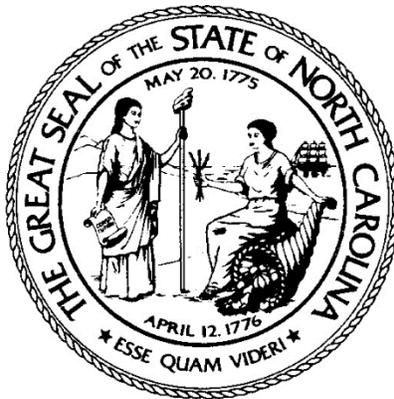


North Carolina Department of Health and Human Services  
Division of Public Health

Annual Report to the  
North Carolina Medical Society  
and Commission for Public  
Health

October 2021



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## EXECUTIVE SUMMARY

### Department of Health and Human Services' State Health Director's Annual Report to the North Carolina Medical Society and Commission for Public Health

October 2021

#### BACKGROUND

General Statute 130A.33 requires the State Health Director to submit an annual report on public health at a joint gathering of the North Carolina Medical Society (NCMS) and the Commission for Public Health. This year's report incorporates America's Health Rankings, Healthy North Carolina (HNC) 2030, and the NC DHHS Strategic Plan and has an emphasis on equity. The report also includes updates on department-wide initiatives, progress toward goals, and ongoing work to combat public health threats including the ongoing COVID-19 pandemic, other emerging communicable diseases, and environmental health

#### STATEWIDE PRIORITIES, PLANS AND METRICS

**Healthy North Carolina 2030**- The North Carolina Department of Health and Human Services (NC DHHS) and the North Carolina Institute of Medicine (NCIOM) convened leaders and experts from a wide array of fields to create [Healthy North Carolina 2030](#). The document lays out the state of public health today, goals for 2030, and metrics to measure progress toward those goals over the course of the decade. With a focus on health equity and the overall drivers of health outcomes (health behaviors, clinical care, social and economic factors, education, and the physical environment), these indicators and targets will help to further drive state and local-level activities, provide a springboard for collaboration and innovation, and serves as the backbone for our ongoing North Carolina State Health Improvement Plan (NC SHIP).

**NC DHHS 2021-2023 Strategic Plan** - The NC DHHS [2021-2023 Strategic Plan](#) is grounded in the Department's values, driven by equity, rooted in our commitment to whole-person care, and responsive to the lessons learned responding to the greatest health crisis in a more than a generation. NC DHHS is and will continue to further advance its mission to improve the health, safety, and wellbeing of all North Carolinians by continually making progress toward accomplishing the Plan's seven goals. Some accomplishments and future plans that align with these seven goals are described below.

#### **1. Advance health equity by reducing disparities in opportunity and outcomes for historically marginalized populations (HMP) within NC DHHS and across the state.**

- a. NC DHHS hired its first-ever Chief Health Equity Officer and a new Assistant Secretary of Equity and Inclusion
- b. The Public Health Workforce Initiative seeks to grow and advance a diverse public health workforce that reflects the communities they serve, and strengthen the capacity of the State and Local Health Departments
- c. Healthier Together is a new public-private partnership between NC DHHS, [NC Counts Coalition](#), and community-based organizations (CBOs) to increase COVID-19 vaccinations among Black, Indigenous, and People of Color (BIPOC) from other HMPs and provides a foundation for a longer-term framework for health equity across the state of North Carolina.
- d. NC DHHS received \$40 million in Centers for Disease Control and Prevention (CDC)

Health Equity Funding to support advancing health equity and decreasing disparities. This funding will support activities of community partners and local health departments in advancing health equity across four main strategy areas.

- e. Access to health insurance coverage is key to improving racial equity. Taking the opportunity to expand Medicaid would be a powerful lever to improve equity.

**2. Help North Carolinians end the pandemic, control the spread of COVID-19, recover stronger, and be prepared for future public health crises with an emphasis on initiatives serving those communities most impacted.**

- a. North Carolina continues its fight against COVID-19 through an innovative, science-based, and data-informed approach that ensures equity is incorporated into each step of the process, as evidenced by the reduction in disparities in vaccination rates among our HMPs.
- b. Key areas of focus over the last year include equity in the COVID response, data transparency, proactive communication, prevention strategies, critical social supports, robust operations including testing, case investigation, contact tracing, quarantine and isolation supports, vaccines, treatment, telemedicine/telehealth and enhanced technology, oral health, and behavioral health needs.
- c. North Carolina’s focus on equity in its pandemic response and data quality and transparency has been spotlighted in numerous national reports and articles as an example of best practice.
- d. North Carolina recognized early that effective and transparent communications would be essential to its pandemic response. The Secretary held more than 150 press conferences; the Department launched an award-winning Whatever the Reason campaign to promote masks that featured North Carolinians across the state; and its vaccine campaign is a research-informed public engagement strategy that focuses on those most impacted by the impact.
- e. The COVID-19 pandemic has created a large “health debt” for North Carolinians from missed or delayed preventive health screenings and delayed care for chronic disease. Panel management and supporting patients with their routine preventive and screening needs, e.g. colorectal cancer screening, breast cancer screening, diabetes care etc., are important priorities as we emerge from the pandemic.

