Call Date

01/26/2026

Call Agenda

Welcome

Jasmine Chaitram, CDC Office of Laboratory Systems and Response (OLSR)

Monkeypox Updates

Christina Hutson, CDC Division of High-Consequence Pathogens and Pathology

CLIA Paperless Certification Process

Penny H. Keller, HHS, Centers for Medicare and Medicaid Services

Importance of Continuity of Operations Planning

Beth Bair, S.C. Department of Public Health

CDC Specimen Submission and Test Ordering Process

Valerie Albrecht, CDC Office of Laboratory Systems and Response (OLSR)

Call Transcript

Jasmine Chaitram: All right. We will get started in just a second. Hopefully folks can hear me. Thanks to everybody who's joining our call this afternoon. We will get started in another minute or so. Thank you for your patience. Thanks to everyone who's joining. We are going to begin in just another minute or so. Thank you for your patience.

Good afternoon, everyone. Thank you for joining the Laboratory Outreach Communication system call. This is our first call for 2026. We haven't had a call in a while, but I'm so glad you're here. We are doing our first call of 2026 remotely, so I apologize in advance for any hiccups. For those of you that were impacted by the storm this weekend, I hope that you're OK and that you and your families are staying warm.

My name is Jasmine Chaitram and I am in CDC's Office of Laboratory Systems and Response. Just a reminder that today's call is being recorded and another reminder is that the findings and conclusions in the slide decks that are being presented here and those that are part of our archives, don't necessarily represent CDC's official position and they are the position of the authors. So please just keep that in mind when you're hearing the presentations and if you go back to the archives.

So I'm going to go ahead and show you our agenda for today. We've got some really good topics lined up. Lots of different speakers.

And before we get into all of that, though, I do want to give you a little bit of background on the Office of Laboratory Systems and Response, OLSR, since that is maybe a new name to some of you since the last time we met. We are obviously in the CDC, and our effort is to improve public health and patient outcomes by supporting fundamental laboratory systems that are a

component of public health and laboratory infrastructure and those systems that we focus our efforts on, are shown here in this slide.

This is our LOCS call and Archives page where you can find the audio and transcripts from all of our calls including today. It will take us a little bit of time to get them posted so that will be about two weeks from now, but anything you need to go back to or share with others that missed the call today, you can find it here on this page.

Just a reminder on how to ask a question. All of the participants are muted, and the chat feature is disabled. So if you do have a question, please use the Q&A feature in the team's meeting to submit that question for today's call. I will not be reading questions out loud because of the situation that I'm in here, working remotely. Our speakers will try to answer the questions in that feature in the Q&A box as you submit them. Any questions that are not answered, we will try to circle back and answer those offline or when we post the transcript and slides. Or you can submit your question to the LOCS mailbox, LOCS@cdc.gov if you have not heard a response from us and you really want one. For any non-laboratory testing questions, you can contact cdc-infostaff@cdc.gov and for any media questions please contact media at media@cdc.gov, and if you are a patient, please direct any of your questions to your healthcare provider.
And as I mentioned, we are in teams now and not zoom, so things are a little bit different for this call. So hopefully that's not too frustrating for anyone. I also have a couple of announcements before we kick off our agenda.

The first one is about the Lab Director University. So this has been an effort between CDC and the Centers for Medicare and Medicaid Services, CMS, to set up a training system for laboratory, anybody who wants to understand the CLIA requirements and regulations for moderate and high complexity testing. And specifically this is for lab directors and clinical and public health laboratories. It's free. It's self-paced, online learning so I encourage you all to check it out. LDU provides a range of testing resources to help laboratory directors and other professionals address any CLIA deficiencies, from documentation to evaluation of testing systems. Supplemental resources include LDU's innovative and exclusive CDART the CLIA Deficiency and Resource tool. CDART helps professional search for, track and download training requirements, or look up specific regulations related to laboratory requirements. So that's also a resource for all of you that you can take advantage of and is available now.

