ODH – COVID-19 Performance Audits

Questions & Answers

Data and Dashboard

Are the COVID-19 numbers accurate?	The two primary testing methods being used include PCR and Antigen Tests. PCR tests are considered the "gold standard" and are very accurate. Antigen tests, often called "rapid tests", had low accuracy at the beginning of the pandemic but have increased in accuracy throughout the pandemic. ODH provides daily updates on the number of confirmed COVID-19 cases in Ohio. We analyzed the provided data to ensure that the number of confirmed cases listed on the Dashboard accurately reflected the data from ODRS. While we did confirm the information provided to us accurately reflected the information on the Dashboard, we could not verify that the dataset provided to us represents the totality of all test data contained in ODRS.
Does reporting the cumulative number of cases recorded since COVID-19 was first detected in Ohio provide a good indication of the extent of COVID-19 currently in the community?	Aggregate data does provide useful information, but does not give a complete picture of the current state of virus spread. Better indications of current spread in the community include multi day trends or an indication of "Active Cases", or the total number of cases less presumed recovered.
Why are there differences between state and local case counts?	Local and state data may be updated at different times and with different frequency so there may be minor variation between local heath departments' dashboards and the state dashboard. Further, AOS identified that some municipalities extend past county boundaries or can consist of multiple health departments within a single county. These factors can cause issues in local health department vs state numbers. We are recommending health department updates be better aligned so there are fewer misconceptions about the accuracy of the data and that ODH work with local health departments to encourage consistent data terminology and messaging.

COVID-19 Deaths

How do the dates when deaths are reported relate to when a death actually occurred?

We found that, under normal operations, death certificates may take up to a year to be finalized, between the time of death, a medical examiner signing off on the certificate, the funeral director signing off, any local investigations being conducted, and the Bureau of vital statistics receiving and certifying the cause of death.

For COVID-19 deaths, where timely reporting is critical, we found that more than a quarter of death certificates were not certified for more than one month after the date of death.

All COVID-19 related deaths are reported by ODH, right now, on the day they are certified, not the date the death actually occurred.

If someone was shot and killed but tested positive for COVID-19, will it be counted as a COVID-19 death?

Did many of the people classified as a COVID-19 death really die from something else?

Physicians signing off on the death certificate are to only mention COVID-19 if it was a contributing factor in the death.

AOS specifically looked for deaths due to gunshots. While no instances of gunshots were found, AOS did find approximately a dozen examples of blunt force trauma and fractures, which were immaterial overall.

Further, we found that approximately 10% of the cases we reviewed had a COVID-19 classification that was not directly related to the cause of death, based on where COVID-19 was listed on the death certificate. The vast majority of these were when a multitude of health issues were present.

The CDC also reviews all death records submitted by the states and codes them as COVID-19 related deaths or not COVID-19 related (although they may have tested positive for COVID-19 at the time of death). The process specifically looks for these types of entries and removes them from the death count if they made it to this point.

The limited death data that we were able to review showed that most (approximately 90%) of COVID-19 classified deaths were categorized based on COVID-19 being the primary cause of death or having a strong influence on the cause of death, rather than from something else.

COVID-19 Tests

Is an inconclusive COVID-19 test counted as a positive test?	No. The audit found an inconclusive PCR test fails to meet criteria to be counted as a case. Presumptive positives, recorded early in the pandemic when testing supplies were scarce relied on other factors to determine if a case was potentially positive, such as specific symptoms or close contact with an individual who had tested positive for COVID-19.
Were many of the "positive" test results actually false positives?	The audit could not review the accuracy of laboratory or antigen tests, as these are determined by the testing manufacturers in conjunction with the FDA. Studies on the accuracy of both PCR and antigen tests show that the tests are more likely to report a false negative than a false positive.
Someone I know waited in line to get tested but decided to leave the line and received correspondence that they were being counted as a positive test. Did this happen?	We did confirm that this had occurred in at least some cases. This was due to clerical errors and overwhelmed staff. We do not believe this was a common occurrence or widespread.
Someone I know received correspondence stating that they were a close contact of someone they know has been dead for 10 years. Did this happen?	During the audit, we did note that some clerical errors had occurred. These appear to be isolated cases and the not systemic problems.

State and Local Health Departments

I travelled internationally and was told I'd be contacted by my local health department for instructions and I was never contacted. What happened?	Based on the information collected during the audit, your health department may not have been made aware of your travel. The LHDs rely on individuals to self-report travel or symptoms. Alternatively, if for some reason the LHD was aware, local health departments were sometimes backlogged thousands of calls at various points over the last year, and many were unable to perform complete contact follow-ups.
Did health departments get money per positive test?	The audit found no indication that health departments received additional funding based on the number of positive tests recorded in their jurisdiction.
Is the death data unreliable because it includes people who mainly died "with" COVID-19 as opposed to "by" COVID-19?	Physicians signing off on the death certificate are to only mention COVID-19 if it was a contributing factor in the death. We found that approximately 10% of the cases we reviewed had a COVID-19 classification that was not directly related to the cause of death, based on where COVID-19 was listed on the death certificate. The vast majority of these were when a multitude of health issues were present.

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Hospitalizations and CARES Act Payments

Do hospitals and healthcare institutions have an incentive to find cases of COVID-19 because they are paid based on COVID-19 diagnoses?	Healthcare institutions and hospitals do receive additional funds through Medicaid and Medicare for COVID-19 patients that they serve. This funding helps cover the cost of treatment, additional PPE and quarantining within the hospital. There also have been several rounds of substantial subsidy payments to various healthcare institutions based on the volume of COVID-19 patients treated. These payments were part of the CARES Act and were intended to reimburse healthcare institutions for the cost of care for COVID-19 patients and lost revenue related to the cancellation of elective procedures and having to prioritize COVID-19 care over other services.
Do they test everyone who comes into the hospital for COVID-19, so that if they test positive, the hospital can put that on the billing and receive more money?	Hospitals test everyone who comes in to the hospital but our understanding, developed during the audit, was that this was to identify individuals who would need to be moved to an area where they would not transmit the virus to non-infected patients and so that hospital employees would know to wear appropriate PPE when treating the patient. Hospital billing codes for Medicare and Medicaid do pay extra for care for individuals diagnosed with COVID-19.
Does COVID-19 hospitalization data include persons admitted to the hospital for other reasons who test positive for COVID-19, but are not hospitalized because of COVID-19?	Hospitalization data does not differentiate people who are hospitalized **due to** COVID-19 versus **with** COVID-19 (hospitalized for other reasons but test positive for COVID-19). All patients who test positive require some level of specialized care (from as little as additional PPE and a specialized ward to ICU care). The lowest levels of specialized care are to prevent the additional spread of COVID-19.