**3. Build an innovative, coordinated, and whole-person — physical, mental and social health — centered system that addresses both medical and non-medical drivers of health.**

- a. NC DHHS has tools in place to execute this work in a variety of settings and across populations, including standardized screening questions and [NCCARE360](#), have been expanded and utilized across the state. NCCARE360 network now includes over 4,600 community-based programs, all five Medicaid Prepaid Health Plans (PHPs), seven Local Management Entity – Managed Care Organizations (LME-MCOs), and 6 large health systems.
- b. On July 1, 2021, North Carolina launched the first phase in Medicaid Managed Care (MMC): LME-MCO Standard Plans. More than 1.6 million Medicaid beneficiaries transitioned from fee-for-service (FFS) Medicaid to five PHPs. At the same time,

NC deployed a nationally unique model of Primary Care Case Management with the Eastern Band of Cherokee Indians in a Tribal Option that manages health care for North Carolina’s approximate 4,000 Tribal Medicaid beneficiaries. In 2022, the department plans to move the majority of the remaining Medicaid members into a Tailored Plan. NC DHHS has leveraged the move to managed care to build an innovative health care delivery system that puts the health of beneficiaries at the forefront and seeks to “Buy Health, not just Health Care”. Features include:

- i. Establishing a payment structure that rewards better health outcomes
  - ii. Caring for the whole person
  - iii. Helping people manage their health through care management
  - iv. Implementing a quality strategy to promote health plan accountability
  - v. Launching Healthy Opportunity Pilots to create new infrastructure and payment vehicles for non-medical drivers of health
- c. The COVID-19 Community Health Worker Program supported community health workers in 55 counties to connect North Carolinians with medical and social supports. NC DHHS was awarded \$9 million to expand a Community Health Worker program to all 100 counties.

#### **4. Turn the tide on North Carolina’s opioid and substance use crisis.**

- a. As North Carolina continues to experience an opioid epidemic and its harmful effects, work has continued by NC DHHS and community partners on the Opioid Action Plan (OAP) during COVID-19 with an aim to reduce expected opioid overdose deaths by 20 percent over four years.
- b. Activities and strategies have included distributing naloxone, growing the NC Safer Syringe Initiative, awarding the CDC fund to local partners, expanding the North Carolina State Unintentional Drug Overdose Reporting System, release of a Request For Applications local justice system projects to prevent opioid overdoses for people who are involved in the justice system, and settlement funds from opioid manufacturers and distributors to be utilized by state and local governments for evidence-based Opioid and Substance Use strategies.

#### **5. Improve child and family well-being so all children have the opportunity to develop to their full potential and thrive.**

- a. NC DHHS is launching a Division of Child and Family Well-Being that will focus on closing equity gaps across the health, social, and educational needs of children and youth.
- b. North Carolina received a historic federal \$805 million investment in early care and learning child care programs. The North Carolina Child Care Stabilization Grants will support working families with access to high-quality, affordable child care and invest in child care staff.
- c. Adaptive approaches and flexibilities have been used to address the needs of children with complex needs during the pandemic and deliver food and nutrition services (FNS) to children.
- d. Work continues on two federal grants awarded to NC DHHS to improve maternal health in the state, Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program and the Maternal Health Innovation (MHI) Program.

This work remained aligned with the state's updated Perinatal Health Strategic Plan that is expected to be released in Fall 2021.

**6. Support individuals with disabilities and older adults in leading safe, healthy and fulfilling lives.**

- a. The Division of Public Health (DPH) has collaborated with the Division of Aging and Adult Services (DAAS) and external partners to secure grants and launch programs to support older adults, including a CDC grant to help promote a public health approach to Alzheimer's disease and related dementias, the first five-year NC Falls Prevention Coalition Action Plan, a Healthy Aging Task Force, a Social Isolation and Loneliness Work Group, and a five-point strategy for long-term care facilities.
- b. NC DHHS has begun work on the Olmstead Plan to support people with disabilities to live their lives as fully included members of the community and in the most integrated settings possible.
- c. Transition to Community Living continues to provide eligible adults living with serious mental illnesses the opportunity to choose where they live, work, and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment, and community integration.

**7. Achieve operational excellence by living our values — belonging, joy, people-focused, proactive communication, stewardship, teamwork, and transparency.**

- a. To enhance data driven decision making and whole person health through a modernized data and IT infrastructure, the Data Strategy Roadmap has five cross-cutting pillars. i) Infrastructure- the Business Intelligence Data Platform has provided a foundation for a broader IT infrastructure; ii) Data Governance- the Data Sharing Guidebook and legal framework facilitates appropriate role-based data sharing; iii) Data Connection – Partnerships with the Department of Information Technology Government Data Analytics Center and the State Health Information Exchange facilitate record linkage across previously siloed data sources, thus facilitating a 360-degree view of the people we serve; iv) Data Quality- DHHS has initiated proactive workstreams aimed at data quality assessment and improvement; v) Data Use- COVID provided an urgent use case through which to demonstrate the importance of actionable data insights.
- b. NC DHHS Team Recognition Awards recognized NC DHHS teams who have gone above and beyond to further the mission of NC DHHS and demonstrated the NC DHHS values during 2020.
- c. The Foundational Capacities of Public Health are the suite of skills, programs, and activities that must be available in state and local health departments everywhere for the health system to work anywhere. With anticipated financial support from the CDC, DPH will use this evidenced-based framework to identify and fill select staffing and training needs at the State and local levels for COVID-19 response and recovery. This approach is designed to advance pandemic response and recovery, while also preparing for community-wide public health needs for the future.
- d. The NCIOM has established a Task Force on the Future of Local Public Health in

North Carolina to develop a vision for the future of local public health in the state and recommendations to achieve that vision. This includes principles of health equity, leadership, connection between clinical services and population health, opportunities for targeted investments, public communication about the value of public health, and data integration to drive improvements in service delivery and outcomes.

## **ADDRESSING COMMUNICABLE DISEASE AND OTHER THREATS**

North Carolina is dealing with multiple public health threats. Chief among these include rising youth e-cigarette use, ensuring early identification of diabetes, addressing environmental contaminants, promoting childhood immunizations, ending the Human Immunodeficiency Virus (HIV) epidemic, reducing congenital syphilis (CS) and viral hepatitis infections, addressing climate change, ensuring the health of citizens post disasters (such as hurricanes), reducing child lead exposure, and limiting the effects of pollution, heat, flooding, and storms. Details about these public health threats are provided in the full report and includes suggestions for providers on how they can be involved with and address these issues.