And then I also just wanted to quickly mention CDC and our efforts towards the 2026 FIFA World Cup. Exciting that it's going to be here in the US, but there is a lot of work that needs to be done to be ready for these many events that are going to be happening. CDC is just starting in our early phases here of planning and mostly just conducting needs assessments to understand what state and local partners needs might be for preparing for these events and responding to anything that might happen locally. We will be updating our response plans and guidance documents and working with partners to create checklists. I encourage all of you that if you have a specific need or looking for specific support or suggestions for how CDC can be supportive, please send those to LOCS@cdc.gov so that we can incorporate them in any of our efforts towards preparing for the FIFA World Cup.

And with that, I think we're going to turn it over to our very first speaker for today, Christy Hutson. You've heard from her before, very happy that she could be here, giving us a monkeypox virus update. Christy, I'll turn it to you.

Christina Hutson: Jasmine, thanks so much to you and your team for inviting me today and very nice to see you all here. So I'll go through these slides without my camera on just to make sure my bandwidth stays good, but someone please interrupt if you have any issues hearing me.

Alright, so as I'm sure you all know at this point there are two types of monkeypox virus which are called clade I and clade II. And then each of these clades has two known sub-clades Ia, Ib, IIa and IIb. Thus far, there have been over 46,000 cases of clade 1 monkeypox in Central and Eastern Africa. We do have new data from these recent outbreaks that indicate that a case fatality rate appears to be around .5% for clade Ib and around 3% for clade Ia. And then you've heard about clade II, which of course is the type that caused the global outbreak that began in 2022. Next slide.

And the next slide, yeah. OK.
So as you can see from this slide, so this is an epi-curve since the 2022 outbreak, clade II, monkeypox continues to cause infections around the world, including in the US, but it really has drastically decreased from that peak in 2022. Next slide.

And here we have a zoomed in version where you can see that cases in recent months, we did have an uptick around September, October of this most recent year. But since then, we have seen a decrease in cases. And as you saw from that previous EPI curve, although there has been an increase within some jurisdictions, overall case counts have stayed relatively low. Next slide.

So the map on the right shows endemic countries in purplish-blue color. And then you can see non-endemic countries where we're seeing sustained clade I transmission in Africa, in orange. Several countries in other parts of Africa, as well as Asia, Europe, North America and South America, as well as Australia have confirmed clade I, monkeypox cases, mostly in travelers who've recently been in areas with clade I outbreak. So far, there have been over 150 cases of travel associated clade Ib, monkeypox around the world, and there have not been any reported deaths in those travel associated cases.

I wanted to highlight the beginning in fall of 2025. There are several countries in West Europe that began reporting clade Ib monkeypox cases among individuals who had no documented history of international travel. These cases were likely related to intimate or sexual exposure among men who have sex with men, and we do expect additional cases in Europe and the United States. In the US, there have been 10 reported cases caused by clade Ib since November 2024 and 7 of those were in people who had recently traveled to areas with known person to person, spread of clade Ib, monkeypox. The remaining 3, which were reported in October 2025 by California did not report any travel and were associated with community transmission in Southern California. These cases were linked to a different US case that did travel to an area with known clade Ib monkeypox. And there has been no additional clade Ib cases reported in Southern California, despite enhanced surveillance. Next slide.

And I just wanted to touch on the US testing. We talked about this previously, we still have very robust testing within the United States, both in our laboratory response network and other public health labs. And then also within some of the commercial labs. Some of this is with the CDC's non-variola orthopox test and then additionally there have been commercial entities and other labs in the US that applied for and received Mpox EUA's which you see on the FDA website. As previously mentioned, a clade II positive result has been used to rule out clade I monkeypox virus infections but a recent recombinant virus could potentially create challenges

with this approach. CDC continues to solicit all orthopox or monkeypox positive specimens from labs that are not clade testing the orthopox and monkeypox positives. Next slide.

