Communicable Disease Branch Coronavirus Disease (COVID-19) Bi-Weekly Key Points

January 25, 2022

The North Carolina Division of Public Health (NC DPH) Communicable Disease Branch will be releasing COVID-19 weekly key points that includes information discussed on the bi-weekly Tuesday Local Health Department call. Recordings of the call will not be made available; please use the information below as a summary of the topics presented on the call. As guidance changes, please use the most recent information provided. For questions, contact the NC DPH Communicable Disease Branch 24/7 Epidemiologist on Call at 919-733-3419.

Important Updates

Available online at https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/coronavirus.html:

- **New:** NCDHHS LHD Bi-Weekly Webinar 01 25 2022.pdf

  Audio recording
  [https://mega.nz/file/VpUnxALY#fPfG042Bdu0hFpPdkJOi509JK8lErVsuZu7g2wUVY](https://mega.nz/file/VpUnxALY#fPfG042Bdu0hFpPdkJOi509JK8lErVsuZu7g2wUVY)

  Video recording
  [https://mega.nz/file/UxUzQYKD#YTEBn9ny84JWHv2x5lNgGjwGYRyXo0tDaSoxRmO2X9o](https://mega.nz/file/UxUzQYKD#YTEBn9ny84JWHv2x5lNgGjwGYRyXo0tDaSoxRmO2X9o)

  **Note:** The document, Local Health Vaccine FAQ, is no longer being updated. COVID-19 Vaccine FAQs can be found at [https://covid19.ncdhhs.gov/vaccines/frequently-asked-questions-about-covid-19-vaccinations](https://covid19.ncdhhs.gov/vaccines/frequently-asked-questions-about-covid-19-vaccinations)

**Epi Picture**

- Reported case rates decreased last week in all age/demographic groups.
  - Decreases likely due in part to decreased testing related to weather events and MLK holiday.
- The percentage of emergency department visits that were for COVID-like illness (CLI) also decreased last week (second week of decline).
- Wastewater surveillance showed declines in some municipal systems, but SARS-CoV-2 concentrations remain at or near record high levels.
  - 5 new sites being added to NCDHHS COVID data dashboard on Thursday (Jan 27th)
  - CDC will begin posting wastewater surveillance data on their COVID Data Tracker site. This will include data from NC and 12 other jurisdictions.
- On January 24, ASTHO, CSTE, NACCHO and partner associations released a statement on transition away from universal case investigation and contact tracing.
  - Largely consistent with NCDPH CI/CT prioritization guidance.
  - NCDHHS will convene small stakeholder group to discuss implications, particularly for K12 settings.
- NCDPH guidance for LHDs on use of at-home tests continues to include that results can be used for public health actions (although these results do not meet criteria to be counted as a confirmed or probable case).
Policy

The below Statewide Standing Orders have been rescinded due to the high prevalence of the Omicron variant of SARS-CoV-2 virus in North Carolina for which these therapies are not an effective treatment.

- Statewide Standing Order for Subcutaneous Administration of Casirivimab/ Imdevimab (REGEN-COV) Monoclonal Antibodies
- Statewide Standing Order for Intravenous Administration of Casirivimab/ Imdevimab (REGEN-COV) Monoclonal Antibodies
- Statewide Standing Order for Intravenous Administration of Bamlanivimab/ Etesevimab Monoclonal Antibodies

The rescission orders can be accessed here: [https://covid19.ncdhhs.gov/guidance#vaccination-info-for-providers](https://covid19.ncdhhs.gov/guidance#vaccination-info-for-providers)

In addition, the FDA revoked their emergency use authorization for these monoclonal antibody treatments – Link to the full press release from FDA.

They may be reactivated in the future depending on the effectiveness of the therapies on circulating variant.

There are several other therapies – Paxlovid, Sotrovimab and Molnupiravir that are expected to work against the omicron variant, and that are authorized or approved to treat patients with mild-to-moderate COVID-19 who are at high risk for progression to severe disease, including hospitalization or death.

