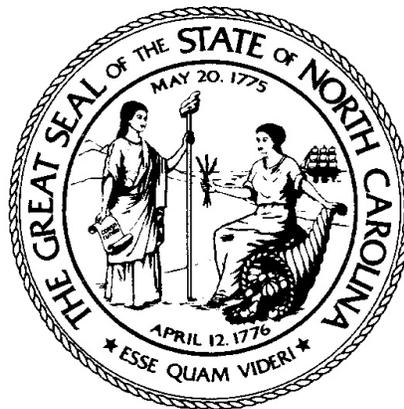


North Carolina Department of Health and Human Services
Division of Public Health

Annual Report to the North Carolina Medical Society

October 2020



State of North Carolina

Roy Cooper, Governor

www.nc.gov

The North Carolina Department of Health and Human Services

Mandy K. Cohen, MD, MPH, Secretary

E. Benjamin Money, Jr., MPH
Deputy Secretary for Health Services

Elizabeth Cuervo Tilson, MD, MPH
State Health Director
Chief Medical Officer

www.ncdhhs.gov

Division of Public Health

Mark T. Benton
Assistant Secretary for Public Health

www.publichealth.nc.gov



NC DEPARTMENT OF
**HEALTH AND
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Background

NC General Statute 130A-33. Commission for Public Health – Regular and special meetings. Each year there shall be four regular meetings of the Commission for Public Health, one of which shall be held conjointly with a general session of the annual meeting of the North Carolina Medical Society. The State Health Director shall submit an annual report on public health at this meeting. The other three meetings shall be at such times and places as the chairman of the Commission shall designate. Special meetings of the Commission may be called by the chairman, or by a majority of the members of the Commission. (1973, c. 476, s. 127; 1989, c. 727, ss. 175, 178; 1993, c. 513, s. 6; 2007-182, s. 2.). The NC Department of Health and Human Services (DHHS), Division of Public Health (DPH), and Dr. Elizabeth Tilson, State Health Director, are pleased to provide this report in fulfillment of this statutory requirement.

Introduction

In prior years, the focus of this annual report has been on North Carolina’s public health through the broad lens of [America’s Health Rankings](#), Healthy North Carolina, major department-wide initiatives, and emerging threats. This year, however, the report will have a focus on the impacts to and response of North Carolina to the COVID-19 pandemic. This unprecedented crisis has required local, state and national leaders to work across agencies and engage public/private partnerships. In particular, local health departments have been front line responders in this public health effort, working with the authority and responsibility of North Carolina’s statutes and rules.

COVID-19

North Carolina has an estimated population of nearly 10.5 million. As of October 11, 2020, there were 231,471 laboratory confirmed cases, 3,770 deaths, 3,381,506 completed tests, and 1,046 are currently hospitalized. On February 24, 2020 North Carolina initiated its response to COVID-19 with the activation of the Division of Public Health’s Incident Command Coordination Center. On March 10, 2020 the response transitioned and expanded to include the State Emergency Response Team (SERT) and transitioned at the State Emergency Operations Center. North Carolina instituted a unified command incident management structure shared between the SERT and North Carolina DHHS. Since the start of the pandemic, North Carolina took early and aggressive action to slow the spread of the virus, managed shortages of testing and PPE supplies, developed hospital surge plans, built testing and contact tracing capabilities, and promoted prevention strategies. Our collective actions flattened the curve of new cases, prevented our health care systems from being overwhelmed and provided valuable time to build our state’s capacity to respond to the crisis.

North Carolina’s strategy includes:

- Prevention:
 - Slow the Spread by phased reopening of high-risk sectors/activities to minimize spread of COVID-19

- Require [face coverings](#) that cover the nose and mouth (indoors and outdoors) when physical distancing of 6 feet is not possible
- Promote the 3Ws ([Wear](#) a face covering, Wait six feet apart, Wash your hands) with targeted and tested messages for high risk populations
- Develop guidance and conduct outreach, training, technical assistance and education to key sector stakeholders and target populations
- Testing and Tracing: Know Who Has COVID-19 and Who Has Been Exposed
 - Build a statewide [testing & contact tracing](#) infrastructure
 - Surge resources in hardest hit communities and populations
 - Hire contract tracers that are members of the communities hardest hit to promote trust
- Isolation and Quarantine: Support People to Stay Home
 - Ensure access to [non-congregate shelters](#) for people who need to isolate
 - Enact policies and fund services and supports to enable people to miss work and stay at home, employ community health workers, connect to primary medical care via telehealth, and leverage the statewide resource and referral platform, [NCCARE360](#), to connect to food, financial assistance and other resources

North Carolina’s overall objectives in the fight against COVID-19 are:

- Protect ourselves, our loved ones, and our neighbors from getting seriously ill
- Restore our economy and get North Carolinians back to work safely
- Get our children back to school so they can learn, play, and thrive
- Address the disproportionate impact of COVID-19 on Historically Marginalized Populations

To determine the effectiveness of our strategy and to determine adjustments, we monitor the following key COVID-19 trends and capacity metrics:

- COVID-like syndromic cases in the emergency departments
- New daily cases
- Positive tests as a percentage of total tests
- Hospitalizations
- Testing
- Contact tracing
- Personal Protective Equipment (PPE)

Health Equity

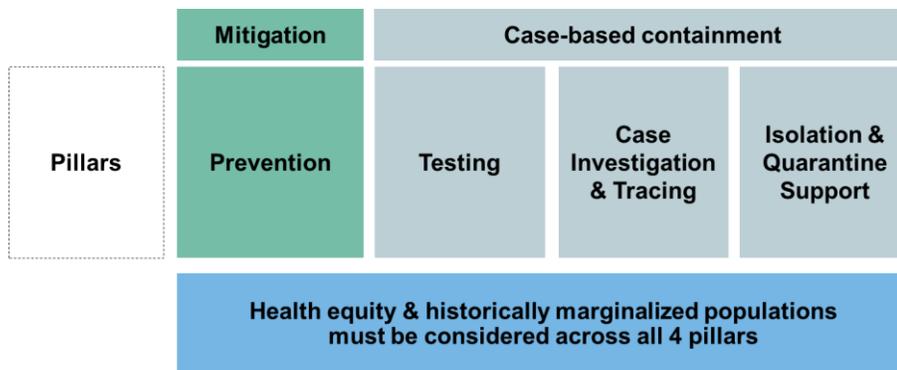
Just prior to the pandemic in January 2020, the NC Department of Health and Human Services Division of Public Health held the [North Carolina Public Health Leaders’ Conference](#) with a focus on Advancing Equity. The discussions at this conference were magnified immediately by North Carolina’s need to respond to the COVID-19 global pandemic.