So I did want to just talk a little bit about the recent recombinant monkeypox virus that was detected in the UK. There have been more than 150,000 cases of clade I and clade II monkeypox reported globally since 2022, but there have been no monkeypox clade I and II co-infections that have been reported anywhere in the world. However, in early December a recombinant monkeypox, containing elements of clade I and clade II virus, were reported in a resident of the United Kingdom, following travel to Asia. As part of routine practices, a lesion sample from the patient was laboratory tested, clade typed and genotyped. Viral sequencing did reveal the virus contained the genetic characteristics of both clades. The geographic area from which this recombinant virus originated is currently unclear. However, this report does provide evidence that while co-infections can occur, we do believe that natural clade recombination is expected to be very rare. One concern that we wanted to highlight with this recombinant virus is, if laboratory testing would be affected. Now the sequence of the recombinant virus is publicly available, so we do encourage any group using a laboratory developed test to perform in silico analysis, to determine the predicted results of the tests for this recombinant virus. The CDC's cleared NVO tests that I just mentioned will detect this recombinant and some partners have shared predictive results for their tests. Let's see.

So for both Cephied and Quest, they have reported that the recombinant monkeypox is predicted to return results for both tests, consistent with the potential clade I infection. So that's NVO positive, clade two negative. And monkeypox generic tests used by HealthTrack is expected to detect this recombinant. I'll just mention that, my mention of these commercial names is for informational purposes only. Does not represent endorsement by CDC or USG. The targets of these tests are not public and analysis was done by the company or its partners, not CDC. However, we were given permission to share these results. If there are additional questions about the predicted test results when using those or other commercial tests, please do contact the specific test manufacturer and CDC does continue to recommend a testing approach using an initial test that targets a conserved area of the viral genome, to ensure monkeypox cases are not missed. Next slide. Right. And that's it for me. Thanks so much.

Jasmine Chaitram: Thank you so much, Christy. And as I mentioned, Christy is still on the line. So if you do have any questions for Christy or anything related to monkeypox testing, please submit those in the Q&A and she will try to answer some of those. We are going to go to our next speaker, Penny Keller from CMS. Very glad that you could be here, Penny. She's going to talk about CLIA paperless certification process.

Penny Keller: Thank you, Jasmine, and thank you for having me on the call today. Good afternoon. I'm Penny Keller, the technical advisor with the Center for Medicare, Medicaid Services and with the Centers for Clinical Standards and Quality with the Division of Clinical Laboratory Improvements and Quality. I'm here today to share some exciting news coming from CMS regarding the CLIA paperless certification process. Next slide please. Ah, perfect.

CMS is improving the Clinical Laboratory Improvements Amendments program known to you as CLIA by switching to an electronic CLIA certification process. On your screen, you'll see that that this news is spotlighted in our CMS CLIA website. Laboratories have until March 1st, 2026 to switch to the new CMS e-mail notification and begin receiving electronic CLIA certificates and electronic fee coupons. After this March 1, 2026 date, paper CLIA certificates and paper fee

coupons will no longer be available. With the new electronic certification process our CLIA laboratories will receive e-mail notifications for CMS, including any important CLIA updates such as the new electronic certification process. Laboratories will receive an electronic copy of this CLIA certificate via the laboratory's e-mail that's on file. The laboratory will also receive an electronic fee coupon for its certification and survey fees. Again, CMS will no longer mail paper CLIA certificates or paper fee coupons to its laboratories after the March 1, 2026 deadline. This does not apply to the CLIA exempt states- Washington and New York, which have their own state licensure programs. Also, in compliance with the executive order 14247, CMS will no longer accept paper checks for CLIA certificates and survey fee payments after March 1, 2026. The laboratories will be required to make their certificate and survey fee payments through pay.gov. This is a secure platform hosted by the US Department of Treasury. Paper checks will not be accepted after March 1, 2026. To pay for your fees online, you must go to www.pay.gov. You will type in CLIA in the search box in the upper right-hand corner and enter your clear ID number, which is included in your fee coupon invoice and follow the screen prompts and instructions.
www.pay.gov accepts debit and credit cards as well as the ACH bank account transfers with the online payments. So what do you need to do to update your e-mail address and to switch to the electronic notification? You must provide a written notification to your state agency by e-mail. Your e-mail should include your laboratory name, lab director, or owner's name, CLIA number, director or designee signature, and this will help the state agency make the switch. Or if you're an accredited laboratory, please contact your accreditation organization and they'll make that update. If you are making multiple updates to your demographics or making changes to your CLIA certificate, you can also fill out the CMS 116 application form and submit it to your state agency. You must check the box, receive notifications, including electronic certificates, via e-mail on this CMS 116 form. Once you are enrolled to receive the electronic notification, you're going to receive a welcome e-mail confirmation.