The Statewide Standing Order for Intravenous Administration of Sotrovimab Monoclonal Antibodies (Jan. 5, 2022) is still active.

In addition, Veklury (remdesivir) is now available for certain non-hospitalized adults and pediatric patients.

Healthcare providers should consult the NIH panel’s COVID-19 treatment guidelines and assess whether these treatments are right for their patients.

Surveillance System Updates

NC COVID Workflows

a. The LHD Acknowledgement Lab Review Workflow is now split by counties. If your county’s workflow is maxed out you can work it to bring it down.

b. Workflows are not meant to be a holding area for events. Each workflow requires a specific activity to move the events along.

c. Even if we were to split the workflow again, you will run into the same problem soon enough given the volume of labs coming in. Also, the more workflows are split, the more it uses system resources and slower the system will run.

d. Tech tip:
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NC COVID Tech TIP

Remove Events from 2 Workflows

Open an event in your “LOCAL—Lab result review required” workflow, then check the Investigation Trail in the Administrative package.

Adding the LHD group will clear the event from your “LHD Acknowledgement Needed” workflow. You have cleared the event from 2 workflows at the same time!

If the LHD Group is missing in the first block, add your county Group and save your update. Return to the lab result review workflow, mark the event as reviewed.

1. We will be hosting a webinar on workflows next week. If you want more information, please check the NC COVID website link here:

2. We are continuing to work towards auto reporting older events. Keep a look out for further information.

3. If LHDs are continuing to receive paper labs and want to enroll sites into NC COVID:
   b. A reminder that we have teams to assist facilities in deciding on the technique that will be most appropriate for your LHD. You can email (Karla.Norsworthy@dhhs.nc.gov or CLDA.SupportServices@dhhs.nc.gov) if you have a facility that hasn’t started on automation and wants help in selecting an option.
   c. For facilities that are using the eCATR PTR (portal entry) option for entering results, if they are having difficulty keeping up during the surge, we recommend that they prioritize entering detail on positive results and use the lab volume survey functions of eCATR to report total positive and negative results. Please have them reach out to CATR@dhhs.nc.gov if they want to explore this further.
   d. We recognize that many facilities that were reporting low volumes now have higher volumes, and the job to manually enter faxes represents a lot of work for local health departments. We welcome requests for us to help get more folks on the automated path. While onboarding may not happen overnight, across these four types of automation, we have received automated reports from over 6000 different facilities. LHDs are
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encouraged to refer people to the overall web site on reporting at
https://covid19.ncdhhs.gov/information/health-care/facilities-reporting-test-results and
remind them of the importance of getting on a path to automate. Email Karla with high
priority facilities that are sending large volumes of faxed lab reports that require hand entry.
Or reach out to helpdesk for assistance.

SLPH

• CMS developed an FAQ on OTC and CLIA Applicability that will address many questions
• Use of OTC/AT-Home in CLIA Setting

Over the counter (OTC) home tests may also be used in CLIA-certified facilities that perform waived,
moderate and high complexity testing; provided the tests have been authorized for use in those settings
by the FDA. Tests issued Emergency Use Authorization (EUA) are not categorized, so they will not be
found in the FDA’s CLIA Database. However, the settings in which an EUA-authorized test may be used
are described in the Letter of Authorization issued by the FDA. Tests authorized under EUA for use at the
point of care (POC) are deemed to be CLIA waived tests while the EUA is in effect. The FDA’s Tables of In
Vitro Diagnostics EUAs provides regularly updated lists of tests granted EUA, including information
about the authorized setting(s). The “Authorized Setting(s)” column describes the setting in which a test
is authorized to be performed, i.e., at home, or in a waived, moderate complexity or high complexity
setting. If an EUA has been authorized for OTC home use, “OTC” will be reflected in the “Attributes”
column, and “Home” will be reflected in the “Settings” column. For example, to determine if an EUA is
authorized to be performed in a waived setting, please ensure that a “W” is reflected in the “Authorized
Setting(s)” column.

