K-12 COVID-19 Response

State Board of Education Meeting

March 3, 2022

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agenda

- **Statewide COVID-19 Updates and Data Trends**
- **Vaccination**
- **Policy Updates**

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Statewide COVID-19 Updates & Data Trends

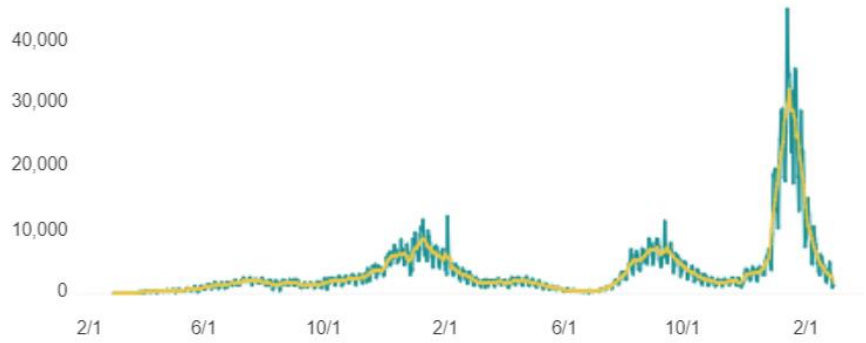
Dr. Betsey Tilson
State Health Director & Chief Medical Officer
NCDHHS

State Board of Education Meeting
March 3, 2022

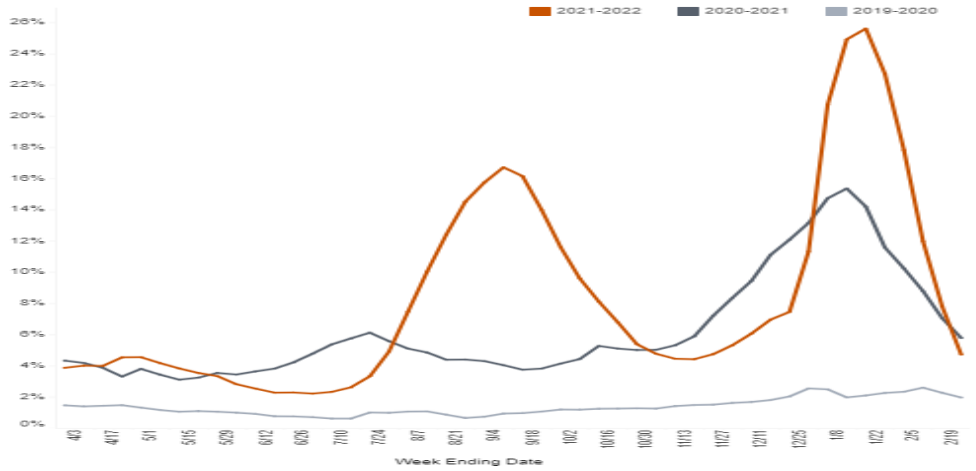
Four Key Metrics – Rapidly decreasing

Daily Cases by Date Reported

Total Cases: 2,590,748

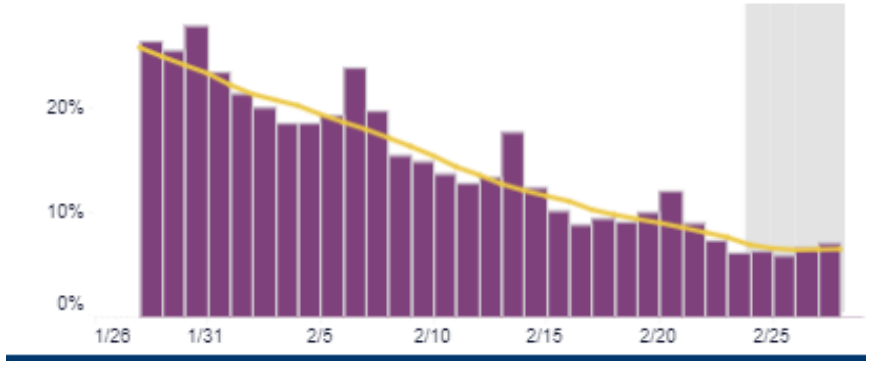


What Percentage of ED Visits this Season are for COVID-like Illness Compared to Previous Seasons?



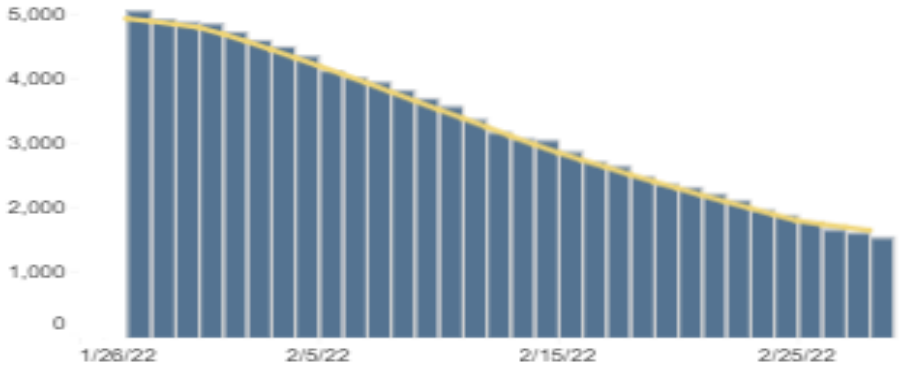
Positive Tests as a Percent of Total Tests

Positive Tests: 7.0%



Daily Number of People Currently Hospitalized

Currently hospitalized: 1,543



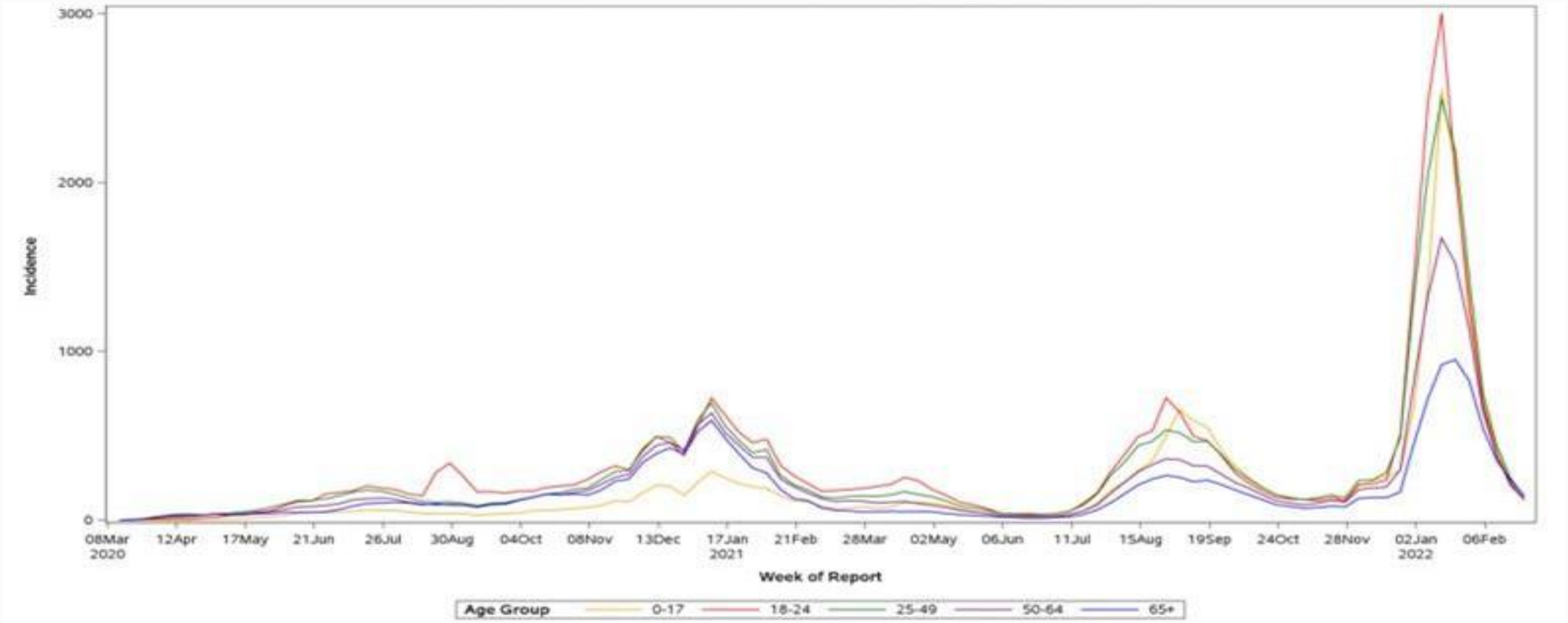
Source: https://covid19.ncdhhs.gov/dashboard