We recommend that you use a business e-mail address or one that many staff have access to. Remember also to notify CMS if there's a change in your e-mail address so that CMS has your laboratory's most up to date e-mail address on file. The new CMS notification e-mail will have the following CMS e-mail address: noreply-cms-ccsq@ccsq.cms.hhs.gov. If you don't see the notification in your e-mail inbox, please check your spam folder. If you do not have it, please contact your state agency for assistance.

If you missed the March 1st, 2026 deadline, don't worry. You can still e-mail your state agency for assistance, and they'll help you with their update. Remember to include in your e-mail your laboratory name, lab director, or owner's name, CLIA number, director or designee signature in that e-mail, or if again, if your laboratory is accredited, contact your accreditation organization for assistance with updating your e-mail address.

So what happens if the laboratory doesn't have a valid e-mail address on file? Your laboratory may experience certification or billing issues, which could include delayed or missed fee coupons, lab certification due to missed payments or denied Medicare or Medicaid payments. You can also go to the CMS CLIA website at www.cms.gov/CLIA. As you can see from the screenshot, you'll see the spotlight highlighting the new paperless certification project. To find more information on our new electronic certification process as well as the electronic fee coupon payment. We also have the factsheet, frequently asked questions, poster and communication toolkit listed on that spotlight, as well as direct links to those documents. I'll put those links in the Q&A box for you as well. And that concludes my update on the new clear certification process. And I'll turn it back over to you, Jasmine. Thank you.

Jasmine Chaitram: Thanks so much, Penny, and thank you for being here today with us. As I mentioned again, questions could go in the Q&A feature and Penny will be sticking around I think in the background to help answer those questions as they come in.

So please submit them that way. Thank you. And also I guess you know if you really want to be diligent, add your name and e-mail address so that we can get back to you in case your question is not answered. All right. We are going to keep moving through our agenda.
Our next topic is "Importance of Continuity of Operations Planning" and joining us today is Beth Bair from the South Carolina Department of Public Health and go ahead, Beth.

Beth Bair: Good afternoon. Can you hear me OK?

Jasmine Chaitram: I can hear you.

Beth Bair: OK, great. We can move to the next slide please. So thank you very much.
I'm happy to be with all of you today to talk about Continuity of Operations for newborn screening in South Carolina. So before I get started, I'd like to acknowledge our partners. in COOP, and that includes, the Tennessee, Florida, North Carolina newborn screening teams; APHL and our newborn screening vendor Revvity. Next slide, please. So during my presentation, I'll be talking about our COOP resource guide that we developed a couple of years ago to help us get through COOP situations, working with our partner states and things that we're currently working on right now to improve COOP situations, lived experiences and how to identify risks to newborn screening, the lessons that we've learned. This will be a kind of a high level overview of the lessons we've learned and maintaining COOP as we continue to work each and every day. Next slide please.
So our COOP resource guide, this has become popular over the past few years. It's a wonderful document. It's about 30 pages long right now, and it continues to grow. It's a shared document between us and South Carolina, the Tennessee, Florida, North Carolina and Georgia newborn screening teams. It includes everything from contacts in the newborn screening lab and newborn screening follow-up programs; our operating hours, which includes days and times because we don't all operate at the same time; our specimen categories and unsatisfactory specimen types; the disorders that we're all testing for, because this can change from one state to another; and our individual cut offs, which can also change from one state to another. Our second-tier testing and how we handle second tier testing; our Courier process and results reporting; how we communicate abnormal results. And images of all of our state cards with our demographic information. So every time we're in a coop situation, I have this document open. It's a wonderful resource and we're always happy to share it with other states who are interested in seeing it. Next slide please.