Additional Information – IP Update

CDC made two modifications to their Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2
Infection or Exposure to SARS-CoV-2 | CDC

• Aligned the infographic and guidance text with the “up to date” and “not up to date” terminology CDC
adopted for general guidance documents. Links are included to CDC’s definition of what it means to be up
to date with all recommended COVID-19 vaccine doses.
  o In general, asymptomatic HCP who have had a higher-risk exposure do not require work
    restriction if they are up to date with all recommended COVID-19 vaccine doses, do not develop
    symptoms, or test positive for SARS-CoV-2.
• Clarified that, in general, asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior
  90 days do not require work restriction following a higher-risk exposure.
Circumstances when work restriction might be recommended for exposed, up to date HCP:

- HCP are moderately to severely immunocompromised.
- When directed by public health authorities (e.g., during an outbreak where SARS-CoV-2 infections are identified among HCP who are up to date with all recommended COVID-19 vaccine doses)
  - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of work restriction of HCP with higher-risk exposures who are up to date with all recommended COVID-19 vaccine doses, including booster dose, as recommended by CDC. In addition, there might be other circumstances for which the jurisdiction’s public health authority recommends these and additional precautions.

Find My Testing Place

Please note that an updated ‘Find My Testing Place LHD’ Excel file is not available for review this week.

Question & Answer

Prioritizing and Reporting

**Q.** Following the prioritization guidance, with almost all case investigation going to CCNC, or automated texts and emails, how are LHDs supposed to keep up to date on clusters and/or outbreaks? If we aren’t investigating, if information isn’t being communicated to us by facilities with possible clusters/outbreaks, and most cases receiving some type of automated guidance, we are at a loss with how to keep up with this.

**A.** We recognize that the pivot away from universal case investigation and contact tracing will mean that some linkages (and clusters) will not be identified. That is why we recommend prioritizing cases in high-risk settings for investigation.

**Q.** Does this mean that eventually covid will no longer be reportable unless it’s an outbreak/cluster?

**A.** No - we are looking at changes to reporting, but that is being considered separately from case investigation and contact tracing. We can still get case reports, provide automated notifications, and link to information and resources without universal case investigation or contact tracing.
Q. In the context of high community transmission and prioritization guidance, should we continue to investigate and report clusters? It is becoming increasingly challenging to parse out epidemiologic links when there is SO much COVID.

A. Understood. We do still recommend investigation of clusters and outbreaks, but if that is not feasible in all settings we encourage prioritizing outbreaks in high-risk settings - e.g., congregate living facilities.

Q. So all of the schools reporting home tests, we would have to open clusters just based on parent word about the home tests?

A. Yes. We have created ways for LHDs to manually enter those results in NC COVID if needed for that type of reason.

Q. Any discussion of creating a portal where positive home tests can be reported? There is an enormous amount of data being lost (school nurses for example being informed of scores of positive home tests that are never part of the bigger data picture).

A. There are on-going discussions but currently we are not planning to collect at-home test results or include them in our reported case data. We are considering options (with CDC and local stakeholders) to pivot our surveillance for COVID away from case reporting and make greater use of other surveillance systems going forward.

Q. We have heard lots of grumbling from our hospital partners regarding the reporting of COVID positives. It is a huge burden for them to individually report their positives and is time consuming for us to receive, even if just faxed or email encrypted. If hospitals have auto-lab reporting into NC EDSS, can they forego individual notifications to us on each case which satisfies the "physician or designee" reporting?

A. Per our reporting guidance (https://covid19.ncdhhs.gov/information/health-care/facilities-reporting-test-results), "Healthcare providers who submit specimens for COVID-19 diagnostic testing to a laboratory for processing will be deemed to have met the Rule .0107 reporting requirements if the healthcare provider verifies that the laboratory that receives the specimens for testing will report those results". So if the lab is reporting those results, providers are not required to send positives to the LHD separately.