CASE RATES DROPPING

Case rates are highest among younger age groups and lowest among older and more highly vaccinated groups.

COVID Cases per 100K Population by Age Group and Report Date

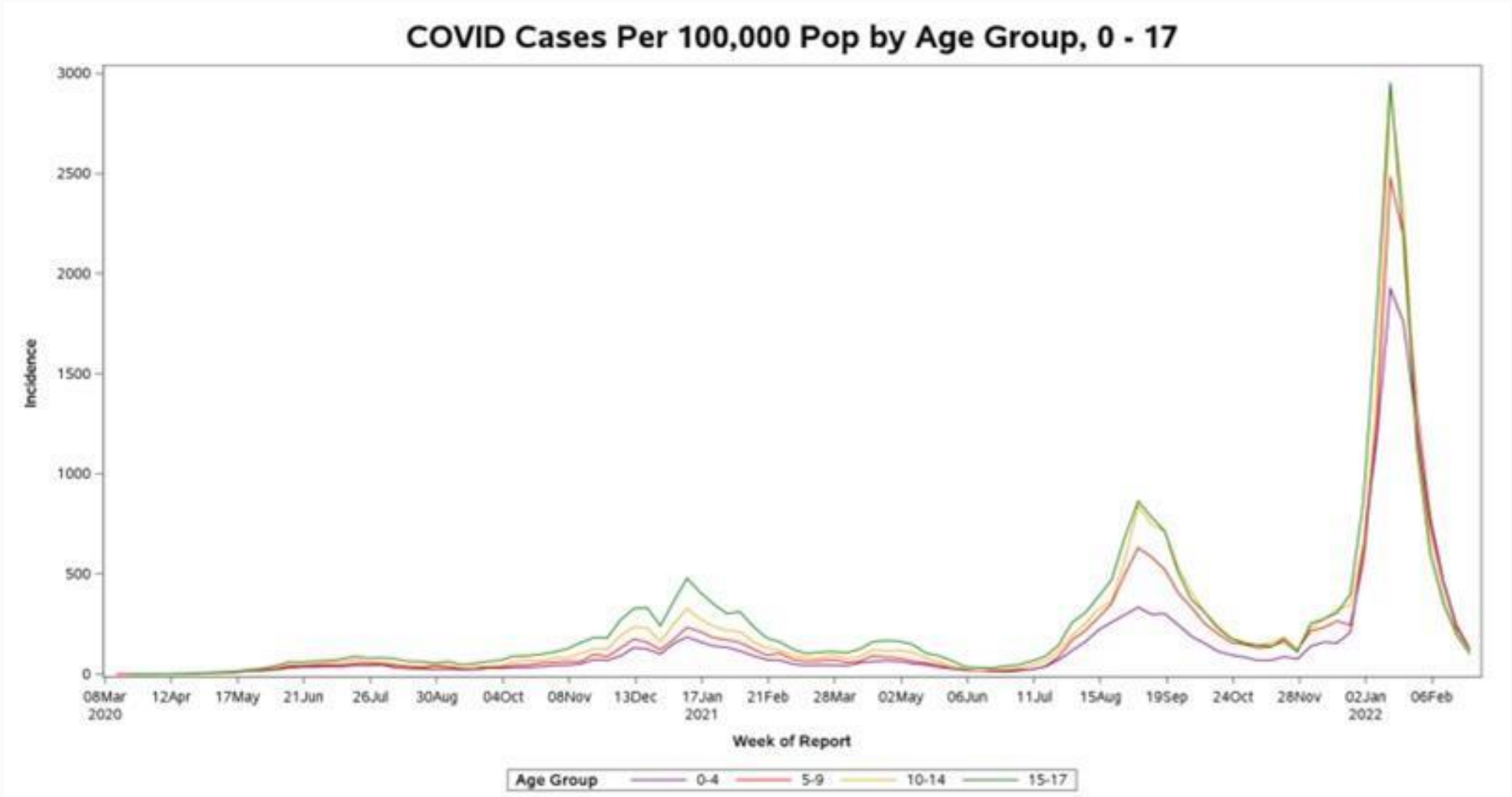
Data through February 26, 2022



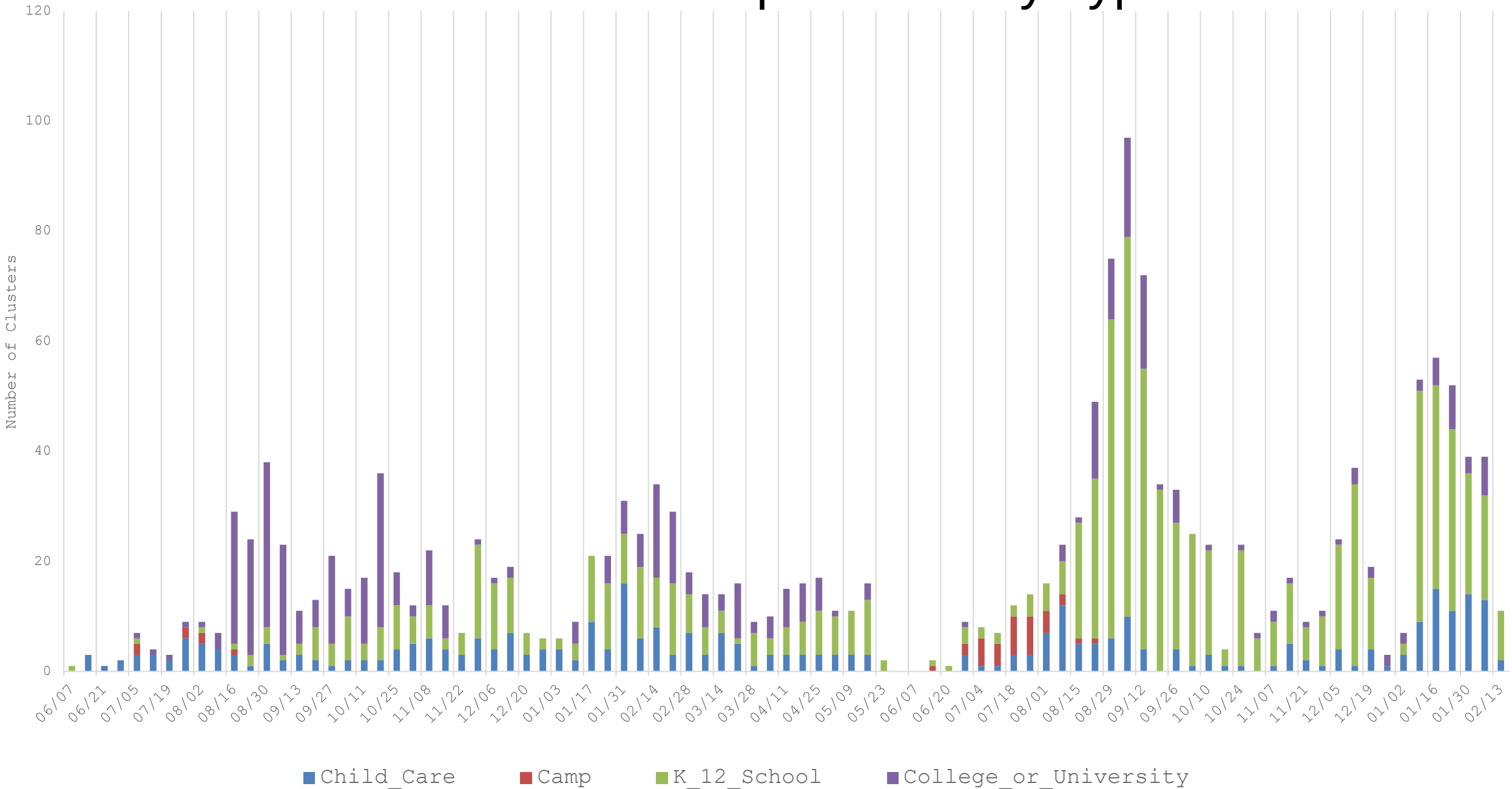
Case Rates Continuing to Decrease Among Children