COVID-19 has disproportionately impacted communities of color and Historically Marginalized Populations for multiple reasons, including existing social, environmental, and health inequities.

Though these health inequities are exposed through the impacts of COVID-19, disparities long existed with detriments to health and economic structures in Historically Marginalized Populations.

At the start of the pandemic, despite making up 22% of North Carolina’s population, African American accounted for 38% of lab-confirmed cases of COVID-19 and 40% of COVID-19 related deaths. As the pandemic continued, the rates of cases increased among our LatinX population. Despite making up about 10% of North Carolina’s population, the LatinX population made up about 48% of COVID-19 cases. Intentional work and focus have been made to address the needs and infection rates of our Historically Marginalized Populations and are described below. While there is more to do, there has been success. By October 2020, the percent of lab-confirmed cases among African Americans decreased to 23%, proportional to the population. The death rate remains disproportionately high at 30%, but is decreasing. The rates of infection in our LatinX population remains disproportionately high at 33%, but is also decreasing. Updated demographic information can be found on the [DHHS dashboard](#).

DHHS’s strategy to COVID-19 uses health equity as a foundation across the four pillars, **prevention, testing, case investigation and tracing, isolation and quarantine support**.



Further attention was paid to populations at increased risk of exposure due to high risk settings. These include, but not limited to:

- Long-Term Care Facilities
- Front line workers in high density occupations
- Migrant Farms
- Correctional Facilities
- Homeless population

Historically Marginalized Populations are disproportionately represented in many of these settings.

Pillars of Response: Prevention, Testing, Case Investigation and Tracing, Isolation and Quarantine Support

Prevention

[Public Education and Engagement](#)

Robust public education materials have been developed, shared, and made publicly available for stakeholders and partners of the NC DHHS website. These are available at covid19.ncdhhs.gov.

A core part of the public education prevention campaign is the 3 Ws to encourage residents to **W**ear a face covering over their nose and mouth, **W**ait 6 feet apart, **W**ash their hands and or use hand sanitizer. To further the reach of the message, DHHS developed the “Whatever Your Reason, Get Behind the Mask” campaign after stakeholder and focus group feedback, especially Historically Marginalized Populations, to inform what may be compelling messages to promote behavior change. More information about the campaign can be found here: [Whatever Your Reason](#).

Executive Orders and Guidance

North Carolina took an aggressive and cautious approach to community mitigation strategy to flatten the curve in the beginning of the pandemic and has incorporated a “dimmer switch” strategy of easing restrictions through phased Executive Orders. Settings that have higher risk of transmissions have had restrictions longer and there is an overall balance of how many higher risk settings are opened at the same time. Some higher risk settings include:

- Indoor Settings
- Setting in which people are sedentary
- Setting with a lot of people
- Settings where there may be increased respiratory effort (e.g. singing, yelling, cheering) that can increase spread of respiratory droplets

As of the date of this report, [Executive Order 169](#) is the most current Executive Order for Phase 3 and the continuation of the cautious approach that included opening previously closed businesses with restrictions and operating requirements beginning on October 2, 2020 and effective until October 23, 2020.

In addition, [Executive Order 147](#) issued June 24, 2020 required face coverings in public settings including retail and restaurants.

North Carolina has also developed and issued [public health guidance](#) for numerous industries and sectors, including for focus and priority populations and settings that included, but are not limited to:

- [Long-Term Care Facilities](#)
- Front line workers in high density occupations ([Food processing](#), [Construction](#), [Manufacturing](#))
- [Migrant Farms](#)
- [Correctional Facilities](#)
- [Homeless shelters](#)
- [Places of Worship](#)
- [Bars](#)

Educational Settings are additional area of focus and robust guidance has been developed and shared for those settings:

- [Pre-Kindergarten and Early Childhood Settings](#)
- [K-12 schools](#)
- [Institutes of Higher Education](#)

Personal and Protective Equipment (PPE)

DHHS has prioritized the mass and targeted distribution of PPE for COVID-19 prevention. Distribution to date (October 2020) includes:

- 1.4 million+ high-risk occupational settings (e.g. meat processing plants, farm and agricultural centers)
- 9 million+ cloth face coverings for K-12 public and private school students and staff
- 64 thousand+ cloth face coverings and cleaning supplies to childcare programs
- 16 million+ procedure masks, gloves, face shields and shoe covers to long-term care facilities
- 5 million+ disposable face coverings and cleaning supplies for elections
- 175 thousand cloth/disposable face coverings for general public/visitors to NC Administrative Office of the Courts

Planning for COVID-19 Vaccine

The next horizon for prevention will be a vaccine for COVID-19. Candidate vaccines against the SARS-CoV-2 virus are being developed under the auspices of Operation Warp Speed and are likely to obtain Emergency Use Authorization by the end of 2020 and perhaps under a full Biologics License Application Approval later in 2021.

North Carolina's initial NC COVID-19 Vaccine plan was using CDC planning assumptions and the CDC Interim Playbook along with the CDC planning scenarios and Key Actions guide.

Key Actions include:

- Determine organizational structure and partner involvement
- Prioritize and identify critical populations
- Propose COVID-19 vaccine allocations
- Ensure Immunization Information System can meet functionality and reporting requirements
- Provider outreach and enrollment
- Develop communications plan

DHHS developed an internal cross-disciplinary planning and coordination team for COVID-19 vaccine activities. The NC Institute of Medicine (NCIOM) convened an external vaccination advisory committee with key stakeholders from diverse backgrounds to inform vaccine priority groups and planning, outreach and response, and communications and messaging.

Critical Populations will include health care workers and first responders at high risk of exposure, staff and residents of Long-Term Care, people at high risk of complications, especially those with high risk of exposure including those in frontline and high-density occupational settings, congregate living settings (incarcerated, homeless), and certain essential services workers. Historically Marginalized Populations are disproportionately represented in critical populations.

Outreach and enrollment of providers who have reach to Critical Populations is key first, and has begun at the date of this report.

DHHS is addressing data flow and system options to ensure accurate enrollment of providers, and daily reporting of vaccine administration and on-hand inventory. DHHS is awaiting further guidance from CDC on allocation information and data system requirements.

Vaccine hesitancy may be higher than usual for this vaccine, especially among Historically Marginalized Populations. Initial priority for communication is promoting trust.

This plan is due to CDC no later than October 16, 2020. The plan will continue to evolve, and operational details will be adjusted as more is known about vaccine availability.

Testing

North Carolina Testing Strategy

Access to testing is essential to supporting and protecting our communities and to understanding the prevalence of the virus in our state to inform public health policy. Since the start of the pandemic, North Carolina significantly ramped up its testing capacity from fewer than 10,000 per day in May to now being one of the top 10 states in the country for total number of COVID-

19 tests with results according to the [Kaiser Family Foundation](#). These efforts are detailed in the ELC State testing [plan](#) submitted to the U.S. Department of Health and Human Services.