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**Department of Health and Human Services' State Health Director's  
Annual Report to the North Carolina Medical Society  
October 2021**

## **Report 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 (NC DHHS), Division of Public Health (DPH), and Dr. Elizabeth Tilson, State Health Director, are pleased to provide this annual report in fulfillment of this statutory requirement.

## **Introduction**

The Annual Report to the North Carolina Medical Society highlights much of the important and ongoing work that our valued public health workforce provides. In prior years, the focus of this report has been on public health in North Carolina through the broad lenses of [America's Health Rankings](#), Healthy North Carolina (HNC), major department-wide initiatives, and emerging threats. Last year, we primarily focused the report on the impacts of and response to the COVID-19 pandemic in North Carolina. This year's report once again returns to a broader focus and incorporates the lens of America's Health Rankings, HNC 2030, and the NC DHHS Strategic Plan and has an emphasis on Equity. The report incorporates updates on department-wide initiatives, progress toward goals, and ongoing work to combat public health threats including the ongoing COVID-19 pandemic, other emerging communicable diseases, and environmental health. As in previous years' reports, we lift up the hard work that has been and continues to be performed by our local health departments who have been front-line responders in this public health effort.

## **NATIONAL AND STATEWIDE PRIORITIES, PLANS, GOALS, AND METRICS**

### **America's Health Rankings**

[America's Health Rankings](#) is an annual report for states built upon the World Health Organization definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The *America's Health Rankings* model includes four drivers, or determinants of health: social & economic factors, physical environment, clinical care, and behaviors, all of which influence the fifth model category, health outcomes.

According to the [2020 report from America's Health Rankings](#), strengths of North Carolina include:

- Low prevalence of 2+ adverse childhood experiences
- High immunization coverage among children
- Low prevalence of excessive drinking

Challenges that persist in North Carolina include:

- High prevalence of high-risk Human Immunodeficiency Virus (HIV) behaviors
- High prevalence of multiple chronic conditions
- High prevalence of avoided care due to cost

**Below are a few of the key metrics from the 2020 report from America's Health Rankings report for North Carolina:**

- Occupational fatalities increased 38% between 2012-2014 and 2016-2018 from 3.7 to 5.1 deaths per 100,000 workers
- High-speed internet increased 11% between 2015 and 2018 from 78.4% to 86.8% of households
- Severe housing problems decreased 7% between 2007-2011 and 2013-2017 from 16.2% to 15.1% of occupied housing units
- High school graduation racial gap increased 10% between 2017 and 2018 from 8.7 to 9.6 percentage points
- Mental health providers increased 21% between 2016 and 2020 from 219.1 to 265.5 per 100,000 population
- Frequent mental distress increased 21% between 2014 and 2019 from 11.4% to 13.8% of adults

### **Healthy North Carolina 2030**

Healthy people and healthy communities are the foundation of a thriving, prosperous state, and improving the health, safety, and well-being of North Carolinians is a core part of the work of North Carolina state government and key partners and stakeholders. One strategy for improving public and population health is to set a vision and road map for efforts and identify a set of health objectives to measure progress. The HNC framework, which is the state-level version of the national Healthy People framework, seeks to do that and sets decennial health objectives for our state.

The HNC project is a set of health indicators with corresponding 10-year targets that are designed to guide state efforts with improving the health and well-being of all North Carolinians. Identifying key indicators and targets enables NC DHHS, DPH, local health departments, health professionals, businesses, law enforcement, community-based organizations (CBOs), and other cross-sectional partners across the state to work collaboratively toward achieving common goals.

The NC DHHS and the North Carolina Institute of Medicine (NCIOM) convened leaders and experts from a wide array of fields to create [Healthy North Carolina 2030](#). The project was

supported by the Duke Endowment, Kate B. Reynolds Charitable Trust, and the Blue Cross and Blue Shield of North Carolina Foundation. The document lays out the state of public health today, goals for 2030, and metrics to measure progress toward those goals over the course of the decade. With a focus on health equity and the overall drivers of health outcomes (health behaviors, clinical care, social and economic factors, and the physical environment), these indicators and targets will help to further drive state and local-level activities, provide a springboard for collaboration and innovation and develop a new vision for public health in our state to improve the health and well-being of all North Carolinians.

**TABLE 1**  
**HEALTH INDICATORS AND DATA**  
 (TOTAL NC POPULATION, 2030 TARGET, AND DATA BY RACE/ETHNICITY, SEX, AND POVERTY LEVEL)

