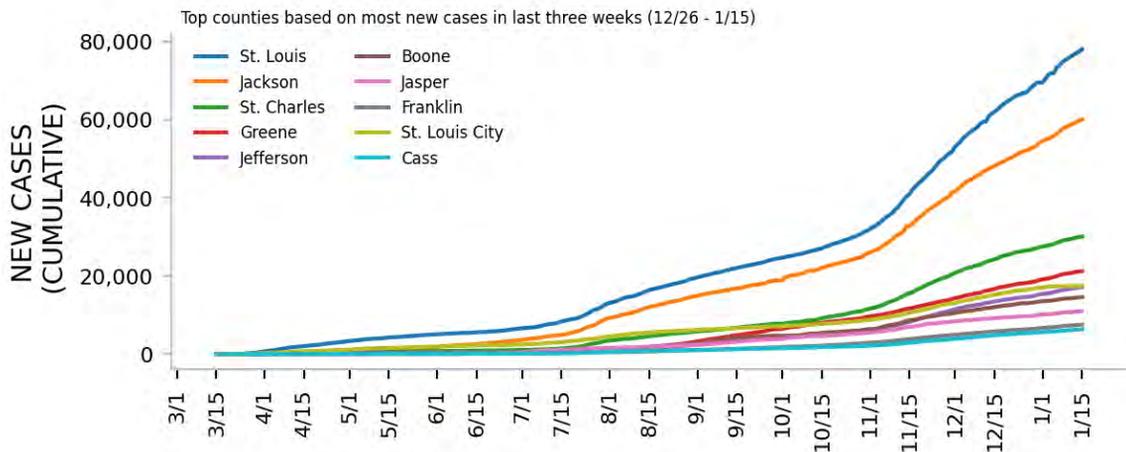
## NEW CASES



## TESTING



## TOP COUNTIES



**DATA SOURCES** – Additional data details available under METHODS

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**Testing:** HHS Protect laboratory data (provided directly to Federal Government from public health labs, hospital labs, and commercial labs) through 1/13/2021.