NC Testing Strategy is based on five priorities: ensure access to testing for anyone with symptoms suggestive of COVID-19; anyone who thinks they have been exposed and anyone at a higher risk for severe disease (e.g., focus populations); implement diverse testing modalities; build testing capacity; leverage public and private funding; monitor, learn and adapt.

Current Recommendations for who should get tested are:

- Anyone with symptoms of COVID-19.
- Close contacts of known positive cases, regardless of symptoms.
 - Get tested immediately if you are experiencing symptoms of COVID-19. If you do not have symptoms, you should wait at least six days after your last known exposure to COVID-19 before you get tested.
- Groups of some of the populations with higher risk of exposure or a higher risk of severe disease if they become infected. People in these groups should get tested if they believe they may have been exposed to COVID-19, whether or not they have symptoms.
 - People who live in or have regular contact with high-risk settings (e.g., long-term care facility, homeless shelter, correctional facility, migrant farmworker camp).
 - People from Historically Marginalized Populations who have been disproportionately impacted by COVID-19. This [fact sheet](#) provides best practices for community testing in Historically Marginalized Populations.
 - Frontline and essential workers (grocery store clerks, gas station attendants, child care workers, construction sites, processing plants, etc.)
 - Health care workers or first responders.
 - People who are at [higher risk](#) of severe illness.
- People who have attended protests, rallies, or other mass gatherings could have been exposed to someone with COVID-19 or could have exposed others.

As of October 11, 3,381,506 people have been tested in North Carolina which represents 32.2% of the population. North Carolina is averaging approximately 30,000 tests a day with an average turnaround time of 2 days.

Community Testing in High Priority and Marginalized Populations (CHAMP)

A specific effort to ensure reach of testing to Historically Marginalized Population has been made. An example is CHAMP, aimed to increase no-cost testing for African American, Hispanic/Latinx, and American Indian communities that currently have limited testing sites. DHHS identified zip codes with low testing capacity and high African American, Hispanic/Latinx, and/or American Indian populations, and further prioritized communities with higher concentrations of elderly individuals, people with multiple chronic conditions, and higher

rates of construction/seasonal farm work. Of the population tested through the CHAMP initiative, 61% were from a Historically Marginalized Population.

Case Investigation/Contact Tracing

COVID-19 is a [nationally notifiable disease](#) with specific NC requirements for reporting of [COVID-19 Diagnostic Test Results](#). When diagnosed or identified through laboratory or clinical criteria, COVID-19 cases are required to be reported by health care providers and laboratories to state, tribal and local health departments. Local health departments have primary responsibility for follow-up case investigation and contact tracing for people diagnosed with COVID-19.

Case investigation and contact tracing are core disease control measures that have been employed by local health department personnel for decades, and an important part of the COVID-19 response.

Case investigation is the process of working with a person (patient) who has been diagnosed with COVID-19 to discuss their test result or diagnosis, investigate their potential exposures, assess their symptom history and health status, and provide instructions and support for self-isolation and symptom monitoring. This interaction is the first step to review the activity history of the person diagnosed with COVID-19 while infectious, and identify people (contacts) who may have been exposed to COVID-19.

Contact tracing is the process of notifying people (contacts) of their potential exposure to COVID-19, provide information about the virus, and discuss their symptom history and other relevant health information. In addition, instructions for self-quarantine and monitoring for symptoms, and support and referrals to testing, clinical services and other essential support services are provided, as indicated.

The case investigation and contact tracing processes help to prevent further transmission of disease by separating people who have (or may have) an infectious disease from people who do not. Prompt identification, voluntary self-quarantine, and monitoring of those contacts exposed to COVID-19, [can effectively break the chain of transmission and prevent further spread of the virus in a community](#).

Workforce – Surging and Ensuring Diversity

As cases climbed in NC, DHHS identified a need for an ability to rapidly provide surge staff to local health departments for these efforts. DHHS successfully partnered with Community Care of North Carolina (CCNC) and local health departments to create the Carolina Community Tracing Collaborative. This was to provide trained, equipped surge Case Investigation/Contact Tracing staff to support the work of local health departments. These staff are hired centrally and deployed at the request of local health departments. There are currently over 3,000 active case investigations and contact tracers working through local health departments. To address the

needs of Historically Marginalized Populations, local health departments and CCNC focused on hiring people from Historically Marginalized Populations to serve those populations. Over 50% of staff hired through Carolina Community Tracing Collaborative are bilingual, 40% Hispanic/Latinx, and 20% Black or African American.

Technology – Supporting and enhancing the ability to reach cases and contacts

North Carolina improved and added new technologies to support case investigation and contact tracing. These improvements include assuring that the reportable disease software was robust enough to handle this unprecedented number of cases. New technology was added in the form of ***COVID-19 Community Team Outreach (CCTO) tool***. This product allows for cases and contacts to be reached through a variety of technologies, including allowing the individual to choose a preferred method, such as phone call, text or email, all within secure systems to protect privacy and security.

Another opportunity to slow the spread is the ***Slow COVID-19 NC Application*** that allows individuals to participate by downloading a free smart phone app powered by Apple/Google to support notification of close contacts. It notifies users if they have been in close contact with someone else who has shared a positive COVID test result within the app. The app is anonymous. Residents' name or personal information are not stored. Through the app, close contacts will receive notifications that guide them through next steps including quarantine and testing guidance. The app was launched September 22, 2020 and as of October 7, more than 100,000 people have downloaded SlowCOVIDNC.

Isolation and Quarantine Supports

Isolating people with an infection and quarantining people with an exposure to someone with a known infection are important control measures to break the chain of transmission and prevent the spread of a disease. However, being able to Isolate and Quarantine can be challenging for many, especially for those who live in congregate settings (e.g., people in homeless shelters) or front-line workers who must report to in-person work to receive pay.

Isolation and Non-Congregate Sheltering

The Non-Congregate Sheltering (NCS) program is a collaborative effort among NC Emergency Management, DHHS, State, counties, and local partners to maintain and expand access to hotel and motel rooms and essential wrap-around services for individuals with no other safe place to quarantine, isolate, or social distance due to COVID-19. NCS services are 100% reimbursable for counties and local partners. FEMA covers 75% and the State covers 25% of allowable costs. North Carolina NCS county participation:

- 16 counties have NCS for both Isolation/Quarantine and Social Distancing
- 14 counties have NCS for Isolation/Quarantine only

- 36 counties have NCS for Social Distancing only
- 34 counties do not currently have NCS coverage

Wraparound Supports and Community Health Workers

Community Health Workers (CHW) are frontline public health workers who are trusted members of the community and support high-need individuals. DHHS has contracted with local/regional partners to hire more than 300 CHWs in 50 of NC's 100 counties using \$14.7 million of CARES Act funds. The key part of the CHWs' role will be helping connect people who need to quarantine or isolate to supports like food and transportation using NCCARE360.