	HEALTH INDICATOR	DESIRED RESULT	TOTAL POPULATION	
			CURRENT (YEAR)	2030 TARGET
1	INDIVIDUALS BELOW 200% FPL	Decrease the number of people living in poverty	36.8% (2013-17)	27.0%
2	UNEMPLOYMENT	Increase economic security	7.2% (2013-17)	Reduce unemployment disparity ratio between white and other populations to 1.7 or lower
3	SHORT-TERM SUSPENSIONS (PER 10 STUDENTS)	Dismantle structural racism	1.39 (2017-18)	0.80
4	INCARCERATION RATE (PER 100,000 POPULATION)		341 (2017)	150
5	ADVERSE CHILDHOOD EXPERIENCES	Improve child well-being	23.6% (2016-17)	18.0%
6	THIRD GRADE READING PROFICIENCY	Improve third grade reading proficiency	56.8% (2018-19)	80.0%
7	ACCESS TO EXERCISE OPPORTUNITIES	Increase physical activity	73% (2010-18)	92%
8	LIMITED ACCESS TO HEALTHY FOOD	Improve access to healthy food	7% (2015)	5%
9	SEVERE HOUSING PROBLEMS	Improve housing quality	16.1% (2011-15)	14.0%
10	DRUG OVERDOSE DEATHS (PER 100,000 POPULATION)	Decrease drug overdose deaths	20.4 (2018)	18.0
11	TOBACCO USE	Decrease tobacco use	YOUTH 19.8% (2017)	9.0%
			ADULT 23.8% (2018)	15.0%
12	EXCESSIVE DRINKING	Decrease excessive drinking	16.0% (2018)	12.0%
13	SUGAR-SWEETENED BEVERAGE CONSUMPTION	Reduce overweight and obesity	YOUTH 33.6% (2017)	17.0%
			ADULT 34.2% (2017)	20.0%
14	HIV DIAGNOSIS (PER 100,000 POPULATION)	Improve sexual health	13.9 (2018)	6.0
15	TEEN BIRTH RATE (PER 1,000 POPULATION)		18.7 (2018)	10.0
16	UNINSURED	Decrease the uninsured population	13% (2017)	8%
17	PRIMARY CARE CLINICIANS (COUNTIES AT OR BELOW 1:1,500 PROVIDERS TO POPULATION)	Increase the primary care workforce	62 (2017)	25% decrease for counties above 1:1,500 providers to population
18	EARLY PRENATAL CARE	Improve birth outcomes	68.0% (2018)	80.0%
19	SUICIDE RATE (PER 100,000 POPULATION)	Improve access and treatment for mental health needs	13.8 (2018)	11.1
20	INFANT MORTALITY (PER 1,000 BIRTHS)	Decrease infant mortality	6.8 (2018)	6.0
			Black/white disparity ratio = 2.4	Black/white disparity ratio = 1.5
21	LIFE EXPECTANCY (YEARS)	Increase life expectancy	77.6 (2018)	82.0

HNC 2030 provides structure for the North Carolina State Health Improvement Plan (NC SHIP). The NC SHIP is based upon the population health framework and uses results-based accountability to identify measurable population level results for the twenty-one priority areas in HNC 2030. The NC SHIP is reviewed and revised annually. With the help of NC Area Health Education Centers (AHEC) and the Foundation for Health Leadership and Innovation, DPH solicited input through a series of 10 virtual community and stakeholder meetings from July-September 2021. Over 400 participants suggested revisions to the plan, including new partnership opportunities and new policy recommendations. The 2022 NC SHIP will be released in January 2022.

## NC DHHS 2021-2023 Strategic Plan

The NC DHHS's [2021-2023 Strategic Plan](#) is grounded in the Department's values, driven by equity, rooted in our commitment to whole-person care, and responsive to the lessons learned responding to the greatest health crisis in a more than a generation. As evidenced below, NC DHHS continues to further advance its mission to improve the health, safety, and wellbeing of all North Carolinians by making progress toward accomplishing the following seven goals:

1. Advance health equity by reducing disparities in opportunity and outcomes for historically marginalized populations (HMP) within NC DHHS and across the state.
2. Help North Carolinians end the pandemic, control the spread of COVID-19, recover stronger, and be prepared for future public health crises with an emphasis on initiatives serving those communities most impacted.
3. Build an innovative, coordinated, and whole-person — physical, mental, and social health-centered system that addresses both medical and non-medical drivers of health.
4. Turn the tide on North Carolina's opioid and substance use crisis.
5. Improve child and family well-being so all children have the opportunity to develop to their full potential and thrive.
6. Support individuals with disabilities and older adults in leading safe, healthy and fulfilling lives.
7. Achieve operational excellence by living our values — belonging, joy, people-focused, proactive communication, stewardship, teamwork, and transparency.

In the next section, we elaborate on these seven goals, highlight some of the work that has been accomplished, and plans for the future.

### **Goal 1: Advance health equity by reducing disparities in opportunity and outcomes for historically marginalized populations within NC DHHS and across the state.**

#### **NC DHHS Departmental Organizational Changes**

NC DHHS hired its first-ever Chief Health Equity Officer who reports directly to the Secretary. This member of the Department's executive leadership team will lead the Department's overarching and cross-departmental work, strategy, and operational goals to promote health equity, diversity, and inclusion across all NC DHHS health and human services. This leader will be responsible for developing, implementing, facilitating, and embedding health equity strategic initiatives into every aspect of NC DHHS's programs, services, actions, outcomes, and internal employee culture; as well as overseeing the Office of Health Equity, Office of Rural Health, and the Office of Diversity and Inclusion.

In addition, NC DHHS hired a new Assistant Secretary of Equity and Inclusion to work hand-in-hand with the Chief Health Equity Officer to develop, operationalize, and evaluate the Department's health equity work. The Assistant Secretary will lead the Department's internal diversity and inclusion work overseeing the Office of Diversity and Inclusion, as well as stakeholder engagement with community stakeholders.

## Public Health Workforce Initiative

The DPH's *Workforce Initiative* builds upon and contributes to NC DHHS's strategic goals by growing and advancing a diverse public health workforce that reflects the communities they serve and strengthening the capacity of the State and Local Health Departments to control the spread of COVID-19, recover stronger, and be prepared for future public health crises with an emphasis on initiatives serving those communities most impacted. The additional DPH staff will be funded using time-limited, federal appropriations from the American Rescue Plan Act (ARPA) of 2021.

### *Investing in workforce diversity, equity, and inclusion*

Diverse and inclusive hiring and retention at all levels is central to achieving health equity. These decisions are informed by the Division's Diversity, Equity, and Inclusion (DEI) Council.