So identifying risks to newborn screening can be challenging. Because we don't always know where the risks are. For instance, in 2021 we had a network outage that affected us the day before Memorial Day weekend and of course, Memorial Day weekend is a very popular holiday in South Carolina. And so we were able to test, but we didn't really know what had impacted our networks. So that very last picture was me, because this was our very first or my very first situation with COOP. I was new in the job and didn't realize that our newborn screening testing could go down. So it was a bit of a harrowing experience and because of that experience I really started thinking about how we can improve COOP situations and fortunately,

we had a lot of great folks in other state newborn screening programs who wanted to work on improving COOP situations. And since then, we've had additional situations where our testing has gone down. Most recently last year, we had a cut fiber optic cable coming into our laboratory, which I'll talk about very soon; and a server migration that affected our network. But with each one of these situations we have gotten better and now it's not so scary. So I'll talk about how we have worked with other programs to improve COOP situations here in South Carolina and elsewhere, next slide please.

So the first thing we did, this was what we considered phase one. This is an image of our newborn screening collection form. We decided to try and standardize our newborn screening collection cards. Now this is not an easy thing to do because each state does newborn screening differently. If people say if you see one newborn screening program, you've seen one newborn screening program. So the first thing we did was to standardize how we have our kit numbers. So now us, Tennessee, Florida and Georgia and I think maybe North Carolina, we all have the two-digit state acronym. So here you can see SC for South Carolina followed by 10 numeric digits. And this was to help us with phase two. Next slide please.

So phase two, which we've started working on late last year and have already had two meetings this year to talk about this was to try and standardize the demographic fields that we all need in order to report newborn screening results to providers. So this is the list of the demographic fields that us, Florida and Tennessee put together that we absolutely have to have, in order to report newborn screening results. And the purpose of this and standardizing that kit number is so that we only need a minimum number of demographics to be able to report those results. And it's going to help us, with our next phase, next slide, please.

So as you can see, this is a process. The next phase is establishing a COOP demographic entry screen so that all of our newborn screening demographics that I just showed that we must have to report results will all be entered on this unique demographic entry screen that will be in all of our newborn screening LIMS systems. And so when you go to type in your demographics and you enter that kit number either SC, TN, FL or whatever, say we're sending our specimens to, it will automatically pull up this unique screen that we will be configured for those specific demographic fields, so that we don't have to include all demographics that were reporting to another state program. We only need what is required in order to report those results. So this is what we're working on right now. We started it just a few weeks ago. And ideally this will all lead to the next phase, which is the pie in the sky dream, which is HL7 Connectivity between states, so that we can get newborn screening collection forms from other states; scan them in the lab and you know, be able to have those in our COOP demographic entry screen for reporting directly back to other state programs. Next slide please.

So, I'll just briefly talk about activating COOP. COOP is very much on a timeline. So for instance, this was an incident last year where our fiber optic cable coming into our lab was cut because we have a brand-new public health lab that's being built right next to ours.
So we all got in in the morning and had no network. So at 8:30 AM, our LIMS administrator notified our IT office and the lab director that our network was down. At that point, we were on the clock because anyone who works in newborn screening knows that timing is very important. We always talk about timeliness and getting specimens and reporting results. So we track by time everything that's happening. So at 10:00 AM we had a meeting to discuss what we could and couldn't do without the network and planned next steps. So at this point, our specimen accessioning group moved to an off-site location with laptops so they could key specimens for other areas of the public health laboratory and our newborn screening. Staff also took laptops so that they could resolve patient specimens from the previous day. Then at 11:30 we had