DHHS is using \$17 million in CARES Act funding for an innovative COVID-19 Support Services program to help people who need access to primary medical care and supports to isolate/quarantine safely in 20 of North Carolina's hardest hit counties. Critical needs like food and medication delivery are provided to meet basic needs of people while in Isolation and Quarantine.

Addressing Non-Medical Drivers of Health

Unmet resource needs are not just a component of our Isolation Supports work, they are critical drivers of health for the statewide population and have been exacerbated in this pandemic. For example, food insecurity rates in North Carolina have doubled since the beginning of the pandemic. Federal and statewide programs have been leveraged or accelerated to meet the need of the populations. For example, federal programs, especially Pandemic-EBT (P-EBT), have been essential (P-EBT provided nutrition benefits to 900,000+ children normally receiving free/reduced lunch).

Statewide NCCARE360 Platform

NCCARE360 is the first statewide coordinated care network to electronically connect people to needed resources and to allow a feedback loop on the outcome of that connection. The platform provides infrastructure for connecting individuals to COVID-related resources and other resources in their communities. DHHS has created both public and private partnerships to develop NCCARE360, such as the Foundation for Health Leadership and Innovation. The statewide reach of NCCARE360 was accelerated to respond to the increase need among our populations and is now operational in all 100 NC counties.

Through NCCARE360, partners have access to:

- Statewide resource directory including a call center with dedicated navigators, a data team verifying resources, and text/chat ability

- A data repository to integrate resource directories across the state to share resource data
- A shared technology platform that enables in-network health care and human service providers to send and receive secure electronic referrals, securely share client information, and track outcomes

Other Focus Areas of Response

Long-Term Care Strategy

One particular setting that has required extensive support and focus has been long-term care facilities focused on a five-point strategy including prevention, building capacity, testing, outbreak management and oversight.

Prevention:

- Requiring facilities to complete Infection Control and Response Assessments as a condition of Medicaid payment
- Conducting remote infection prevention and control consultation with skilled nursing and other long-term facilities across the state through a partnership with the Centers for Disease Control and Prevention and the North Carolina Statewide Program for Infection Control and Epidemiology.
- Providing a toolkit to support long-term care facilities' preparation and response to COVID-19 outbreaks in their facility. The toolkit contains an infection control assessment, infection staffing worksheet, infection prevention educational resources and other tools.
- Creating 10 regional prevention response teams through local health departments to provide ongoing infection prevention technical assistance to facilities
- Providing more than 3,500 long-term care facilities with personal protective equipment to give them time to build their supply network.
- Providing virtual training for thousands of staff working in long-term care sites.

Building capacity:

- Filled staffing shortages in long-term care facilities and other health care facilities through a partnership with East Carolina University School of Nursing to match Registered Nurses and Certified Nursing Assistants with facilities, particularly long-term care facilities, seeking to urgently hire staff for temporary, part-time or full-time roles.
- Providing targeted funding to support nursing homes and adult care homes to provide the additional care needed for residents with COVID-19 including the hiring of staff
- Implementing several temporary regulatory changes to assist providers in caring for their residents during the COVID-19 pandemic, including adopting an emergency rule granting reciprocity to nurse aides certified in other states to work as nurse aides in North Carolina

Testing:

- Requiring nursing home staff testing through Secretarial Order and distributing CARES funding to assist with testing costs
- Contracted with CVS Pharmacy to conduct baseline testing of nursing home residents and staff during the summer
- Requiring testing of all staff and residents weekly when there are one or more cases identified
- Point of care antigen testing machines distributed by federal government to most long-term care facilities to assist with testing

Outbreak management:

- Supporting local health departments in investigation and recommendations to facilities with outbreaks
- Created Outbreak response strike teams to support staffing and outbreak response protocols

Oversight:

- Inspected all 428 CMS certified nursing homes and continuing to conduct focused infection control surveys of nursing homes with new cases

NC Medicaid and COVID-19

DHHS is transitioning its Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system (Medicaid Direct) to managed care (Medicaid Managed Care) per Session Law 2015-245. This transition represents the most significant change to either program since their inception. The process to transition to managed care resumed on July 1, 2020 (Session Law 2020-88) after being suspended in November 2019 when a state budget that included required managed care spending and program authority was not ratified. The Medicaid Program is a powerful lever to improve population and public health.

NC Medicaid has been committed to ensuring beneficiaries continue to receive Medicaid and NC Health Choice services with no interruptions or delays due to COVID-19. This includes making it easier for health care providers to deliver Medicaid services by temporarily modifying certain policy conditions and expanding coverage to include additional forms of clinical service. These changes both facilitate access for patients experiencing COVID-19 symptoms, and limit close contact for routine care, particularly for those at higher risk of severe illness. Additionally, it is crucially important to keep our health care workforce accessible to provide care in creative ways due to prolonged quarantines following exposures.

Medicaid employees determined and enacted innovative approaches in response to the pandemic, while continuing to maintain demanding daily operations. Highlights of Medicaid's response to the pandemic are included below (source: NC Medicaid COVID-19 Response Program Accomplishments internal report, Oct. 8, 2020).

Increased Access to Quality Care and Beneficiary Experience

- Launched the NC Medicaid Optional COVID-19 Testing program to reimburse individuals without insurance for COVID-19 testing costs.
- 82,620 pharmacy mailing and delivery fees paid, with \$228,000 paid to providers; early refills and coverage of up to a 90-day supply of medication, as prescribed
- 200 individual flexibilities implemented across LME-MCOs
- 135 telehealth flexibilities implemented, which spanned 482 billing codes
- 1.2 million telehealth claims processed
- 272 prior authorization and service limit waivers put in place
- 1.1 million Medicaid eligibility extensions conducted (632,000 individual cases)
- 516,000 enrollment applications processed since March 1, 2020

Supporting Providers, Facilities and Practices

- Temporary rate enhancements for certain services and facilities, including Federally Qualified Health Centers and Rural Health Centers, to help maintain access, and support health care practices as they transitioned to new approaches to delivering care to beneficiaries.
- 126 disaster applications processed
- 93 provider closures managed and 228 affected beneficiaries assisted with finding access to care
- 3,285 Medicaid enrollment reverifications extended
- \$30.8 million issued to 17 independent rural hospitals to support emergency response
- \$2.8 million issued to non-outbreak providers to support emergency response

Temporary Policy Modifications

To enact policy changes not covered under the NC Medicaid State Plan, DHHS submitted more than 20 waiver documents to the federal government. These included COVID-19 1115 Waiver, 1135 Waivers, Medicaid Disaster State Plan Amendments, CHIP Disaster State Plan Amendment, Concurrence Letter and Appendix Ks for 1915(c) waivers.