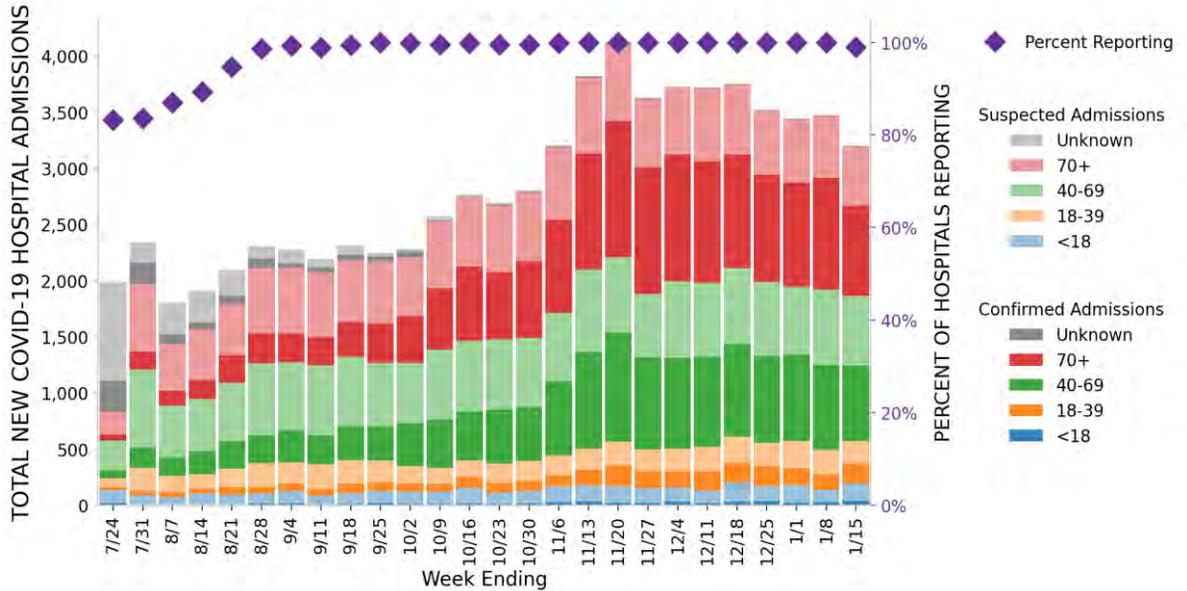


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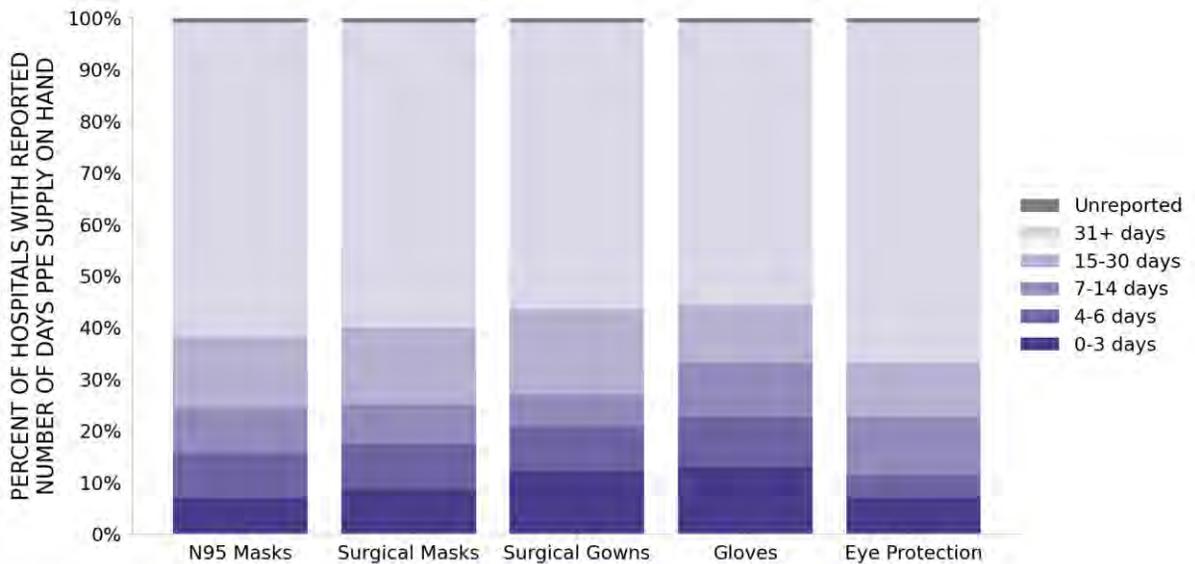
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115 hospitals are expected to report in Missouri

## HOSPITAL ADMISSIONS



## HOSPITAL PPE SUPPLIES



**DATA SOURCES** – Additional data details available under METHODS

**Hospitalizations:** Unified hospitalization dataset in HHS Protect. These data exclude psychiatric, rehabilitation, and religious non-medical hospitals. Hospitals explicitly identified by states/regions as those from which we should not expect reports were excluded from the percent reporting figure.

**PPE:** Unified hospitalization dataset in HHS Protect. These data exclude psychiatric, rehabilitation, and religious non-medical hospitals. Values presented show the latest reports from hospitals in the week ending 1/13/2021.



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## COVID-19 COUNTY AND METRO ALERTS\*

Top 12 shown in table (full lists below)

### METRO AREA (CBSA)

### COUNTIES

<b>LOCALITIES IN RED ZONE</b>	<b>24</b> ▼ (-1)	St. Louis Kansas City Springfield Columbia Joplin Jefferson City St. Joseph Cape Girardeau Sedalia Branson Poplar Bluff West Plains	<b>87</b> ▼ (-11)	St. Louis Jackson St. Charles Greene Jefferson Boone Jasper Franklin Cass Clay Christian Cole
<b>LOCALITIES IN ORANGE ZONE</b>	<b>0</b> ▼ (-1)	N/A	<b>7</b> ▲ (+3)	Barry Ray Benton Osage Madison Mississippi Dade
<b>LOCALITIES IN YELLOW ZONE</b>	<b>0</b> ▼ (-1)	N/A	<b>1</b> ▼ (-3)	St. Louis City
<b>Change from previous week's alerts:</b>		▲ Increase      ■ Stable      ▼ Decrease		