updates from IT with an ETA on someone coming from AT&T to repair the damaged fiber optic cable. At that point, staff were continuing to work without the network. But there's not a lot you can do without your network, as you can imagine. So I will go through the rest of this. I'm sure you can read all of this. We document everything that's happening at each time point.
Next slide please.
So what have we learned over the past five years by having these different COOPS situations? Communication is key. Every time we're in a COOP situation where we're sending our specimens to other states or they're sending them to ours, we have regularly scheduled meetings throughout the event so that we continue talking about what's working and what each state needs to get through the event. You have to know the other states, hours of operation, disorders tested, cutoffs, unsat types, testing and reporting. And experience makes a huge difference. If you've never been in a COOP situation, it's always good to exercise COOP. Know what your commercial carriers' routes are and if they have variable schedules, especially on holiday weekends. We learned that the hard way during that Memorial Day weekend event. Time zones matter. We learned this the hard way as well when sending specimens to Tennessee, because we didn't realize they were in a different time zone. That's important for reporting purposes. You're going to need support from multiple groups, so make sure that you talk with IT, procurement, LIMS and your vendor who will need to support you. Next slide please.
Yes. And things you can do now. COOP planning is not a sprint. It's something that everyone should be working on, but you have to be intentional about it. So start talking about COOP with your partners. Read a APHL CONPLAN plan. Right now they're on version 3. It's very, very helpful resource. Establish MOU's with partner states and/or vendors. That's very important when sending specimens to another state lab. Hold round table exercise. It includes your internal partners that will need to be involved. Establish a COOP SOP, so you know what's going to happen when you're in a COOP situation. And remember that every situation is different. You can plan and plan and plan, but every situation will be unique and every situation is different.
Next slide please.
So here is my contact information. I'm always happy to talk about COOP and COOP planning. We're very active in this and thank you for listening.

Jasmine Chaitram: Thank you, Beth. I really appreciate that presentation.
Hopefully others picked up some good tips and are thinking about their own COOP.
We're kind of in a COOP situation now. Weather related with the winter storms that have come through and having to change operations at CDC. So hopefully others are thinking about that and the presentation that you just gave is useful to them. Appreciate your time.
OK. We are going to go to our last topic for today, which is "The CDC specimen submission and test ordering process". We're really trying to communicate broadly about some things happening at CDC, and Val Albrecht, who is also in the Office of Laboratory Systems and Response, is here to talk about that with us. Go ahead, Val.

Valerie Albrecht: Great. Thanks Jasmine. Can you all hear me?

Jasmine Chaitram: I can hear you just fine. Thanks.

Valerie Albrecht: OK. Great. All right. Well, good afternoon. Thanks for having me, I'm Val Albrecht. And as Jasmine mentioned, I'm going to provide some updates regarding the CDC specimen submission process. So first of all, if you were to navigate to the "Submitting Specimens to CDC Web page, you'll find a lot of useful information, including a link to the CDC test order directory . Can you click once Jasmine? No, sorry, don't click that. Just click.