Overall, nearly 250 temporary policy modifications were submitted, which involved working closely with community partners to identify needs, and with state and federal partners for review and approval of waivers to the state plan.

Communication

NC Medicaid launched an outreach strategy starting with existing channels and expanded to new ways for beneficiaries and providers to receive and obtain information. Since March 2020, NC Medicaid has through:

- 1.2 million informational letters mailed to beneficiaries' homes
- 43,825 providers attended more than 100 educational provider webinars that shared new flexibilities, listened to specific concerns, and shared resources to apply for federal funding
- 116,500 calls managed by the Medicaid Contact Center with an average wait time of only 26 seconds
- 41,469 calls received through the COVID-19 Triage Line established with CCNC
- 1,046 unique inquiries received through a dedicated COVID-19 email address with 94% already answered

Additionally, new communication resources included:

- Medicaid COVID-19 Guidance and Resources website for quick access by beneficiaries and providers to information they need to receive and deliver care. Resources include lists of policy flexibilities, Special Medicaid Bulletins, NCTracks provider messages, telehealth-specific resources, billing codes and webinars, and complements the DHHS COVID-19 and State websites.
- Established an online COVID-19 provider Knowledge Center where providers can find answers to questions.

NC Medicaid continues to work closely with beneficiaries and providers, and community, state and federal resources to evaluate additional approaches should they be needed in the future.

More information can be found at the NC Medicaid COVID-19 Guidance and Resources website at [medicaid.ncdhhs.gov/coronavirus](https://www.ncdhhs.gov/medicaid/coronavirus).

Child and Maternal Health and COVID-19

Early Childhood

We are learning more about the direct impacts of [COVID-19 on young children](#). Based on what is known to date, children, especially those less than 10 years of age, may be less likely to have and spread COVID-19 than adults, and most children will have very mild illness as a result. Although rare, some children can have severe disease, need hospitalization, and have developed multisystem inflammatory syndrome (MIS-C) after exposure. North Carolina closely tracks the number of cases in children, cases of MIS-C, and deaths, along with any clusters in child care and school settings. While young children have not experienced the greatest direct COVID-19 burden, the short- and long-term indirect impacts on young children from the pandemic are concerning, including their physical health, mental health, and social wellbeing.

DHHS continues to use the latest research and trends to inform North Carolina's approach to decisions around safety precautions in essential child care, how schools should operate during

the COVID-19 pandemic, in addition to the larger reopening strategy. DHHS is committed to supporting young children and their families during the pandemic and beyond as part of the vision that all North Carolina children will get a healthy start and develop to their full potential in safe and nurturing families, schools and communities.

Maternal Health

Since healthy individuals and healthy pregnancies lead to healthy babies, a focus on preconception and prenatal health are critical to reducing preterm birth, low birth weight, infant mortality, and the staggering disparities. The NCIOM in collaboration with DHHS established the Task Force on Maternal Health starting in June 2020 to bring together stakeholders and experts virtually throughout the state to identify evidence-based solutions to best improve maternal health outcomes and guide and develop a Maternal Health Strategic Plan. The Task Force will build upon the work of the NCIOM Perinatal Systems of Care Task Force and will align with the state's Perinatal Health Strategic and Early Childhood Action Plans. DHHS released [Interim COVID-19 Guidance for Maternal Health and Pregnancy](#) related to concerns around pregnancy and COVID-19.

Well Child Care and Immunizations

Among the many impacts of COVID-19 is a marked decrease in well child visits and childhood vaccinations. In addition to staying protected against vaccine-preventable diseases with needed immunizations, well child care includes many benefits to children's physical and mental health, including access to developmental or mental health screenings. DHHS partnered with CCNC and NC AHEC to launch the *Keeping Kids Well* program, working with practices experiencing a greater number of care gaps to improve these measures and work to raise awareness among parents and caregivers across North Carolina. DHHS has also worked with partners on Medicaid flexibilities in response to COVID-19, sharing best practices to maintain safety precautions, launching a social media campaign for routine and influenza vaccinations, and outreach to improve overall immunization and well child care rates.

In addition to routine immunization to protect individuals and communities against vaccine-preventable diseases, raising awareness of the health risks of seasonal influenza and the need for the influenza vaccine are even more important this year in the context of the COVID-19 pandemic to maintain hospital capacity and protect individuals from influenza as well as COVID-19. DHHS will roll out a statewide media campaign starting in October 2020 to raise awareness and advocate for getting one's influenza vaccine. New this year, the NC Immunization Program implemented a bidirectional, streamlined borrowing process with seasonal influenza vaccine to prevent missed opportunities for both Vaccines for Children (VFC)-eligible and full insured children to increase flu coverage. NC Immunization Program

will also be supplying influenza vaccine for uninsured adults through Local Health Departments, Federally Qualified Health Centers and Rural Health Centers for the 2020-2021 season.

Acknowledging the multifactorial barriers experienced by families, schools and providers as a result of COVID-19 pandemic and allowing for additional time to address disruptions, a [State Health Director Memo](#) and Governor Cooper's [Executive Order 156](#) delayed but did not waive documentation deadlines for immunization and health assessment requirements for the 2020-2021 school year. Immunization requirements were suspended effective August 11 through September 30, and then went back into effect on October 1 with a 30-calendar day 'grace period' beginning on October 1 (or the student's first date of attendance if after October 1). The Executive Order aligns the school health assessment with immunization requirements and extends school reporting. While this delay allows additional time, families were strongly encouraged to obtain required immunizations as early as possible.

Nutrition

With the economic toll from the pandemic coupled with in-person school closures, DHHS partnered with NC Department of Public Instruction as part of the NC COVID-19 Education and Nutrition Working Group to ensure food access. USDA granted North Carolina many waivers to provide flexibilities in nutrition programs, including DHHS programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Child and Adult Care Food Program (CACFP), Supplemental Nutrition Assistance Program (SNAP), and to establish new programs like P-EBT and online ordering. The P-EBT program, a collaboration between DHHS and the NC Department of Public Instruction, helps families purchase food with an EBT card for children whose access to free and reduced-price meals at school may have been impacted by COVID-19. DHHS implemented online ordering so that families enrolled in FNS can order food online for curbside pickup or delivery at retailers like Walmart and Amazon using FNS benefits. With these flexibilities and new programs, recipients can continue to receive benefits and follow safety precautions.