Case Rates

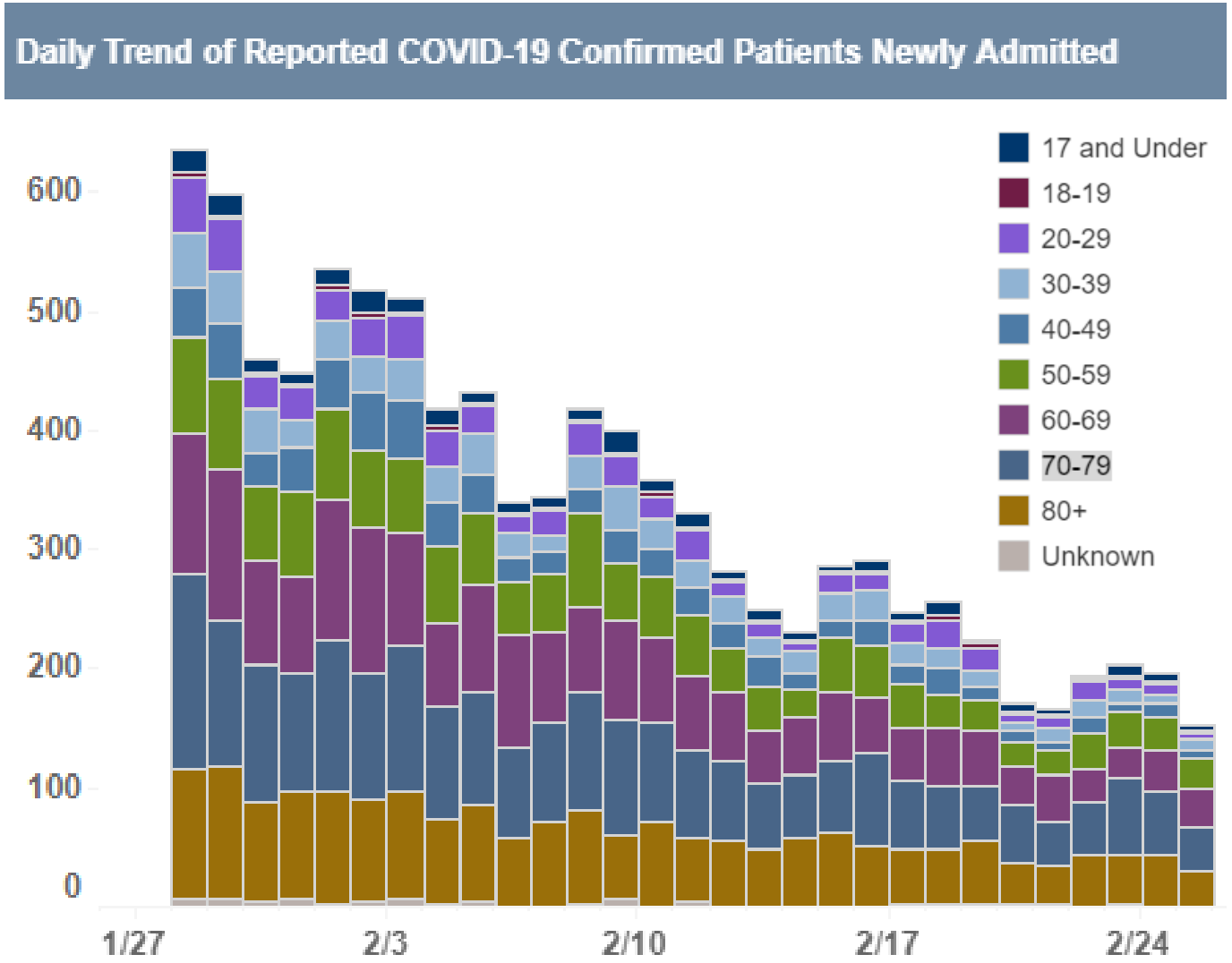
Data through February 26, 2022

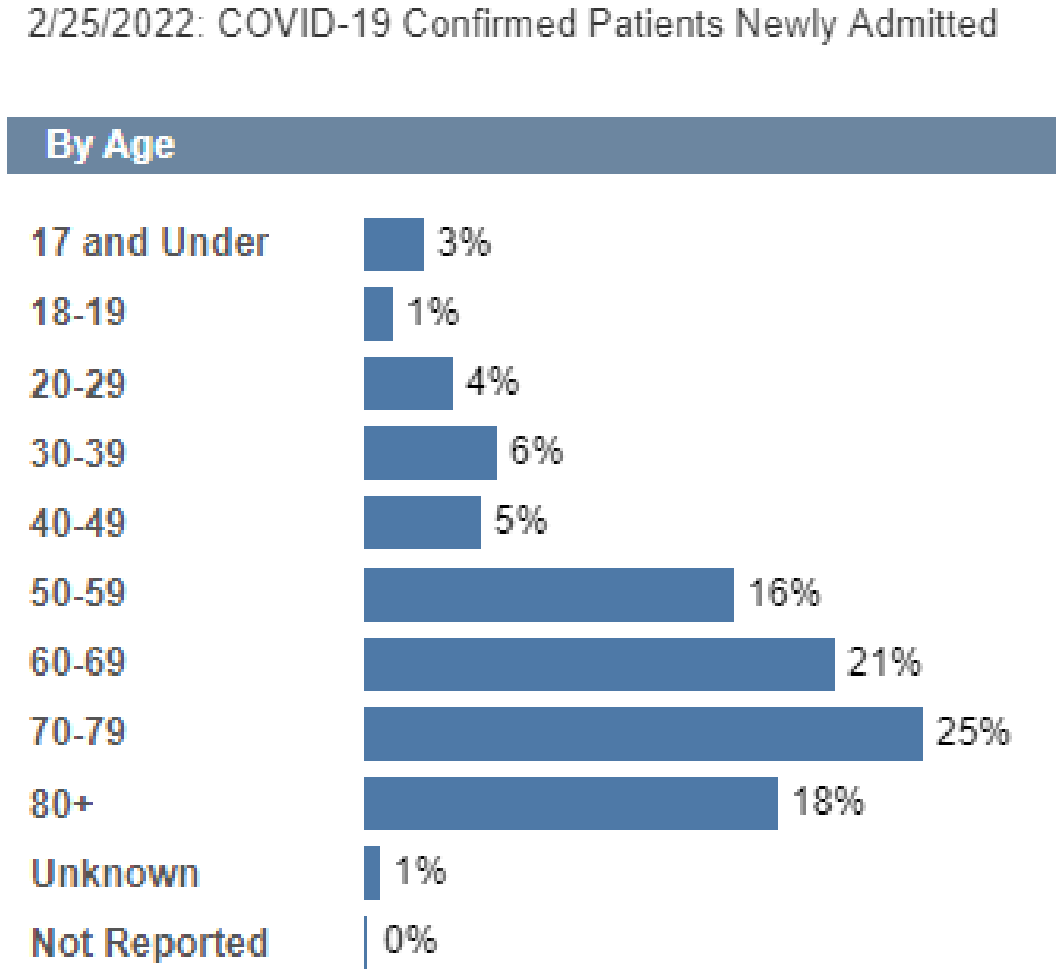


Educational Clusters per Week by Type 2/21



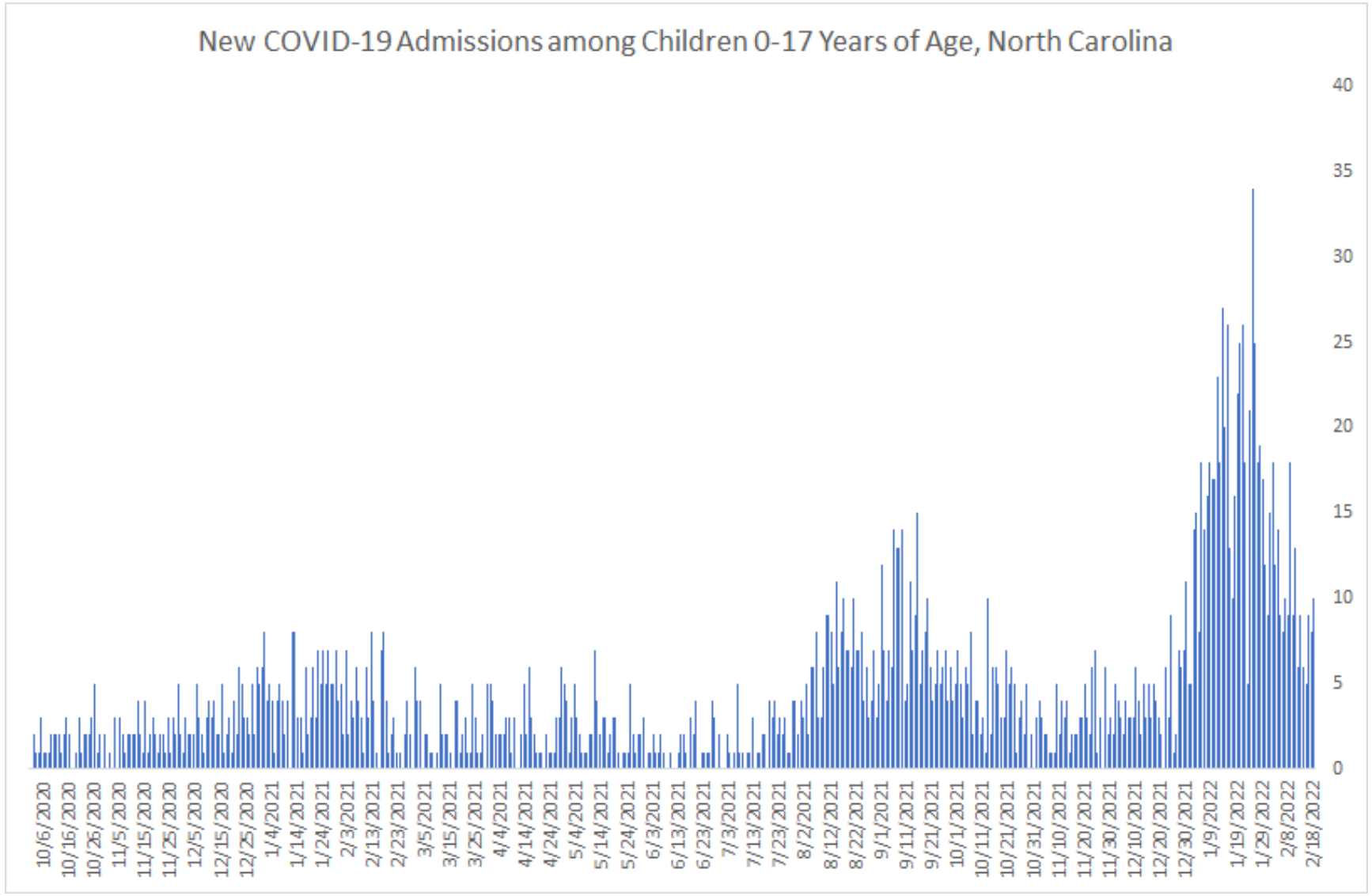
Hospitalization Trends Among Children





https://covid19.ncdhhs.gov/dashboard/hospitalizations

Trends in hospitalizations in children



MULTI-STATE DATA ON RELATIVE HOSPITALIZATION RATES DURING OMICRON SURGE

Hospitalizations of Children and Adolescents with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, July 2021–January 2022

Weekly / **February 18, 2022** / **71(7);271–278**

- Coinciding with Omicron surge, COVID-19–associated hospitalization rates among children and adolescents aged 0–17 years increased rapidly in late December 2021

- The Omicron peak for hospitalizations for children and adolescents (7.1 per 100,000) was **four times** that of the Delta variant peak (1.8), with the largest increase observed among children aged 0–4 years.