**All Red CBSAs:** St. Louis, Kansas City, Springfield, Columbia, Joplin, Jefferson City, St. Joseph, Cape Girardeau, Sedalia, Branson, Poplar Bluff, West Plains, Rolla, Kirksville, Mexico, Warrensburg, Fort Leonard Wood, Hannibal, Sikeston, Lebanon, Marshall, Kennett, Moberly, Fort Madison-Keokuk

**All Red Counties:** St. Louis, Jackson, St. Charles, Greene, Jefferson, Boone, Jasper, Franklin, Cass, Clay, Christian, Cole, Cape Girardeau, Buchanan, Pettis, Taney, Callaway, Platte, Webster, Lincoln, Camden, Newton, Howell, Phelps, Audrain, Johnson, Pulaski, Vernon, Butler, Adair, Scott, Laclede, Lawrence, Crawford, Lafayette, Saline, Warren, Stone, Washington, Wright, Marion, Miller, Dunklin, Clinton, McDonald, Bates, Livingston, Randolph, Henry, Texas, Macon, Stoddard, Moniteau, Morgan, Andrew, Pike, Cooper, Perry, Ste. Genevieve, New Madrid, Gasconade, Barton, Harrison, Ozark, Oregon, Grundy, Douglas, DeKalb, Wayne, Carroll, Ripley, Pemiscot, Gentry, Linn, Dent, Lewis, St. Clair, Daviess, Bollinger, Sullivan, Iron, Montgomery, Caldwell, Monroe, Clark, Shannon, Reynolds

\* Localities with fewer than 10 cases last week have been excluded from these alerts.

**Note:** Lists of red, orange, and yellow localities are sorted by the number of new cases in the last 3 weeks, from highest to lowest. Some dates may have incomplete data due to delays in reporting. Data may be backfilled over time, resulting in week-to-week changes.

**DATA SOURCES** – Additional data details available under METHODS

**Cases and Deaths:** State values are calculated by aggregating county-level data from a CDC-managed dataset compiled from state and local health departments; therefore, the values may not match those reported directly by the state. Data is through 1/15/2021.

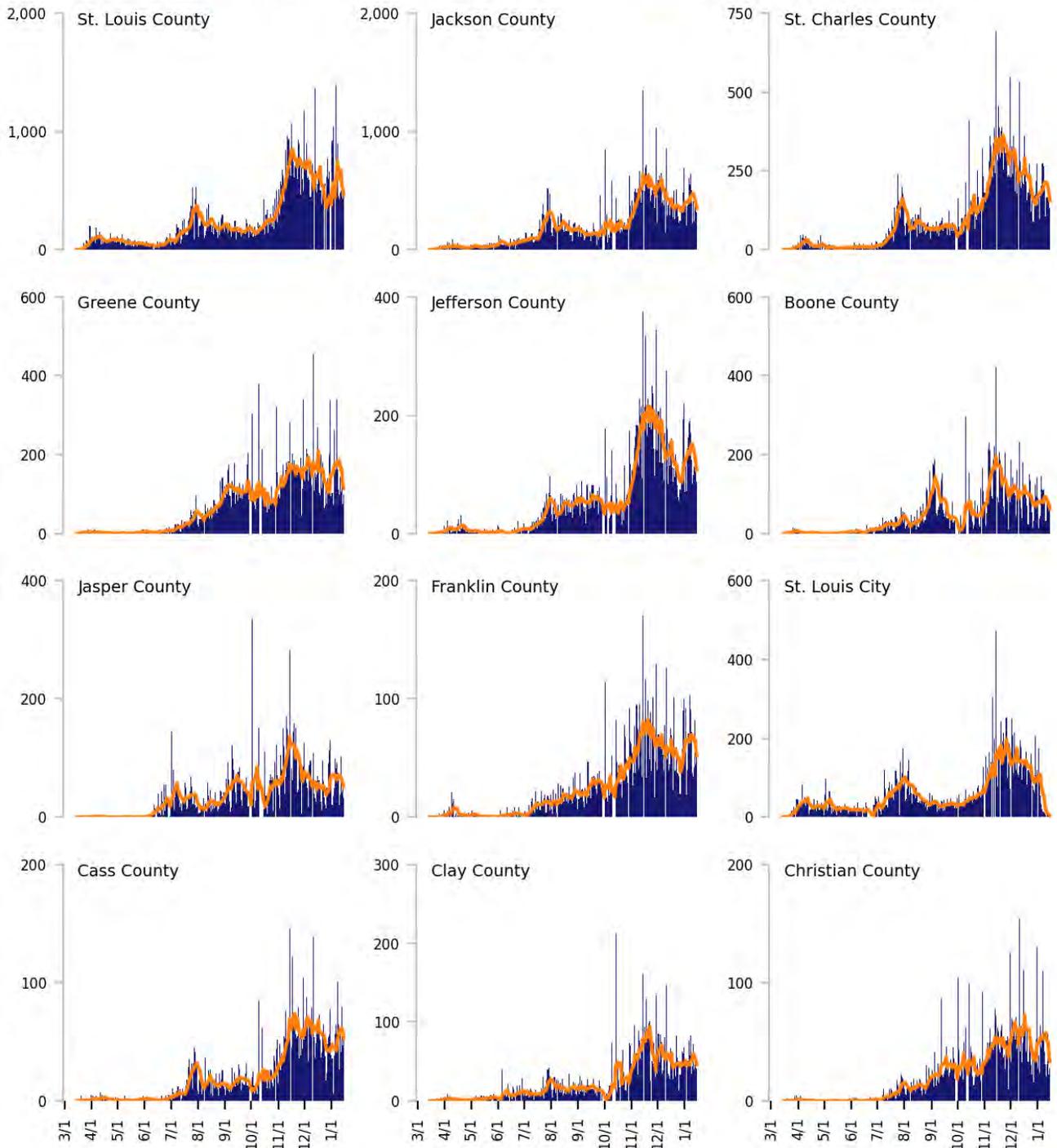
**Testing:** HHS Protect laboratory data (provided directly to Federal Government from public health labs, hospital labs, and commercial labs) through 1/13/2021.