Child-serving programs

Throughout the COVID-19 pandemic, services for children and families have continued, adapting as needed to meet the needs of individuals and safety precautions including physical distancing.

COVID-19 brings an additional layer of complexity to emergency preparedness activities for everyone, but especially for families with children and youth with special health care needs (CYSHCN). In response to the pandemic, many preparedness recommendations and activities have shifted to incorporate public health guidelines and protocols to ensure the health and safety

of the public in an emergency. It is critical that families of CYSHCN know where to find up-to-date information in an emergency, understand what protocols and recommendations have changed in response to COVID-19, and how these changes may affect their emergency plan and family preparation based individual needs. Emergency response, especially sheltering, during COVID-19 is very different and families need to be aware of their options and risks associated with congregate and non-congregate shelters, understand COVID-19 protocols in shelters, and be informed about the specific sheltering and evacuation plans in their community. DHHS continues to work with partners to advocate for emergency plans in place which include what to do if an emergency affects critical services, such as electricity, access to medication, or transportation. In the current environment, creating this emergency plan far in advance is even more important because “normal” access to health-related needs may be further reduced. In addition, the preparation of an emergency kit is an essential part of the emergency plan and additional items such as PPE should be added to an emergency kit. An emergency or potential emergency creates additional stress on top of an already stressful situation. Many CYSHCN and their families have been living through many months of disrupted routines at home and school and the potential of increased risk for COVID-19 exposure; therefore it is critical that parents of CYSHCN pay special attention to the mental health and wellbeing of their children and themselves in an emergency.

Programs that include home visiting components have adapted to continue to provide remote services and some providing in-person with safety precautions in place. Nurse-Family Partnership (NFP) home visiting program replaced in-home visits with an already established telehealth option to stay connected with families served and allowed all sites to continue enrolling new families via telehealth throughout the pandemic. NFP sites also do “porch drop offs” to provide clients with program materials, essential items, and program engagement materials, in addition to drive-by graduation ceremonies, drive-through family events, and virtual support groups. The NFP National Service Office (NSO) has provided consistent guidance to ensure that the program continues to meet all model elements through the use of telehealth. In addition, through a partnership with a cellular company, the NFP NSO was able to provide cellular phones to sites with clients in need to ensure that services were able to be continued for those who otherwise may not have been able to keep in touch with their nurse home visitor.

Care Management programs (including Care Management for At-Risk Children, CMARC, and Care Management for High Risk Pregnancy, CMHRP) have found new ways to support individuals served in this program, including telephonic care, video conferencing and mailings, as well as face-to-face interaction with safety precautions in place if necessary. During interactions with individuals and families, staff are providing additional education on COVID-19, including guidance related to pregnancy or how COVID-19 relates to toxic stress.

The North Carolina Infant-Toddler Program (NC ITP), which provides supports and services for children birth to age 3 with developmental delays/disabilities or certain established conditions, moved to a virtual/remote service delivery mode in March 2020 to help mitigate the spread of COVID-19. The NC ITP has implemented teletherapy, virtual eligibility evaluations, remote/virtual service coordination and other teleservices statewide, with the assistance of Medicaid policy flexibilities. Teleservices have afforded continuity of care for families enrolled in the ITP and service provision for families entering the program with children with developmental delays and established medical conditions. Since the beginning of the pandemic, the NC ITP has seen an overall decline in referral rates by approximately 37% and a 16% decline in enrollment.

K-12 and Higher Education Guidance/Engagement

Because of the benefits, returning students to in-person education has been a priority for the state. Robust guidance has been issued with multi-layered health and safety protocols including reduced density, 6 feet social distancing, face coverings for staff and students, enhanced cleaning, and symptom screening.

DHHS issued numerous [K-12 school guidance resources](#):

- [StrongSchoolsNC Public Health Toolkit K-12 Guidance](#)
- [Infection Control and PPE Guidance](#)
- [Reference Guide for Suspected, Presumptive, or Confirmed Cases of COVID-19](#)

At the start of the school year, schools could open for in-person learning with requirements aligning with a hybrid approach of in-person and remote learning (Plan B in the Toolkit Guidance). About half of the districts, representing one-third of students have opted for hybrid approach of in-person and remote learning (Plan B), while the other half of the districts representing two-thirds of students opted for full remote learning (Plan C). Beginning October 5, full in person learning (Plan A) was made an available option for K-5.

DHHS convened a Higher Education Work Group in June 2020 to discuss cross cutting issues with 15 UNC, community college, and independent college and university presidents and chancellors. [Interim DHHS Guidance for Institutions for Higher Education](#) provides overall guidance on prevention and risk mitigation strategies. The updated Interim [DHHS Guidance for Off-Campus Shared Housing Settings Specific to Institutions for Higher Education](#) reflects early lessons learned that viral spread is originating in communal living settings on and off campus, social gatherings on and off campus and with athletic teams.

DHHS is closely coordinating with higher education and health departments. DHHS is surging testing resources during outbreaks for on- and off-campus community testing and ensuring

isolation and quarantine capacity. DHHS is working with higher education institutions to support and inform proactive surveillance strategies.

North Carolina's Behavioral Health Response to COVID-19

Baseline Data and Unmet Need Pre-COVID-19

Though North Carolina has been rated in the highest tier for being prepared for public health emergencies, there are gaps in the state's healthcare system and unmet behavioral health needs that existed prior to this pandemic.¹ Out of North Carolina's more than 10 million residents, over 1.5 million over the age of 18 had a mental illness in a given year (prior to the pandemic) and 1 in 5 were not receiving mental health services at all (approximately 305,000).²³ The gap is even larger among those with substance use disorder (SUD). Prior to the pandemic there were approximately 578,000 North Carolinians over the age of 18 with SUD who needed treatment at a special facility for substance use in a given year. Eight out of nine (over 500,000 of them) but did not receive this service,⁴⁵ This unmet need increased the state's vulnerability to a public health emergency like the COVID-19 pandemic.