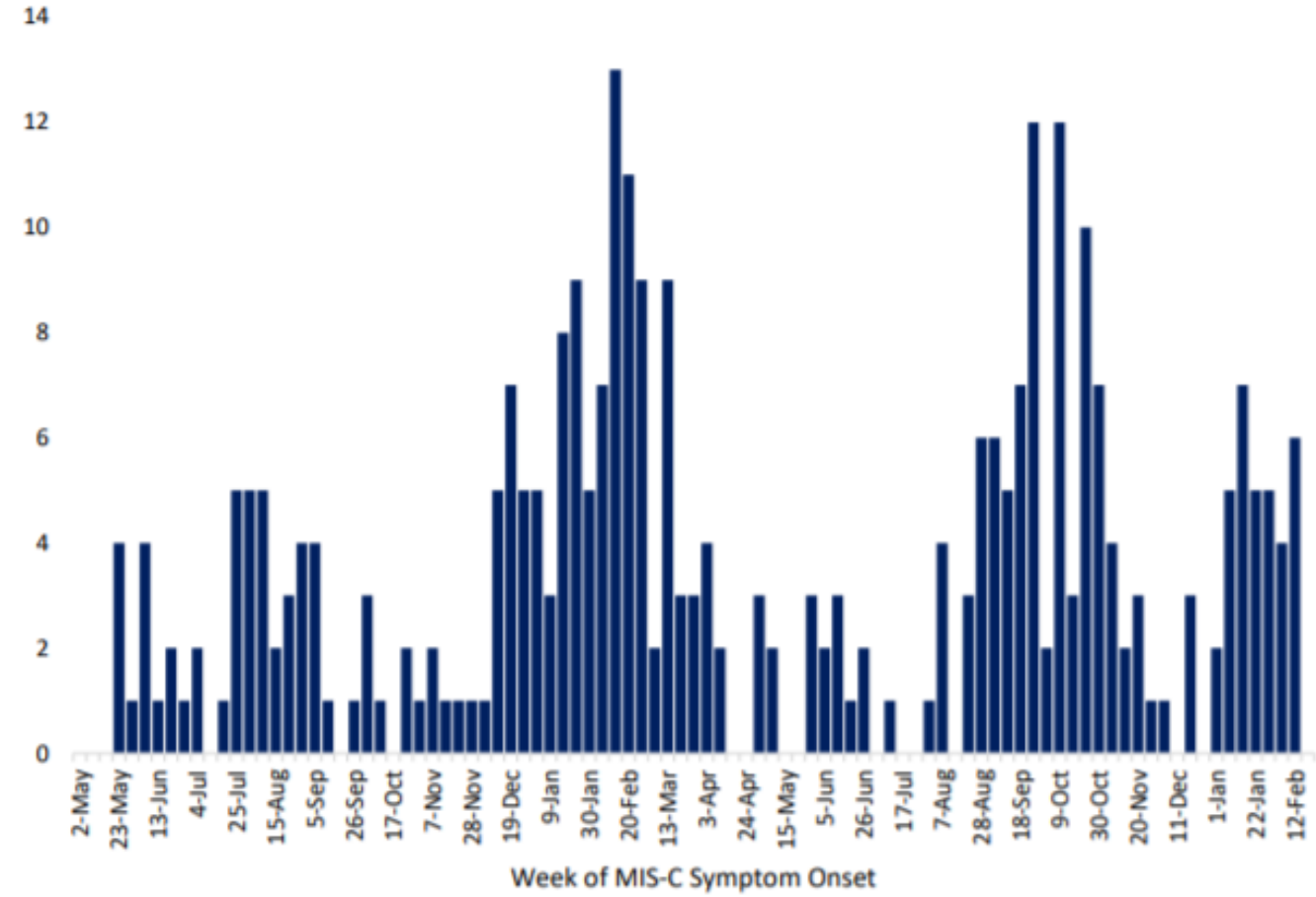
- The monthly hospitalization rate among unvaccinated adolescents aged 12-17 years (23.5/100,000) was **six times** higher than for vaccinated adolescents.

- The large majority had COVID-19–related symptoms at admission (87%) and COVID-19 as the primary reason for admission (81%)

Multisystem Inflammatory Syndrome in Children (MIS-C)

How many cases of Multisystem Inflammatory Syndrome in Children (MIS-C) associated with COVID-19 have been reported in North Carolina?

Number of New Cases Reported Week Ending February 19, 2022	Total Reported Cases in NC
16	313



https://covid19.ncdhhs.gov/dashboard/respiratory-virus-surveillance

INCREASING LEVELS OF SOME IMMUNITY ACROSS THE STATE

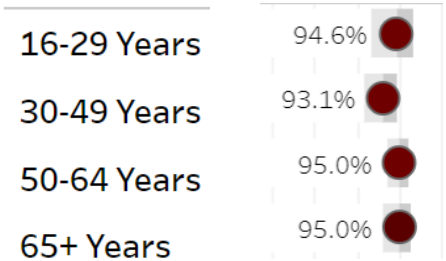
Severe Acute Respiratory Syndrome Coronavirus 2 Seroprevalence and Reported Coronavirus Disease 2019 Cases in US Children, August 2020–May 2021 – **Comparison of reported cases to antibodies in blood**

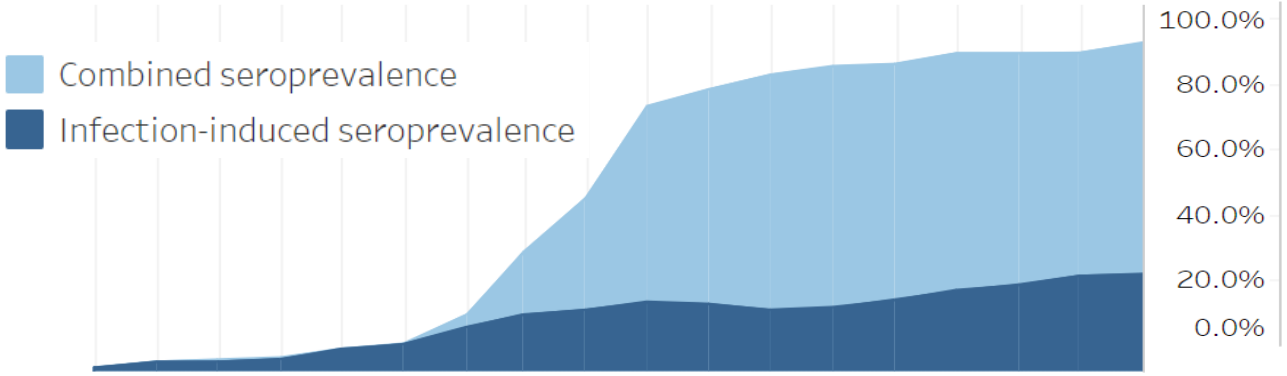
- Reported cases an undercount of actual cases; Overall likely **2.5 times more actual cases than reported cases**; likely **4.7 more actual cases than reported cases in children** (only about 1 in 5 cases were reported for children)

Nationwide COVID-19 Infection- and Vaccination-Induced Antibody Seroprevalence (Blood donations)

- Estimates the percentage of the population **ages 16 and older** that have developed antibodies against SARS-CoV-2, the virus that causes COVID-19, from vaccination or infection. Data through December 2021
- **US – 94.7%**

NC – 94.3%





Multi-State Assessment of SARS-CoV-2 Seroprevalence Commercial Laboratory Survey (MASS-C) currently provides estimates of the percentage of **all people** in the United States with **resolving or past infection** with SARS-CoV-2. Higher rates of past infections in children than adults – data through Jan 20, 2022

	US	NC
Total	43.3%	40.0%
0-17 years	57.8%	52.5% (0-11 yrs 52.9%, 12-17 yrs 52%)
18-49 years	48%	44.6%
50-64 years	37.1%	32.4%
65+ years	23.3%	18.6%

Post-infection immunity

- Antibody levels are associated with protection in the community, but individual antibody levels may vary.
- People post-infection have some level of immunity
- Low risk of re-infection for 3 and likely at least 6 months after initial infection; Uncertain of the strength and consistency of protection after that
- Variability in levels of protection and severity of disease may be associated with more protection; asymptomatic or mild disease may have less protection
- It is unknown what level of post-infection antibodies (i.e. blood test for antibodies) are needed for protection from an infection. There is no FDA-authorized or approved test that can determine whether someone is fully protected.
- Protection from vaccination can provide a more robust, reliable and more consistent level of immunity to protect people from COVID-19 than infection alone
- Vaccination after infection significantly improves protection from reinfection.