# Top 12 counties based on number of new cases in the last 3 weeks

— Daily COVID-19 Cases (7-day average)    ■ Daily COVID-19 Cases

TOTAL DAILY CASES



**DATA SOURCES** – Additional data details available under METHODS

**Cases:** State values are calculated by aggregating county-level data from a CDC-managed dataset compiled from state and local health departments; therefore, the values may not match those reported directly by the state. Data is through 1/15/2021. Last 3 weeks is 12/26 - 1/15.

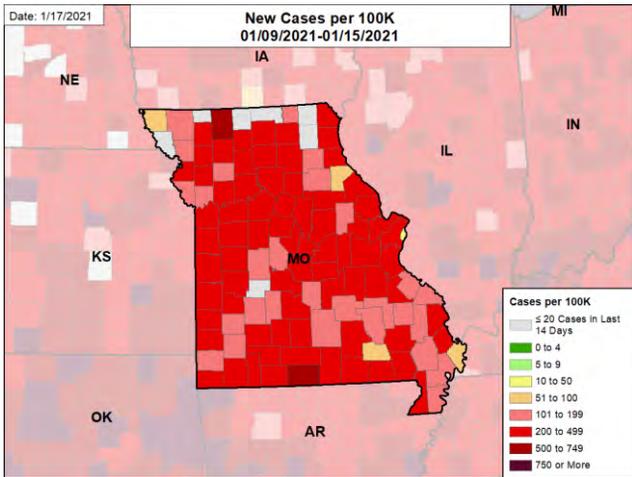


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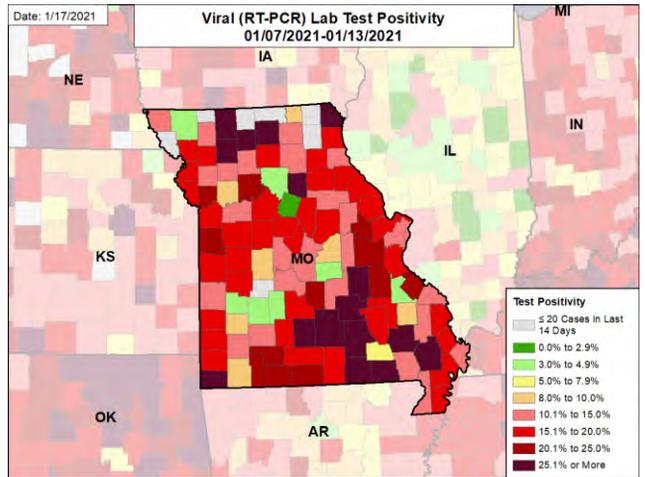
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## CASE RATES AND VIRAL LAB TEST POSITIVITY