Worsening behavioral health in the Context of COVID-19

At the beginning of the pandemic, Americans reported anxiety about the possibility of getting COVID-19 and/or the possibility of family and loved ones contracting the virus.⁶ Exacerbated by interruptions to daily routines created by the pandemic, individuals who report that their lives have been significantly disrupted are more likely to report negative mental health impacts.⁷ Additionally, periods of economic downturn are linked to increased rates of depression, anxiety, substance use, and other behavioral health conditions.⁸ Approximately 27% of North Carolina's labor force has filed an unemployment claim since the pandemic began.⁹¹⁰

Indicators of Behavioral Health Outcomes

¹ Trust for America's Health (2/5/20) New Report Places 25 States and DC in High Performance Tier on 10 Public Health Emergency Preparedness Measures. <https://www.tfah.org/article/new-report-places-25-states-and-dc-in-high-performance-tier-on-10-public-health-emergency-preparedness-measures/>

² Any mental illness defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Mental health services defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medications (excluding treatment for substance use)

³ 2017-2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 states and the District of Columbia); published 12/18/19. <https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates>

⁴ 2017-2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 states and the District of Columbia); published 12/18/19. <https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates>

⁵ Needing But Not Receiving Substance Use Treatment refers to respondents who are classified as needing illicit drug or alcohol treatment, but who did not receive illicit drug or alcohol treatment at a specialty facility

⁶ New Poll: COVID-19 Impacting Mental Well-Being: Americans Feeling Anxious, Especially for Loved Ones; Older Adults are Less Anxious (3/25/20). American Psychiatric Association. <https://www.psychiatry.org/newsroom/news-releases/new-poll-covid-19-impacting-mental-well-being-americans-feeling-anxious-especially-for-loved-ones-older-adults-are-less-anxious>

⁷ Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R. Hamel, L., Munana, C., & Chidambaram, P. (8/21/20). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

⁸ Frاسquilho, D., et.al. Mental Health Outcomes in Times of Economic Recession: A Systematic Literature Review. BMC Public Health. 2016. Retrieved from: <https://pubmed.ncbi.nlm.nih.gov/26847554/>

⁹ Unemployment claims data; <https://des.nc.gov/need-help/unemployment-claims-data> accessed 9/28

¹⁰ US Bureau of Labor Statistics, North Carolina's economy at a glance; https://www.bls.gov/eag/eag.nc.htm#eag_nc.f.p

Survey data indicates that 2.7 million North Carolinian adults (over 33%) are experiencing symptoms of depression and/or anxiety disorders in a given week.¹¹ This suggests a tripling of the 11% who reported symptoms in the first half of 2019.¹² These increases have persisted throughout the pandemic and point to widespread behavioral health pressure on the state's population. Nationally, there has been an increase in calls to the National Suicide Prevention Lifeline (1-800-273-8255).¹³ Calls coming into North Carolina's call center have remained consistent with pre-pandemic volume; however, the nature of the calls received are more serious in nature than those prior to the pandemic.

Sustained mental distress can lead to mental illness, which is often linked to and co-occurring with SUD. There are indications that access to and use of substances has increased during the pandemic. A nationwide survey conducted during the pandemic found that 1 in 4 respondents reported binge drinking at least once in the week prior to being surveyed (up from 1 in 6 in 2019).¹⁴¹⁵ Despite experiencing a 19% decrease in overall Emergency Department (ED) visits through August of 2020 from the previous year, North Carolina has seen a 21% increase in medication/drug overdose ED visits that is largely driven by a 24% increase in opioid overdose ED visits.¹⁶

For every five percentage point increase in the rate of unemployment, an additional 304 North Carolinians would be expected to die each year (126 from suicide and 178 from drug overdose).¹⁷¹⁸ We are only experiencing the beginning of the behavioral health impacts from this pandemic.

Individuals with Intellectual/Developmental Disabilities

People with intellectual and/or developmental disabilities (I/DD) are 4 times as likely to contract COVID-19 and 2 times as likely to die from COVID-19, compared to the general population. One factor in this increased risk is that people with I/DD are more likely to live in settings with

¹¹ US Census Bureau "Household Pulse Survey"; Anxiety and/or depression prevalence data; Census Bureau Household Pulse Survey; 12 survey periods; 4/23-7/21 <https://data.cdc.gov/NCHS/Indicators-of-Anxiety-or-Depression-Based-on-Report/8pt5-q6wv>

¹² Early Release of Selected Mental Health Estimates Based on Data from January-June 2019, National Health Interview Survey. (5/2020). National Center for Health Statistics. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/ERmentalhealth-508.pdf>

¹³ Russel, D. & Hopkins, J.S., Amid Coronavirus Calls and Texts to Mental-Health Hotlines are Surging. The Center for Public Integrity. <https://publicintegrity.org/health/coronavirus-and-inequality/coronavirus-calls-texts-mental-health-hotlines-are-surging/>

¹⁴ Coe, E., Enomoto, K. (4/2/20) Returning to Resilience: The impact of COVID-19 on mental health and substance use. McKinsey & Company. <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/returning-to-resilience-the-impact-of-covid-19-on-behavioral-health#>

¹⁵ CDC. Binge Drinking is a Serious but Preventable Public Health problem (12/2019). <https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm>

¹⁶ Injury Free NC (8/17/20). North Carolina Emergency Department for Opioid Overdose: July 2020.

<https://www.injuryfreenc.ncdhhs.gov/DataSurveillance/StatewideOverdoseSurveillanceReports/OpioidOverdoseEDVisitsMonthlyReports/StatewideOpioidOverdoseSurveillance-ED-Data-July2020.pdf>

¹⁷ Brown, E., & Wehby, G. L. (2017, July 26). Economic conditions and drug and opioid overdose deaths. Medical Care Research and Review, 76(4), 462–477.

<https://doi.org/10.1177/1077558717722592>

¹⁸ Phillips, J. A., & Nugent, C. N. (2014). Suicide and the Great Recession of 2007–2009: The role of economic factors in the 50 U.S. states. Social Science & Medicine, 116:22–31. doi:10.1016/j.socscimed.2014.06.015

other residents where staff come in and out even more than in facilities with aging populations. Many people with I/DD have expressed anxieties relating to their increased risk of contracting COVID-19.¹⁹

Increasing Access

DHHS has interagency, multidisciplinary workstreams dedicated to behavioral health and IDD populations with significant community outreach and focus on Historically Marginalized Populations.

North Carolina has applied and been approved for an [1135 waiver and an Appendix K waiver](#) from the Centers for Medicare and Medicaid Services (CMS) to request flexibility of several Medicaid rules in order to be more flexible in responding to the needs of North Carolina citizens. The State rapidly modified [telehealth policies for Medicaid](#) and [telehealth policies for state-funded services](#) and quickly approved LME/MCO telehealth policies to allow for a broad array of behavioral services to be offered by telephone and two-way audio/video. The State instituted measures to maximize tele-behavioral health; including, allowing MD to MD consultation, psychiatry evaluation and management codes to be billed via telehealth, telephonic/patient portal with established patients, psychotherapy to be done via telehealth (crisis, individual, group and family), research based behavioral health treatment via telehealth, and inpatient psychiatry to bill subsequent and discharge visits via telehealth. In addition, enhanced behavioral health services to support community services were permitted to use telehealth, such as, Assertive Community Treatment, Community Support Teams, Multi-systemic Therapy, Intensive In-home Services, Mobile Crisis, and Peer Support Services.