Brief: SARS-CoV-2 Infection-induced and Vaccine-induced Immunity

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

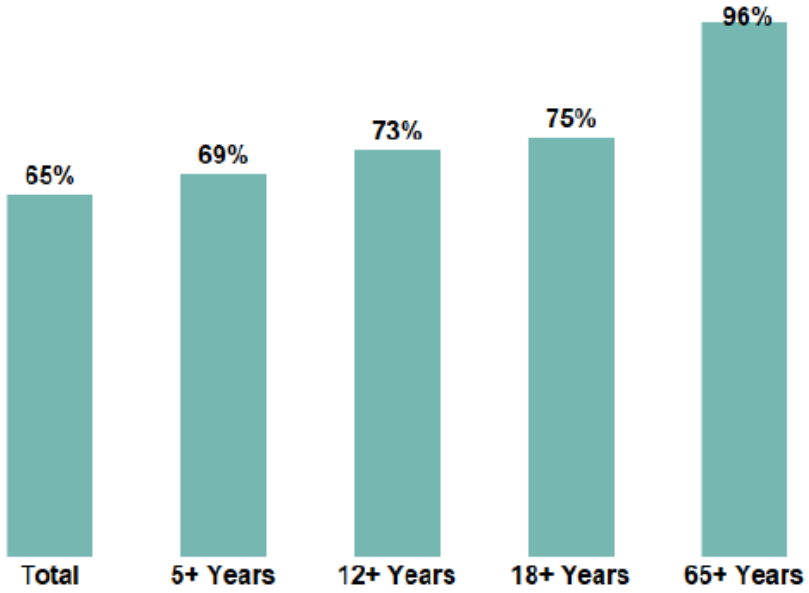
Vaccination Update

March 3, 2022

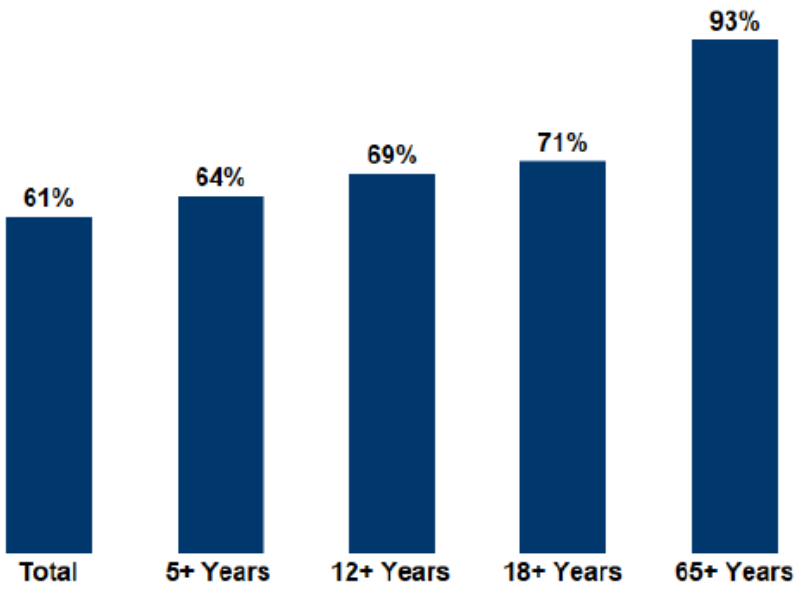
Statewide Vaccinations – Population Summary

Percent of Population Metrics

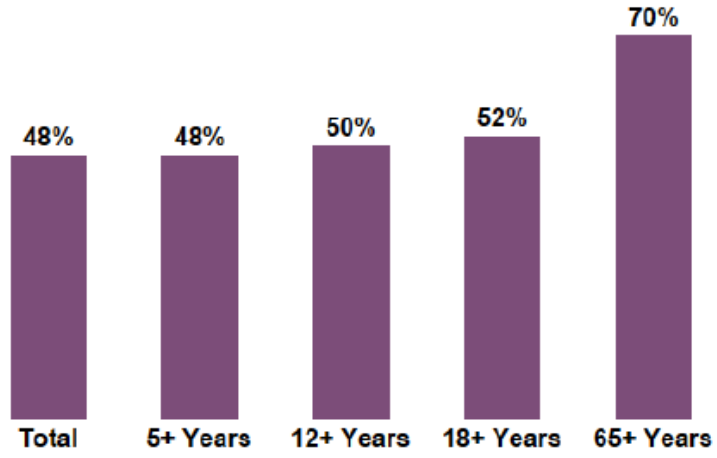
Percent of Population Vaccinated with at Least One Dose



Percent of Population Vaccinated with Two Doses or One Dose J&J

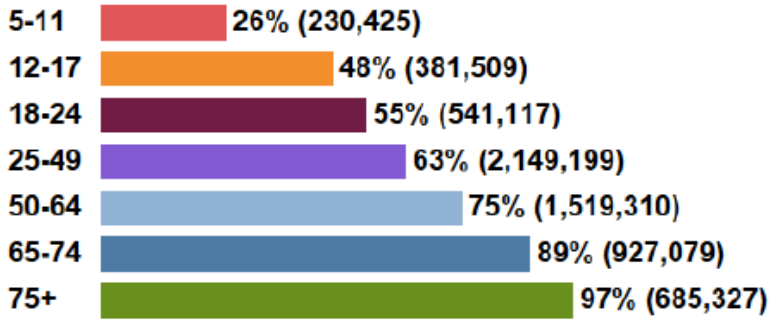


Percent of Vaccinated Population with at Least One Booster/Additional Dose

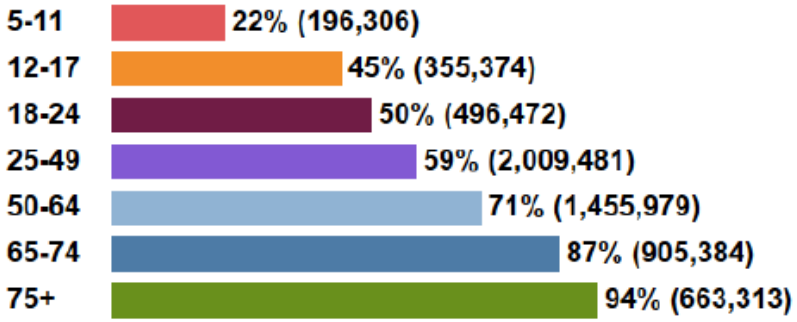


Percent of Population Metrics By Age Group

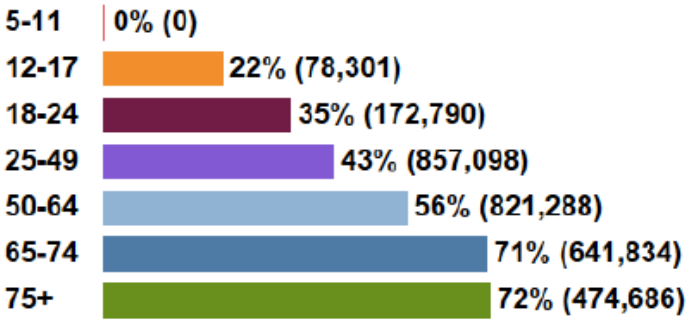
Percent Vaccinated with At Least One Dose