There's some animations I included. Sorry. There we go. Thank you. OK. So this resource will really help you understand the specific submission requirements for each test order that the CDC performs, and this includes information like acceptable sample type, the minimum volume required, as well as if any supplemental information is required. So also on the submitting specimens to CDC Web page, you'll find information about CSTOR. You click again. Ah, wait a minute. Click one more time please. There we go.
All right. So CSTOR, which is the "CDC Specimen Test Order and Reporting" web portal.
And this will also include details on how to onboard for the purposes of electronically submitting testing requests, as well as accessing patient reports. More to come about CSTOR in some later slides, and then finally you'll also find a link to download the CDC specimen submission form. This is also known as the 50.34. And this form is required for all samples that are sent to CDC for testing, OK, next slide please. Click one more time. And one last time. Perfect. OK.
So if you have been to the CDC test order directory lately, you might have noticed a change in some of the names. So a few months ago we separated the test orders into CLIA or non-CLIA designations. Now the difference between the two is listed in the specimen labeling field in the directory. Essentially, the CLIA test orders require two primary patient identifiers, while the non-CLIA test orders will prohibit this information from being included in the specimen. No, sorry. In the submission form. Next slide please.
OK.
So for those of you not familiar with CSTOR, this is a web portal that helps to streamline the process to request test orders, submit specimen information as well as securely receive results from the CDC. It's an online alternative to the 50.34 and it is the preferred method for submitting specimens since it does provide a centralized repository of all of your test order approvals, specimen data, shipments status as well as CDC reports. At this time, we have over 115 external organizations connected with almost 1000 users on CSTOR. Next slide please. OK. So some key benefits of onboarding and using CSTOR. These include faster, more secure specimen submission, as well as report retrieval, test order requests, and approvals rejections- they are all tracked electronically in one system, so no need to sift through emails to determine approvals and rejections. Submitters can also directly attach supplemental forms at the test order or the specimen level in the web portal. Data can be corrected on the platform before the samples get accessioned at CDC. This will help prevent rejection of test order requests as well as prevent delay in testing due to rejections. Reports in CSTOR are easy to access. Anyone within the organization can access, and they're also searchable, so you can look up test order name, submitter ID's, lots of different fields that that the report delivery queue is searchable by. And next slide please.
OK.
So all SPHLS are currently onboarded to CSTOR, so our next step was to open the web portal to allow original submitters to onboard. Next slide. OK. So we started this effort in the summer of 2024 and these were our goals for allowing and opening it up for original submitters to onboard. So for CDC, we anticipated higher quality, more secure data submissions coming to CDC, as well as streamline submissions and report delivery through a centralized hub. For our SPHL partners, more visibility into the submissions from the original submitters within their jurisdiction, and this led to easier distribution of the CDC's reports back to these original submitters. And then for original submitters- you know some of the key goals of onboarding to CSTOR- faster, smoother workflow to receive SPHL approval and then be able to submit specimens to CDC as well as access reports. Next slide please.
OK.
So what is the process for an original submitter to onboard to CSTOR? So first, this original submitter will request CSTOR access via a RedCap form. This is also found on that initial webpage that I discussed submitting specimens to CDC. Once they submit the form, there will

be an initial review by our CSTOR Help Desk just to validate some of the information.
And then the SPHL CSTOR Lab Admins that was selected by the original submitter to onboard under, they will review and approve any onboarding request to their jurisdiction. The original submitter CSTOR Lab Admins will then onboard via SAMS, and then the original submitter CSTOR Lab Admins will essentially get access to CSTOR. Next slide.

Jasmine Chaitram: Val, can you take a second to say what SAMS is?

Valerie Albrecht: Absolutely. So it's a Secure Access Management services and it's just a way for CDC to verify who you are. So again, that's the secure part of going through that process to adequately determine you are who you say you are, and then you'll be able to have access. OK, so once all of that has been completed, the original submitter can then proceed to the submission workflow. In CSTOR, each SPHL has the ability to configure which test order will require SPHL review or approval, and this is at the submitter level.
So when the original submitter goes in to create a test order request and specimen submission forms, if that test order requires SPHL pre-approval, that will then get triggered to the SPHL side and CSTOR where they will review and approve if needed. If the test order also requires CDC approval, then it will trigger the CDC side for a review and approval. The original submitter will then finalize any of the specimen forms, and they will electronically ship the package. They'll move through the rest of the workflow and CSTOR, including tracking the testing progress, as well as being able to view the final patient report once it's released. So I hope this was a helpful overview and if you do have any other questions, I'll put in the chat, but please reach out to CSTOR@cdc.gov for any additional information or training or demo if interested. Thanks.

Jasmine Chaitram: Thank you, Val. So we've made it through our agenda. I do want to mention that we have another call already scheduled for April 20th at the time that we were previously having these calls, which is going to be 3:00 PM and if anything changes, we'll let you know. We usually do send out reminders through our LOCS e-mail, so you should get a notification and have awareness of when that call is happening, and the time and the agenda-things like that. I do want to thank our speakers for joining us today and also all of you for participating. Really appreciate your time and your flexibility with the question part of the call. I again apologize for any inconvenience around that and any disappointed folks about not getting their questions answered live, but please do submit those to LOCS mailbox if you didn't get them answered on the call today, and I wish you all a wonderful rest of your day. Thanks again. Bye for now.