Awareness and crisis management

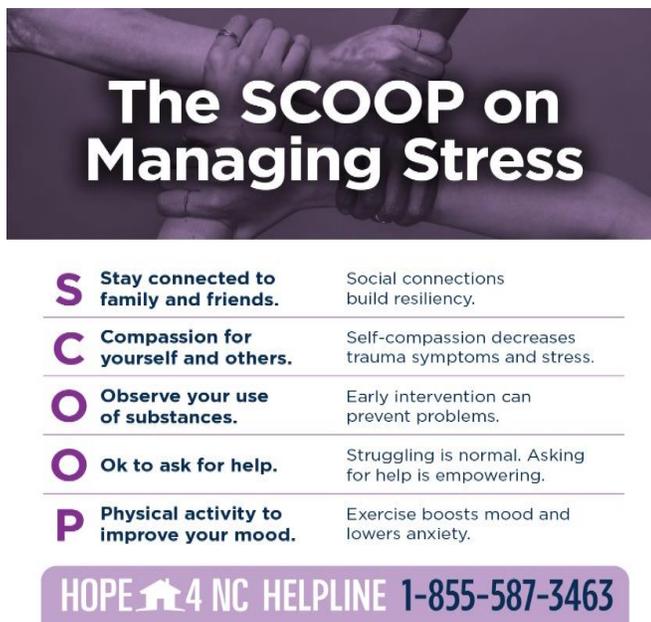
DHHS has three initiatives to raise awareness, manage crisis and promote resiliency: Hope4NC Helpline, Hope4Healers Helpline, and “the SCOOP on managing stress.”

Hope4NC Helpline (1-855-587-3463) connects North Carolinians to mental health and resilience supports and is available statewide, 24 hours a day, seven days a week during the COVID-19 crisis. The Hope4NC helpline includes a Crisis Counseling Program tailored for COVID-19 that will provide immediate crisis counseling services to individuals affected by the COVID-19 crisis. **Hope4Healers Helpline (919-226-2002)** is a partnership with the North Carolina Psychological Foundation. This initiative provides mental health and resilience supports

¹⁹ Shapiro, J. (7/31/20). One Man's COVID-19 Death Raises the Worst Fears of Many People with Disabilities. NPR. <https://www.npr.org/2020/07/31/896882268/one-mans-covid-19-death-raises-the-worst-fears-of-many-people-with-disabilities>

for health care professionals, emergency medical specialists, first responders, and other staff who work in health care settings who are experiencing stress from being on the front lines of the state’s COVID-19 response. It is available 24 hours per day, seven days a week, and staffed by licensed mental health professionals for follow-up.

We have also developed evidence-based behavioral health messaging aimed at prevention using the acronym **SCOOP**:



The graphic features a background image of several hands clasped together in a supportive grip. Overlaid on this is the title "The SCOOP on Managing Stress" in large, bold, white font. Below the title is a list of five items, each with a colored letter icon (S, C, O, O, P) and a brief description. At the bottom of the graphic is a purple banner with the text "HOPE 4 NC HELPLINE 1-855-587-3463" in white font.

S	Stay connected to family and friends.	Social connections build resiliency.
C	Compassion for yourself and others.	Self-compassion decreases trauma symptoms and stress.
O	Observe your use of substances.	Early intervention can prevent problems.
O	Ok to ask for help.	Struggling is normal. Asking for help is empowering.
P	Physical activity to improve your mood.	Exercise boosts mood and lowers anxiety.

HOPE 4 NC HELPLINE 1-855-587-3463

Expanding services

North Carolina has received \$116 million in funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act and \$3.5 million from other federal sources. These funds have been targeted for behavioral health and IDD populations and designed to leverage other programs to ensure a coordinated response that drives systemic change. This includes funding for increased staffing and care costs at residential facilities and group homes, managing crisis (including the Hope4NC line), behavioral health care for the under/uninsured, and naloxone.

The Opioid Action Plan with COVID-19 Impact

Work continues on the Opioid Action Plan (OAP) during COVID-19. The Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC) meets quarterly to highlight innovative work being done across North Carolina. With COVID-19, meetings were changed to virtual and meet monthly, with the exception of November, until the end of the year. The September meeting focused on how treatment has changed due to COVID-19. Remaining

meetings (October and December) will focus on syringe service programs and justice-involved work.

The [Opioid Action Plan Dashboard](#) was launched in June 2018 and provides county level data on the key OAP metrics. This dashboard enables local, county, and state partners to directly access the data to monitor the opioid epidemic in their counties. The dashboard has been presented at numerous stakeholder meetings to educate partners on its availability and application. The most recent 2019 and 2020 year-to-date data can be viewed on the dashboard online. A new data dashboard tracking the metrics outlined in OAP 2.0 is set to launch in late 2020.

Public Health Preparedness Disaster Response with COVID-19 Impact

With strong relationships and collaboration between Public Health Preparedness Disaster Response (PHPDR) and NC Emergency Management, response to COVID-19 ensures we continue to be able to respond and prepare for COVID-19 and other disasters. When the State Emergency Operations Center (SEOC) activated in March 2020 for COVID-19, PHPDR facilitated: Receipt and distribution of strategic national stockpile resources, PPE verification in support of massive procurement efforts, testing resource request verification and shipments, and support for local health departments in responding to outbreaks and unprecedented challenges.

When the SEOC moved to an extended virtual status in late April, PHPDR adapted to support the virtual response for COVID-19 and other disaster responses. The National Special Security Event was held in Charlotte, requiring both an in-person and virtual presence that PHPDR fulfilled. Throughout the year, PHPDR has continued to support local responders and our state partners in responding to everyday incidents while also navigating the additional challenges of COVID-19 to include strained resources and more remote support than in previous years. While the way in which the services are delivered may have changed, the quality and strength in partnerships has continued to be exemplary.

This hurricane season presented additional challenges in updating and revising plans that accounted for the complexities of the COVID-19 pandemic. One of PHPDR's key response roles in hurricanes is in recruiting and supporting local public health nurses to work in shelters during and post landfall. Much of this coordination effort is eased by bringing a team of public health workers into a coordination center. In 2020 that meant doing this virtually. All systems for tracking and organizing were moved online and personnel practiced using technology systems both old and new. Working with Emergency Management Human Services Branch there was considerable focus on encouraging the use of non-congregate shelters (i.e. hotel rooms) which also aligned with a smaller staffing footprint. The job description for public health nurses was updated to reflect their duties more accurately when assigned to shelters. Sheltering procedures

were reviewed to ensure effective recommendations were made for monitoring all shelter workers and clients, and isolating clients who may have COVID-19. As Hurricane Isaias impacted the North Carolina coast, a remote response was activated which engaged all PHPDR stakeholders for a brief period of time.