Percent Vaccinated with Two Doses or One Dose J&J



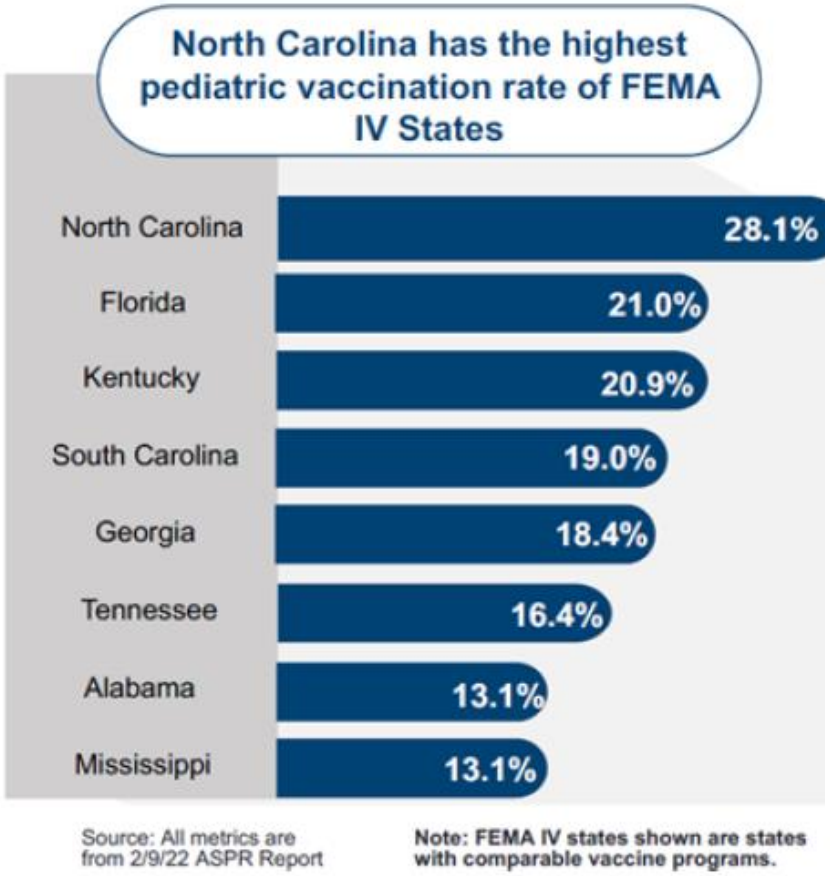
Percent Vaccinated with At Least One Booster/Additional Dose



TLP: RED

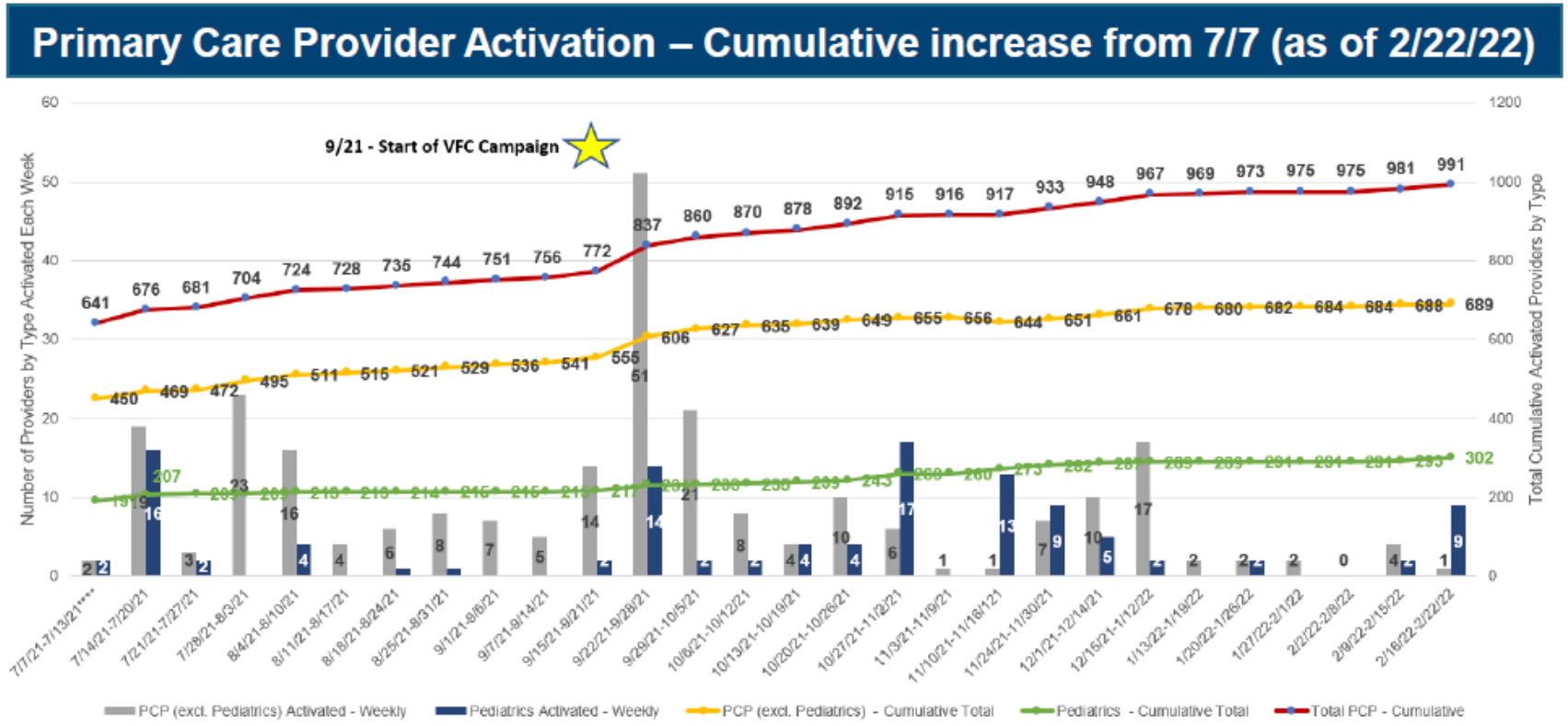
Vaccinations Data: December 14, 2020 - February 24, 2022 at 6:15 a.m.

