

This document contains information about several changes, many of which will occur with the expiration of the federal COVID-19 Public Health Emergency (PHE) declaration at 11:59pm on Thursday, 5/11/23.

Reporting of COVID-19 Cases and Deaths to Public Health *(more details on attached memo)*

- NCDHHS will no longer consider SARS-CoV-2 to be a novel coronavirus for the purpose of public health reporting.
- This means that physicians will **no longer be required to report COVID-19 cases or deaths to their local health department beginning Friday, 5/12/23.**
- NCDHHS encourages physicians and other clinicians to **continue to report outbreaks, clusters, or unusual cases of COVID-19 that might require public health investigation or intervention**, similar to reporting of outbreaks of other non-reportable conditions like influenza.

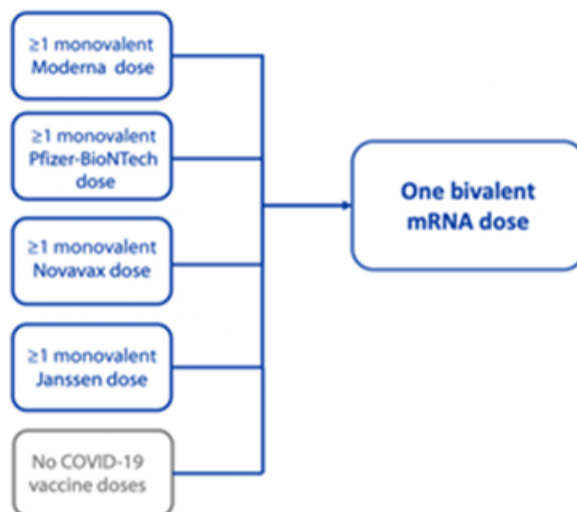
Publicly Posted Data *(more details on attached memo)*

- CDC will stop tracking & posting COVID-19 Community Levels and Community Transmission.
- CDC will track COVID-19 deaths through death certificate data.
- NCDHHS will continue tracking respiratory virus activity (i.e., Emergency Department visits for COVID-like illness, influenza-like illness, & RSV-like illness; COVID-19 and influenza hospital admissions; and COVID-19 wastewater surveillance) on the [NC Respiratory Virus Summary Dashboard](#).

COVID-19 Vaccines

- Since COVID-19 will no longer be a reportable disease following the end of the PHE, **starting 5/12/23, healthcare providers will not be allowed to administer COVID-19 vaccines (even those that are fully approved by the FDA) to minors without parent/guardian consent.** ([NC law](#) only allows minors to consent to immunizations that prevent reportable communicable diseases.)
- The CDC recently simplified COVID-19 vaccine recommendations and added more flexibility for people at higher risk of severe illness who want the added protection of additional doses.
 - These changes are reflected in their updated [Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the US](#) and highlighted here.
 - **Everyone 6 months of age and older now only receives the updated (bivalent) COVID-19 vaccine.**

New recommendations for people aged ≥ 6 years without immunocompromise who have not yet received a bivalent mRNA dose, regardless of COVID-19 vaccination history



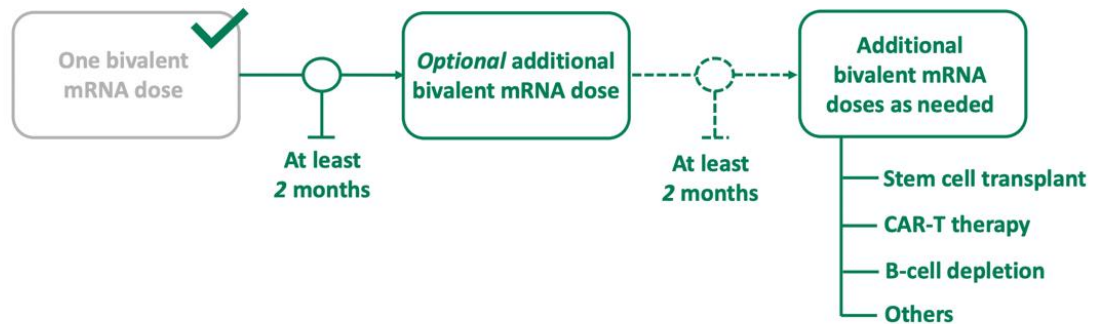
- **Option of additional dose(s) for people at higher risk of severe illness**

Flexible for people at higher risk of severe COVID-19: People aged ≥ 65 years who have already received a bivalent mRNA dose



New flexibility for people at higher risk of severe COVID-19: People aged ≥ 6 years *with immunocompromise** who have already received a bivalent mRNA dose

*Including those with imminent immunocompromise (e.g., prior to organ transplant, etc.)