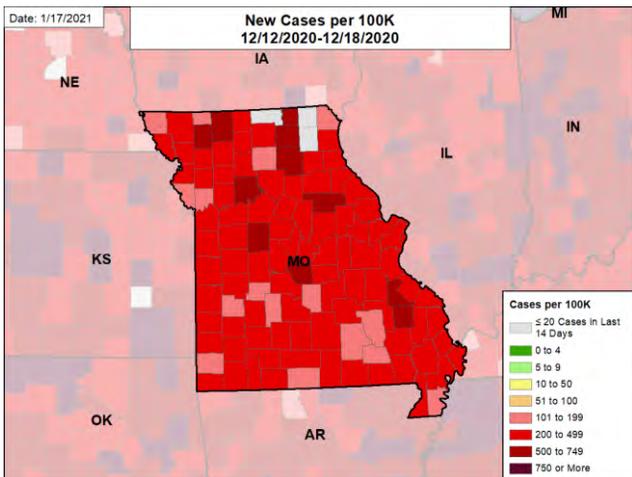
### NEW CASES PER 100,000



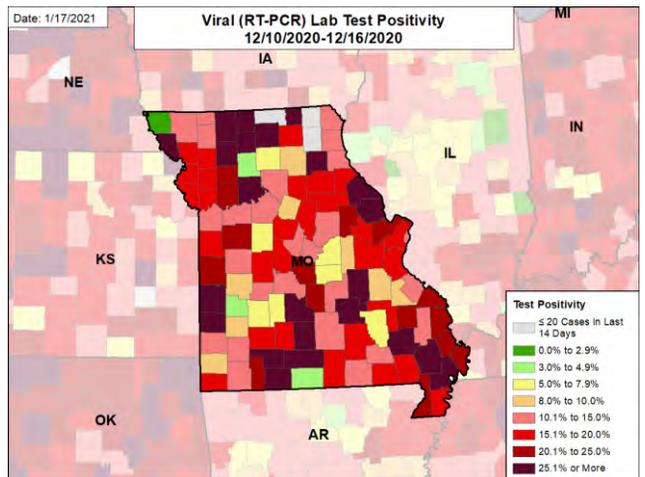
### VIRAL (RT-PCR) LABORATORY TEST POSITIVITY



### NEW CASES PER 100,000 ONE MONTH BEFORE



### VIRAL (RT-PCR) LABORATORY TEST POSITIVITY ONE MONTH BEFORE



#### DATA SOURCES – Additional data details available under METHODS

**Note:** Some dates may have incomplete data due to delays in reporting. Data may be backfilled over time, resulting in week-to-week changes.

**Cases:** State values are calculated by aggregating county-level data from a CDC-managed dataset compiled from state and local health departments; therefore, the values may not match those reported directly by the state. Data is through 1/15/2021. The week one month before is 12/12 - 12/18.

**Testing:** HHS Protect laboratory data (provided directly to Federal Government from public health labs, hospital labs, and commercial labs) through 1/13/2021; week one month before is 12/10 - 12/16.