- **Grow diverse talent pipeline:** sponsor an HBCU internship program, support community colleges and HBCUs for initiatives on careers in governmental public health, and execute a DEI outreach and networking plan for recruitment.
- **Hire talent:** include diverse hiring panels; set-aside advertising positions on job boards that reach HMPs; and track and report on race and ethnicity data for applications received as well as successful hires.
- **Grow careers:** track race and ethnicity for training and professional development opportunities, and use data to drive decision-making for offering coaching and mentoring opportunities.
- **Improve culture:** require supervisors to complete training on inclusive teams, offer and promote DEI training for staff, and support human resources positions for salary recalibration based upon equity data.

In addition to supporting these initiatives, workforce development and resource allocation to Local Health Departments will help extend these priorities to the regions.

## Healthier Together

Healthier Together is a new public-private partnership between NC DHHS and [NC Counts Coalition](#) to increase COVID-19 vaccinations among Black, Indigenous, and People of Color (BIPOC) from other HMPs and provide a foundation for a longer-term framework for health equity across the state of North Carolina.

Healthier Together has implemented strategies to drive demand and increase access to vaccines to BIPOC and other HMPs by conducting outreach and education efforts, coordinating local vaccine events at trusted and accessible locations, helping people schedule and get to vaccine appointments, providing on-site interpretation services, and helping ensure people get to second dose appointments. As shown in the graphic below, Healthier Together is working to address systemic inequalities by leveraging the following:



As part of this initiative, Healthier Together has provided grants to CBOs to do this work and hire regional health equity teams to support CBOs in their outreach and education efforts, help match vaccine providers with CBOs, and work with NC DHHS to ensure that communities have the vaccine supply, outreach, and transportation resources they need to get people vaccinated. As we move from COVID-19 response to recovery, we will extend this program’s infrastructure as a foundation for a longer-term framework for health equity.

Thus far Healthier Together has:

- Awarded \$500,000 in grants to support 27 CBOs across NC to support equitable access to vaccines.
- Healthier Together CBOs contacted over 400,000 people from mid-June to mid-August through a combination door-knocks, literature drops, phone calls, text messages, direct social media messages, events, relational contacts, and site-based outreach, resulting in:
- Narrowed the gap in COVID-19 vaccinations for HMPs, particularly LatinX/Hispanic and Black/African American communities. By September 2021, LatinX/Hispanic residents had higher vaccination rates compared to non-Hispanic residents for all age groups except those over 85 years old. Strategies included earning and sustaining trust, embedding equity in vaccine operations, and sharing accountability.

### **CDC Health Equity Funding**

Earlier this year NC DHHS received \$40 million in Centers for Disease Control and Prevention (CDC) funding to support advancing health equity and decreasing disparities. This funding will support activities of community partners and local health departments in advancing health equity across four main strategy areas below:

**Strategy 1 - Expanding Health Equity Resources & Services will focus on:** Increasing the ability of health programs to connect to needs like transportation, housing, and food; Addressing major public health issues that either exacerbate the risks of COVID-19, such as smoking, or that have been accentuated as a result of COVID-19, such as mental health with a focus on HMPs; Targeting particularly high-risk groups, such as incarcerated women & people with substance use disorders (SUDs) with COVID-19-related public health resources.

**Strategy 2 - Improving Health Equity Data and Reporting will focus on:** Investing in foundational data infrastructure & skills to measure health disparities and share aggregated data publicly to inform public health action; Building a Centralized Health Equity Data program for the gathering, analyzing, and sharing public health data to protect the health of all citizens with an emphasis on HMPs.

**Strategy 3 - Augmenting Critical Health Equity Infrastructure will focus on:** Capacity building for local health departments to create a health equity infrastructure for their COVID-19 response strategies; Engaging a coalition of multi-sector stakeholders that include members of underserved rural communities & organizations to increase access to critical COVID-19 testing, contact tracing, and other supportive services; Augmenting health equity staffing to coordinate efforts across DPH and with local health departments and create performance management systems with health equity lens.

**Strategy 4 - Partner Mobilization will focus on:** Supporting Community Based Organizations and rural health providers' use of NCCare360, NC's closed loop resource referral platform; Supporting communities in each of 8 NC Prosperity Zones to create community changes that support healthy living; Funding 20 community-based and faith-based organizations through Healthier Together to provide culturally & linguistically appropriate COVID-19 services and information to build trust and capacity in communities; and Expanding communications resources to reach people where they are through people and channels that they trust with a focus on American Indian, people with disabilities, Spanish-speaking populations. These funded activities will achieve reduced COVID-19-related health disparities and improved state and local capacity and services to prevent and control COVID-19 among populations at higher risk and that are underserved, including racial and ethnic minorities and rural communities.

## **Access to Care**

Recently published documents shine a spotlight on the reality of racial disparities in access to health care in North Carolina. A [new report from the Commonwealth Fund](#), a non-partisan, health care policy nonprofit, showed that racial disparities in access to health care across the country have decreased significantly since the Affordable Care Act was implemented in 2014.

Medicaid expansion has been key to improving equity in health insurance coverage, access to care and health improvements. Studies show larger Medicaid coverage gains and reductions in uninsured rates in expansion states compared to non-expansion states occurred across most or all of the major racial and ethnic categories. Additional research also suggests that Medicaid expansion has helped to reduce disparities in coverage by income, age, marital status, disability status, and, in some studies, race and ethnicity.

Studies have also shown that Medicaid expansion has increased coverage rates for women during the childbearing years and has improved health outcomes, including reducing rates of maternal death and decreasing infant mortality rates. A study released in 2018 found that while the infant mortality rate declined in both Medicaid expansion and non-expansion states between 2010 and 2016, the decline in Medicaid expansion states was more than 50 percent greater than in non-expansion states. This research also showed that the decline in infant mortality rates linked to

expansion was greatest among African American infants. Multiple studies found that expansion was also associated with significantly greater increases in early-stage cancer diagnosis rates.