- Children ages 6 months - 6 years of age who are moderately or severely immunocompromised also can receive additional doses of bivalent mRNA vaccine. For details, see [Table 2](#) in the CDC's Interim Clinical Considerations.
- The CDC will host a [webinar about the Updated Recommendations for COVID-19 Vaccine Use](#) on Thursday, 5/11/23, from 2 – 3 pm.
 - Free Continuing Education is available for both the live and recorded versions of this webinar.
- Despite the end of the PHE, all COVID-19 vaccines purchased by the federal government remain free.
 - Commercialization (i.e., the transition of vaccines previously purchased by the US government to established pathways of procurement, distribution, and payment by both public and private payers) may occur in early Fall 2023, concurrent with the potential release of an updated booster formulation. Vaccines will remain free through the Vaccines for Children Program, most commercial insurers, Medicare, and Medicaid.

Updated CDC COVID-19 Infection Prevention Recommendations for Healthcare Settings

- With the sunsetting of COVID-19 Community Transmission levels, the CDC has updated its [recommendations for healthcare settings](#).
- As described in [CDC's Core IPC Practices](#), source control (i.e., masking) remains an important intervention during periods of higher respiratory virus transmission. **Without the Community Transmission metric, healthcare facilities should identify local metrics that could reflect increasing community respiratory viral activity to determine when broader use of source control in the facility might be warranted.** There is no single metric that will replace Community Transmission levels and guide masking decisions.

- Some options for local healthcare facilities to consider following include the [NC Respiratory Virus Summary Dashboard](#) and the Mission Health Public Health Epidemiologist Surveillance Report (email Gillian.Agyemang@HCAHealthcare.com if you want to receive this biweekly report).
- **Implementation of Source Control (masking)**
 - **Source control is recommended for individuals in healthcare settings who:**
 - Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
 - Had [close contact](#) (patients and visitors) or a [higher-risk exposure](#) (healthcare personnel) with someone with SARS-CoV-2 infection, for 10 days after their exposure
 - **Source control is recommended more broadly as described in [CDC's Core IPC Practices](#) in the following circumstances:**
 - By those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days); or
 - Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas (e.g., emergency departments, urgent care) or patient populations (e.g., when caring for patients with moderate to severe immunocompromise) during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission
 - Have otherwise had source control recommended by public health authorities (e.g., in guidance for the community when COVID-19 hospital admission levels are high)
 - The overall benefit of broader masking is likely to be the greatest for patients at [higher risk for severe outcomes](#) from respiratory virus infection and during periods of high respiratory virus transmission in the community.
 - Additional information is available in the updated Appendix of the recommendations.
- **Implementation of Universal Use of PPE for Healthcare Personnel**
 - If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), healthcare personnel should follow [Standard Precautions \(and Transmission-Based Precautions\)](#) if required based on the suspected diagnosis).
 - As SARS-CoV-2 transmission in the community increases, the potential for encountering asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection also likely increases. In these circumstances, healthcare facilities should consider implementing broader use of respirators and eye protection by healthcare personnel during patient care encounters that involve a higher risk of transmission.

Free COVID-19 At-Home Tests

- At-home test kits currently remain available through state and federal programs. Encourage your patients to take advantage of these opportunities to stock up on test kits. Click [here](#) for more details.
- The FDA has extended the expiration date of many at-home test kits. Click [here](#) to find updated expiration dates.

As always, if you have any questions about COVID-19 or other communicable diseases, please contact **Buncombe County Communicable Disease nurses at 828-250-5109 (available 24/7)**.