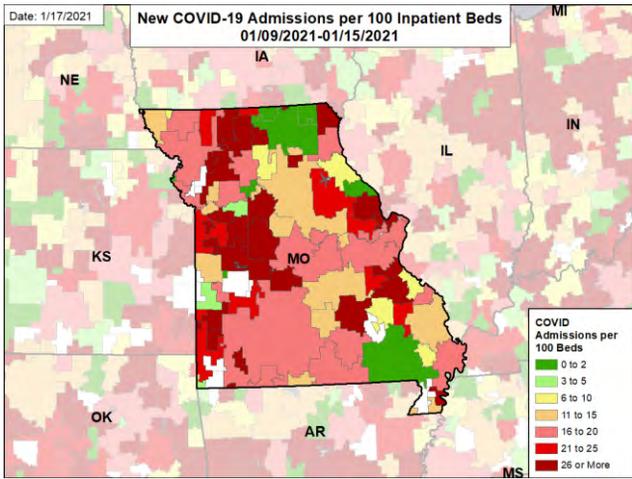


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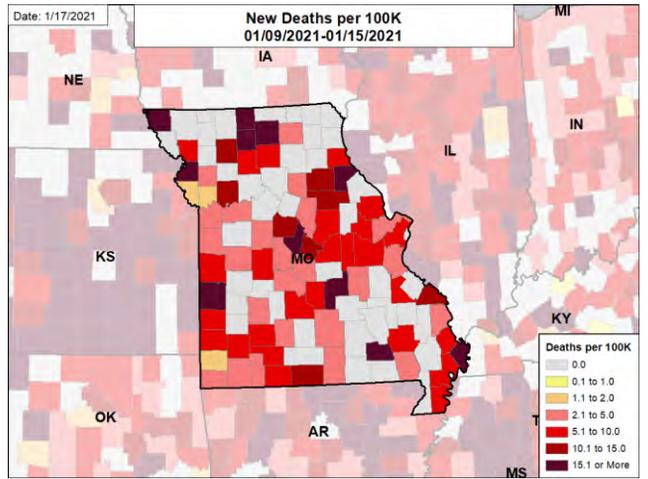
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## HOSPITAL ADMISSIONS AND DEATH RATES

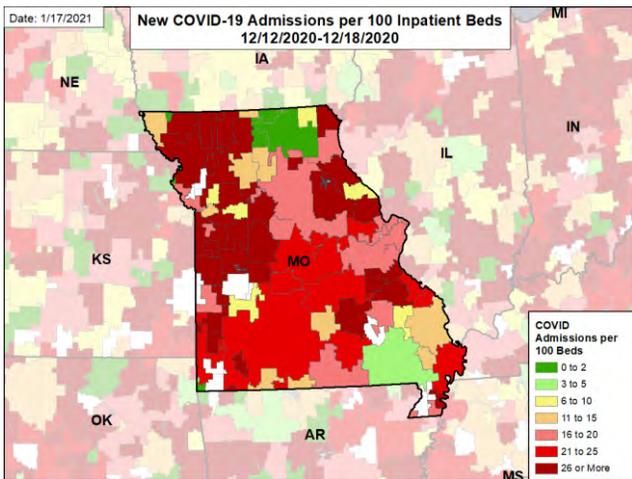
### TOTAL NEW COVID-19 ADMISSIONS PER 100 INPATIENT BEDS



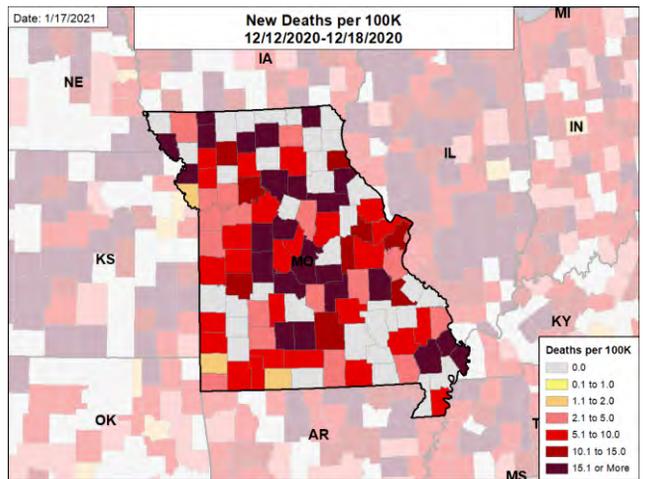
### NEW DEATHS PER 100,000



### TOTAL NEW COVID-19 ADMISSIONS PER 100 INPATIENT BEDS ONE MONTH BEFORE



### NEW DEATHS PER 100,000 ONE MONTH BEFORE



**DATA SOURCES** – Additional data details available under METHODS

**Note:** Some dates may have incomplete data due to delays in reporting. Data may be backfilled over time, resulting in week-to-week changes.

**Deaths:** State values are calculated by aggregating county-level data from a CDC-managed dataset compiled from state and local health departments; therefore, the values may not match those reported directly by the state. Data is through 1/15/2021. The week one month before is 12/12 - 12/18.

**Hospitalizations:** Unified hospitalization dataset in HHS Protect. Totals include confirmed and suspected COVID-19 admissions.