However, North Carolina has not yet taken the opportunity to expand Medicaid, and as such, the improvements that other states have realized, have not occurred in our state. More than 600,000 North Carolinians would gain access to health care through Medicaid expansion.

**Goal 2: Help North Carolinians end the pandemic, control the spread of COVID-19, recover stronger, and be prepared for future public health crises with an emphasis on initiatives serving those communities most impacted.**

North Carolina has and will continue to fight against COVID-19 through an innovative and informed approach. A key focus throughout the pandemic has been learning from the past in order to create a better future. These lessons learned have helped drive effective strategies to combat not only COVID-19 but other public health threats as well. Key areas of focus over the last year include equity in the COVID response, data transparency, proactive communications, prevention strategies, critical social supports, robust operations including testing, case investigation, contact tracing and quarantine isolation supports, vaccines, treatment, telemedicine and enhanced technology, oral health and a focus on behavioral health needs. In addition, looking ahead, North Carolina will need to address the chronic disease “debt” that has been accumulated throughout the Pandemic.

Last year’s State Health Director’s report noted receipt of federal funding to cover the initial cost of testing, contact tracing, case investigation and personal protective equipment (PPE). NC DPH has subsequently received federal support in excess of \$1 billion to pay for our ongoing pandemic response efforts (testing, tracing, etc.) as well as administration of COVID-19 vaccinations, in addition to improvements in our statewide public health infrastructure and expanding our workforce so that we are better prepared for future pandemics and other disease outbreaks. These federal grants are all time-limited and non-recurring, and the bulk of which came from two sources: grants appropriated through the American Rescue Plan Act of 2021 (ARPA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES). Those grants included \$199.6 million for vaccinations, \$315.9 million for school testing and other efforts to support children returning to onsite instruction, \$62.3 million to increase the public health workforce, \$20.2 million to improve COVID-19 detection and mitigation efforts in jails and prison, and \$5.5 million to better support state and local level disease intervention specialists – the frontline personnel who are responsible for contacting and connecting to care anyone who has been diagnosed with particular communicable diseases.

**Equity in COVID-19 Response**

*The Office of Minority Health and Health Disparities*

The Office of Minority Health and Health Disparities advocates for policies and programs that increase racial and ethnic minorities’ access to health and human health services. It also oversees many important initiatives to systematically address the health status gap between white and minority populations in the state. Below, we highlight the important work this Office is doing to address equity with North Carolina’s COVID-19 efforts:

## *Historically Marginalized Populations Workgroup*

In the beginning of the COVID-19 global pandemic, NC DHHS convened the HMP Work Group, consisting of NC DHHS leadership and external partners, to ensure that members of these communities were not overlooked and were given the proper access to educational resources and supplies, culturally and linguistically appropriate services, and financial opportunities in response to the growing crisis. The vision of the HMP Work Group is to decrease disparities in the rates of COVID-19 infections and improve outcomes for HMPs for COVID-19 and beyond. The mission of the HMP Work Group is to protect HMPs from COVID-19 infection, complications when infected, and transmission to others by investing in and directing resources toward prevention and vaccination; testing; case investigation and contact tracing; wraparound services; behavioral health; and to ensure CBOs serving HMP have access to state resources to support their communities. HMP Work Group members have been embedded into program-level initiatives to create a feedback loop that ensures two-way conversations, input, feedback, and influence. The HMP Work Group approach is facilitated by NC OMHHD staff and co-led by the NC OMHHD executive director.

The HMP Workgroup is an integral part of our state's COVID-19 response. HMP stands for "historically marginalized population" and can be defined as individuals, groups, and communities that have historically and systematically been denied access to services, resources, and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination, and other forms of oppression.

Long-standing and well-documented structural marginalization has resulted in poor outcomes – health, social, political, economic, and overall increased vulnerability to harm for HMPs and communities. The NC DHHS HMP Workgroup works to achieve health equity and improve health outcomes within the state COVID response effort by directly engaging HMPs and collaborating with like-minded individuals who share these same values.

The five HMP Workstreams (sub-committees within the Workgroup) are as follows:

- WS1 Prevention
- WS2 Testing and Screening
- WS3 Community Engagement
- WS4 Health Equity Education and Empowerment
- WS5 Economic Opportunity and Employment Equity

The HMP Workgroup Prevention Workstream Team created the Historically Marginalized Populations Engagement Toolkit for Healthcare Systems & Providers to help providers and health care professionals appropriately engage HMPs in all stages of emergency preparedness planning and COVID-19 response efforts. The toolkit provides a framework for embedding health equity into the organizational infrastructure of state and local health systems for sustainable health care and delivery transformation. We have continued to extend our reach and impact with communities and providers by releasing the provider engagement toolkit, geared towards helping to cultivate and sustain state and local level partnerships. The [HMP Engagement toolkit](#) has been featured as a national and international model.

## ***Funding***

At the start of the COVID-19 pandemic, we saw disparities in the number of positive cases/infections and the number of deaths coming from members of HMPs based on race and ethnicity metrics. To promote health messages, provide educational resources, and donate PPE to communities with the greatest needs, NC OMHHD was able to provide funding opportunities to trusted, community-based, and faith-based organizations in communities across the state. The three different focused funding efforts added a total amount of \$5.7 million to support organizations that largely served LatinX, African American, and other historically marginalized communities.