Q. Do we need to be reporting weekly our monoclonal inventories while the EUA is rescinded?

A. Continue to report until/unless other guidance is given.

Q. For a person who tested positive for COVID in the last 90 days and has developed new symptoms, should we advise an antigen test (in place of PCR)? I ask especially in relation to daycares and schools.

A. Yes, antigen testing is the preferred method for people who have tested positive in the prior 90 days.

Q. Are any other counties having problems with addresses from outside of their counties feeding into their workflows?

A. Yes, we have heard from some counties, sometimes the labs location/provider location updates the group. That's why we ask that you check the admin package and lab. If it happens frequently, please let us know and we (or you) can try to work with the lab to update that feature. Email us with questions at helpdesk.
Q. We have had several individuals that report doing a DHHS survey when called. They state it is the same info as what we are asking upon interview. Is this info being pulled into their NC COVID account and sent to state at that point? Just do not want to duplicate info when time is so precious.
A. They may be referring to the automated survey that is part of CCTO. The data entered are only basic demographics, plus case patients can enter contact names. These data stay in CCTO, they don't go to NC COVID, and are only a small part of the data gathered in an interview, but it can replace contact data entry if the person is willing to enter contact information directly. For more information on this, speak with your CCTC regional team or supervisor.

Tests and Testing Supplies
Q. Any information on more testing supplies? I have several LTCFs that have ordered supplies and just cannot get them. They are obligated to test biweekly or as needed and cannot even get this done due to tests being unavailable.
A. NC DHHS is working to distribute and secure additional tests from manufacturers to help with the demand. You can submit a request for antigen tests at this link: https://surveymax.dhhs.state.nc.us/TakeSurvey.aspx?SurveyID=84MI8m6M#

Q. If we requested test kits and received a partial order and still have a need, should we submit an additional order request? Or should we rely on our original order to be filled, as supplies become available.
Q. They have submitted several requests for test kits through this link and have not received any notification or update on shipments coming.
A. Please email NCDHHS_Antigen@dhhs.nc.gov. They can provide an update.

Q. Are we truly seeing less sensitivity in rapid tests compared to previous variants, or is it just that the numbers are so high we notice it more?
A. Antigen tests have always been less sensitive than molecular tests, like PCR. Antigen tests remain more specific than sensitive. A positive result is truly a positive and no additional test is needed. A negative result should be followed by a PCR if the individual is symptomatic and strongly considered if there is a close contact exposure. Antigen tests remain an important testing tool when used correctly. Data is emerging about differences in sensitivity for some variants, like Omicron; however, early data conflicts and these differences are still being studied. Antigen tests should be used as intended and authorized by the FDA. Some tests require certain frequency (i.e. 2 tests 24 to 48 hours apart). Some should only be used within a specific time from symptom onset (i.e. 1 to 5 days). Antigen tests currently authorized use nasal swabs or nasopharyngeal (NP) swabs, not throat (OP) swabs. Tests must be used with the authorized specimen type. Using other specimens increases the risk of false positive or false negatives.

Mask Distribution
Q. Do we need to be planning to receive additional N95s from the SNS at the Federal level and/or mass quantities of at-home tests to distribute to the public? If so (for both or either), can information be provided concerning what NC DHHS does know about these shipments and distribution.
A. We do not have additional information about direct ship from the Federal level, but if your LHD would like to order additional N95 masks for community distribution, LHDs qualify as healthcare entities and can request additional masks here: https://covid19.ncdhhs.gov/RequestMasks . When you order the masks, the verbiage
may look like you are ordering for staff, but you can feel free to enter the masks you feel like you need for high risk, vulnerable community distribution.

**Q.** We are receiving a lot of calls from the public regarding NC N95 distribution to pharmacies. Are we to direct the public to pharmacies to receive an N95 or what is the pharmacy's directions on distribution? We received N95s but do not have enough for mass distribution to the public.