NORTH CAROLINA PEDIATRIC VACCINATIONS



Source: All metrics are from 2/9/22 ASPR Report

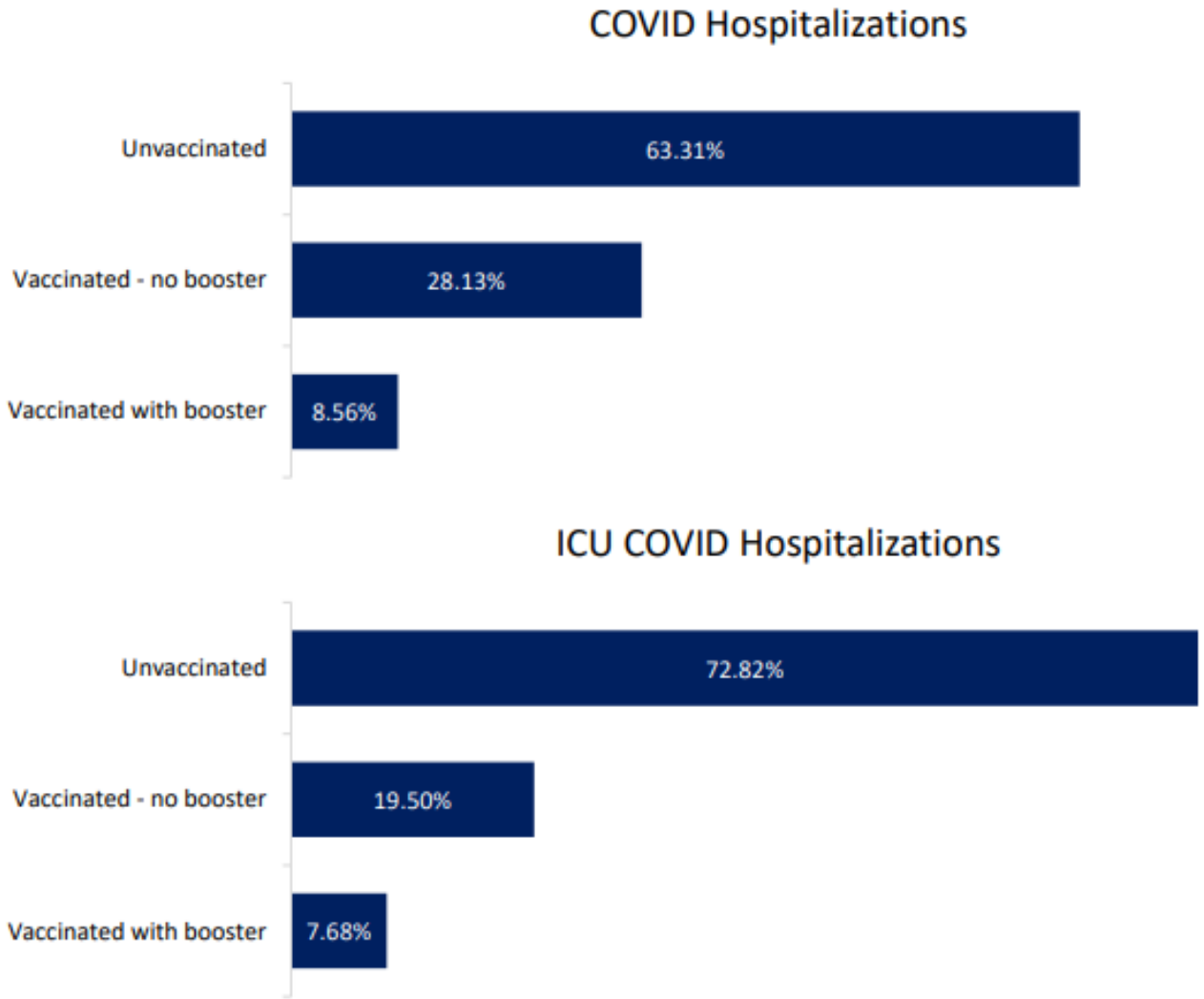
Note: FEMA IV states shown are states with comparable vaccine programs.



FDA expected to review data for vaccines for those 6mos to 4 years in April

NORTH CAROLINA COVID-19 ADMISSIONS AND VACCINATION STATUS

COVID-19 Admissions Mostly Among Unvaccinated (data for week ending February 19, 2022)



- **Source: NC COVID-19 Data Dashboard:** https://covid19.ncdhhs.gov/dashboard/cli-surveillance

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Policy Updates

March 3, 2022

Contact Tracing and Exclusion

- As the pandemic evolves, the most effective and appropriate public health tools for the current phase of the pandemic should be applied.
- While contact tracing has been an important tool for slowing the spread of COVID at earlier points in the pandemic and remains important in certain high-risk congregate settings, individual contact tracing and exclusion of identified contacts is a less effective tool for responding to the pandemic at this phase in other settings due to several factors that include:
  - Emergence of variants with shorter incubation periods and more rapid transmission
  - Most contagious periods prior to symptom onset and during the first few days of illness
  - Large number of asymptomatic and less severe cases
  - Many infections are never identified by public health agencies because persons with asymptomatic or mild cases may not get tested as well as the increasing use of over the counter at-home tests.
  - Low proportion of infections being detected or reported to public health during time when people are in their most infectious time period.
- Therefore, the ability to intervene during the window where contact tracing and exclusion can decrease transmission is limited.

Toolkit Policy Change – Contact Tracing and Exclusion

- Individual contact tracing and exclusion from school after an identified exposure (regardless of location of exposure) is no longer recommended statewide in K-12 schools, effective February 21, 2022.
- Schools should continue to notify potentially exposed people; notification can be on an individual, group, or school basis.
- People who have been notified of an exposure should:
  - Wear a well-fitting mask for 10 days after the last known exposure, unless an exemption to face covering applies.
  - Be tested immediately if symptomatic, and on day 5 after exposure, unless the person tested positive for COVID-19 within the last 90 days. If school wide notification is done, at least weekly testing is recommended.
- Local Health Director may choose to maintain contact tracing and exclusion from school.

Mask Recommendations

- The COVID-19 landscape is different as we emerge from the latest surge; as we have throughout the pandemic, we are adapting our response based on the current stage of the pandemic.
- We are learning more about the virus, and we now have a wider array of effective tools to reduce risk:
  - Vaccines and boosters are widely available and help protect against severe illness, hospitalization, and death.
  - Immunity in community is increasing
  - Treatment is available for those at higher risk of severe disease.
- Trends are decreasing, lowering the risk of infection, and improving hospital capacity.
- Our goal is to use the most tailored and effective tools for the stage of the pandemic, get people back to the experiences and places they love, and reduce the risk of COVID-19 and to protect those at highest risk of severe illness.
- Universal mask mandates are a less important tool in lower risk settings like schools.

Toolkit Policy Change – Mask Recommendations- Effective March 7th

- NC DHHS no long recommends universal mask requirements in schools or other lower risk settings
- Effective February 25, 2022, CDC does not require wearing of masks on buses or vans operated by public or private school systems, including early care and education/child care programs.
- Recommend that students/staff who are at high risk for severe disease, are unvaccinated or are not up to date on vaccines wear a mask in indoor settings
- Recommend that students/staff wear a mask for 10 days following an exposure to a person with COVID-19
- Ensure students/staff wear a mask for at least 10 days after symptom onset or testing positive if they have COVID-19
- Because masks can add a layer of protection for those who want it, schools should support students and staff who choose to wear a mask