## ***Andrea Harris Social, Economic, Environmental, and Health Equity Task Force***

The Governor's Executive Order 143 established the creation of the Andrea Harris Social, Economic, Environmental, and Health Equity Task Force to address the highlighted disparities in communities of color that are disproportionately impacted by COVID-19. The five major focus areas of the Andrea Harris Task Force include access to health care; economic opportunity and business development; educational opportunity; environmental justice and inclusion; and patient engagement. The Governor's Executive Order 143 specifies that the executive director of the NC OMHHD will serve on this task force to provide subject matter expertise around health equity strategies and approaches. Also highlighted in the Governor's Executive Order 143 is the charge of NC DHHS to reevaluate and elevate the mission of NC OMHHD and request appropriate funding and resources to meet updated needs. This level of support from the state and NC DHHS leadership continues to allow the office to identify the most effective ways to provide support to communities across the state. Currently, the executive director of NC OMHHD also serves as the chair of the Patient Engagement Subcommittee for the Task Force.

## ***Internal and External Support for Equity***

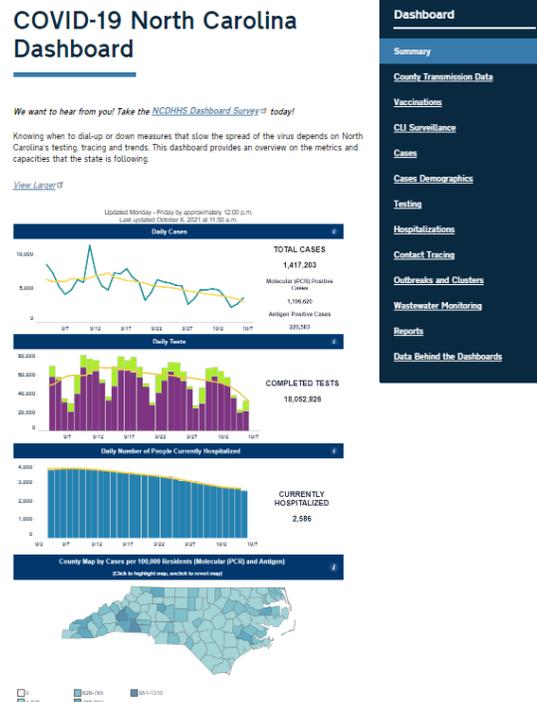
The work of NC OMHHD continues to support equity efforts both internal and external to state government and NC DHHS. Recently, NC DHHS released an updated strategic plan that focuses on equity being achieved throughout the work of the Department and match up metrics with HNC 2030 metrics. Subject-matter expertise is utilized by internal and external partners to serve on boards, committees, advisory groups, and workgroups. In accordance with Executive Order 143, NC OMHHD is evolving to be a part of the new Office of Health Equity at NC DHHS which will be overseen by the new Chief Health Equity Officer and the Assistant Secretary of Equity and Inclusion, along with the Office of Rural Health and the Office of Diversity and Inclusion. Internal equity efforts around COVID-19 initiatives have been coordinated by a core equity team including department-wide focuses on connecting the dots through our collective work with the Health Equity Brain Trust, Special Populations, HMP Workgroup, Healthier Together, Community Health Workers, Case Investigation/Contact Tracing, the CDC Health Disparities Grant Team, and the newly formed Data Equity Team.

North Carolina's focus on equity in its pandemic response has been spotlighted in numerous national reports and articles as an example of best practices.

## Data Transparency

### COVID-19 Dashboard – Keeping North Carolina Informed

NC DHHS keeps health care workers, government officials, and the general public informed using its COVID-19 Dashboard which helps them to know when to dial up or down measures that slow the spread of the virus depending on North Carolina’s testing, tracing, and trends. This dashboard provides an overview of the key metrics and capacities that the state is following as well as robust vaccination data. The key metric data dashboard is updated every weekday. A screenshot of the dashboard is shown below:



Throughout the pandemic, NC DHHS has worked to improve data accuracy and transparency in its reporting. NC DHHS now publishes over 15 public-facing dashboards and reports every weekday or on a weekly basis. The information on the data dashboards is used to promote equity, track progress and guide decision-making. Having the most accurate information available is important so local and state leaders have the data needed to inform decision-making.

NC DHHS has also worked to increase the amount of data being transmitted electronically from laboratories and healthcare providers. These data serve as the foundation for the dashboard and drive decision making at all levels. NC DHHS received approximately 75% of all laboratory reports electronically at the start of the pandemic but today has achieved a reporting level of 97% of all COVID-19 PCR tests being reported electronically.

COVID-19’s strain on the state’s healthcare resources—both services and supplies—created several issues voiced by state representatives, hospital administrators, and clinicians. In response, NC partnered with Apriss Healthcare to implement the Apriss Open Beds Critical Resource Tracker (OpenBeds CRT). Even with the federal government’s guidance around data reporting, administrators and clinicians lacked a specific definition of reporting, resulting in inaccurate or

subjective data. Antiquated data collection and reporting systems could not scale quickly enough to ensure compliance with constantly changing federal reporting requirements, and State administrators lacked a complete, real-time view of available ICU beds, PPE, and other resources across the state’s hospitals. Finally, the manual hours associated with daily tracking and reporting of data were not sustainable long term, during this pandemic or any future crisis.

In response, the OpenBeds Critical Resource Tracker (CRT) was developed which is a web services API solution that enables the state of North Carolina and its hospitals to view critical data and operate more efficiently. Automated data submission to the state and federal government (via HHS Protect) replaces time-consuming manual reporting. Submission of data through a single system in a simple, standardized manner eliminates subjectivity. Data is updated as often as every hour, reassuring state users of its integrity. Real-time, unique views are provided at the hospital, regional, and state level, meaning hospital and state administrators see different displays that fit each of their data analysis needs.

Visibility of available critical COVID-19 resources help the Department of Health and Human Services identify surpluses, shortages, or gaps to better manage patients’ needs, assess resources, and allocate funding. There are 120 acute care hospitals using the tracker with 80 hospitals automating reporting to the State and Federal Government. The efficiency of the system reduced reporting burden for health care settings.