**A.** We don't have a clear understanding or line-of-sight into federal distribution of N95 masks to pharmacies, FQHCs or LHDS. But for NC DHHS purposes, LHDS qualify as healthcare entities and can request additional masks here: [https://covid19.ncdhhs.gov/RequestMasks](https://covid19.ncdhhs.gov/RequestMasks). LHDS aren't required to order additional supply, but some LHDS have requested additional masks to continue this effort. When the LHDS order the masks, the verbiage may look like you are ordering for staff, but you can feel free to enter the masks you feel like you need for high risk, vulnerable community distribution.

**Schools**

**Q.** It would be helpful if Strong Schools had a specific guidance for household exposures. Our LHD and school nurses receive a lot of push back from parents when we explain that an unvaccinated household contact’s quarantine begins AFTER the case's isolation is complete.

**A.** It is in the FAQs. We can consider pulling it into the actual toolkit.

**Q.** In a mask required school where kids are eating within 6 feet, I want to confirm that an unvaccinated close contact (who ate with the positive person during their infectious period, within 6 feet) would be excluded from school under current strong schools guidance.

**A.** The exposed person does not need to be excluded if they are participating in the test-to-stay option (described in the toolkit) or if they meet other criteria for exemption from quarantine. Otherwise yes.

**Q.** What constitutes a test to stay program with schools? I know they recommend testing upon exposure then 5 days but what if they decline testing? So there is no post exposure tests done. Do they quarantine or just continue to attend and wear masks?

**A.** In a mask required setting, because the secondary and tertiary attack rate are low, exclusion from school is not required and a test at day 5 is recommended, but not required. If they decline testing, they can continue to attend and wear a mask as long as they stay asymptomatic.

**Q.** If someone has tested positive within the 90 period, but then is a close contact and symptomatic, would we treat them as presumed positive? (in a school)

**A.** People who have had COVID-19 within the past 90 days and recovered should consult with a healthcare professional for testing recommendations if they develop new symptoms. CDC does not have more detailed guidance on this issue, but in general if there are new symptoms in someone who had a recent previous positive – e.g., within two weeks – and did not initially have symptoms, they do not need to retest but should reset their isolation period with symptom onset being day 0. If they develop new symptoms a longer time after the previous positive, they should be retested and treated like a new case for isolation purposes (although they won’t count as a new case in NC COVID).

**Q.** So in a mask required school setting, is quarantining no longer required even if they don't opt to test?
A. Per page 16 in Strong Schools toolkit - Individuals in a mask-required setting do NOT need to be excluded from school after an umasked close contact, if they have no symptoms. Testing on day 5 is recommended, but not required. While the individual does not need to be excluded from a school setting, quarantine measures may still apply in non-school settings - meaning those people should not participate in non-school activities.

Vaccination

Q. If we have a child that starts with a pediatric dose of Pfizer and they got their first dose at age 11 but when they come back for their 2nd dose they are 12, do we give the pediatric dose for the second one since that is what they started with or do they receive the 12 and up Pfizer?

A. Answer to this and many similar questions can be found at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html. The specific answer is children should receive the vaccine dosage and formulation based on their age on the day of vaccination with each dose. If a child turns 12 years old between their first and second dose, they should receive the age-appropriate 30 µg Pfizer-BioNTech COVID-19 Vaccine (purple or gray cap) formulation for their second dose to complete their series. However, the FDA authorization does allow children who will turn from age 11 years to 12 years between their first and second dose in the primary regimen to receive either dose.

Q. Has the change in the virus had any impact on effectiveness of the vaccine since it was developed when another variant was circulating?

A. Here are some articles about vaccine effectiveness:


Effectiveness of a Third Dose of mRNA Vaccines Against COVID-19–Associated Emergency Department and Urgent Care Encounters and Hospitalizations Among Adults During Periods of Delta and Omicron Variant Predominance — VISION Network, 10 States, August 2021–January 2022