The North Carolina Department of Health and Human Services’ vaccine data dashboard now includes county-level vaccination information not only from state-supplied providers, but also from federal providers, including federal pharmacy program providers, as well as the U.S. Department of Veterans Affairs, U.S. Department of Defense, Federal Bureau of Prisons, and Indian Health Service. North Carolina has also been recognized nationally for the quality and transparency of the demographic data on its vaccine data dashboard, which is used to promote the equitable administration of the COVID-19 vaccine.

Additionally, to align with new updates to the national COVID-19 surveillance case definition, NC DHHS began reporting reinfections with COVID-19 as part of COVID-19 case counts starting October 4th. A reinfection means a person was infected once with COVID-19, recovered, and then tested positive at least 90 days after their initial positive test. As of September 26, 2021, more than 10,000 reinfections had occurred in North Carolina since the pandemic began in March 2020. Including reinfections on NC DHHS dashboards provides a more accurate representation of COVID-19 case counts in North Carolina and at the county level going forward.

The data dashboard is powered by a newly developed cloud-based enterprise data warehouse (the “Business Intelligence Data Platform” or BIDP) that ingests data from different sources and allows for daily automated dashboard updates.

NC DHHS has been nationally recognized for its pandemic response data transparency, particularly in the area of equity. Bloomberg News repeatedly named North Carolina as best in the nation in data quality for vaccinations by race and ethnicity.

### ***Social Vulnerability Index Map***

Another tool to help North Carolina reach its goal of vaccinating as many North Carolinians as

quickly and fairly as possible is a map that shows census tracts in North Carolina with the highest rates of social vulnerability and the lowest rates of COVID-19 vaccination. Social vulnerability is measured by the Social Vulnerability Index ; the higher the score, the higher the social vulnerability. The map also includes the ability to see where COVID-19 vaccine providers and CBOs that have offered to support vaccine events are located.

## **Proactive Communication**

North Carolina recognized early that effective and transparent communications would be essential to its pandemic response. The Secretary held more than 150 press conferences; the Department launched an award-winning “Whatever the Reason” campaign to promote masks that featured North Carolinians across the state; and its vaccine campaign is a research-informed public engagement strategy that focuses on those most impacted by the impact.

## **Prevention**

Prior to the availability of vaccine and treatment, non-pharmaceutical prevention efforts were the main levers for intervention. Several key prevention activities include:

- Distributed over 65 million pieces of PPE across the state to health care providers, K-12 employees and students, and childcare teachers.
- Informed by the four key metrics of percent of emergency department visits due to COVID-19-like-illness, lab-confirmed daily COVID-19 cases, the percentage of COVID-19 tests that are positive, and COVID-19 hospitalizations, developed an iterative, dimmer switch policy approach through Executive Orders for closing and opening and imposing capacity restrictions for public settings.
- Continued to engage with partners to promote prevention, including faith, school, and business leaders.
- Worked with stakeholders to develop over 120 guidance resources to help businesses and individuals conduct their activities safely.
- Released updated [Strong Schools NC Toolkit for the 2021-22](#) school year.

## **Critical Supports**

With workers being out of work and children being out of school, critical supports were needed, especially for young families. These include supports for food to address food insecurity:

- As of July 28, 2021, NC DHHS, in partnership with the NC Department of Public Instruction, has provided more than \$1.7 billion in critical food assistance benefits to more than 1.2 million children across the state.
- Developed texting tool to help parents find food for their children.
- Increased Food and Nutrition Services (FNS) to approximately 360,000 households and child care supports
- Provided emergency child care subsidies to over 20,000 children of essential workers and school-age subsidies to 7,700 children (\$34M)
- Stabilized 4,200 child care facilities with operational grants and PPE (\$124M)
- Supported 30,000 child care teachers/staff with bonuses (\$38M)
- Stood up hotline to help critical workers find childcare

## **Robust Operational Capacities**

NC DHHS has built, sustained, and added on to a robust operational capacity in order to ensure it can respond appropriately to the COVID-19 pandemic and adapt and respond quickly to changing conditions in our state. Listed below are some of the operational capacities that have been built in North Carolina and the operations they have supported:

### **Testing**

Testing is an important strategy to quickly identify someone with COVID-19 to inform treatment, case investigation, contact tracing, isolation, and quarantine. To support the need for testing, North Carolina:

- Built a statewide testing and tracing infrastructure
- Created an innovative universal testing strategy within skilled nursing facilities that has been cited as a national model by the Rockefeller Foundation
- Supported the administration of over 7 million COVID-19 tests and stood up 750 testing sites across the state
- Launched an expanded COVID-19 screening testing program to support public, charter and private K-12 schools in protecting students and staff from the spread of COVID-19
- Executed a State Health Director Standing Order to expand access to testing, especially for those people not well connected to a medical provider

### **Case Investigation, Contact Tracing, 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, the existing case investigation and contact tracing infrastructure quickly became overwhelmed with the spread of COVID-19. North Carolina developed a statewide contact tracing system and expanded a surge staff of 1,560 contact tracers that was able to augment the contract tracing infrastructure at the local health departments.

In addition, NC partnered with Google and Apple to implement SlowCOVIDNC quickly after Apple and Google released an exposure notification application programming interface (API) which was only made available to public health authorities. This API, combined with the SlowCOVIDNC exposure notification app enables the ability to provide automated notification of an exposure to know and unknown contacts who may have been exposed to an individual who has tested positive.

Almost 980,000 people have downloaded SlowCOVIDNC, and close to 3,500 exposure notifications have been sent through the official exposure notification app of NC DHHS. SlowCOVIDNC alerts users when they may have been exposed to someone who has tested positive for COVID-19. The app relies on users to anonymously submit their positive results to notify others. It is free, completely anonymous, and does not collect, store or share personal information or location data. It can be downloaded for free on the Apple App Store and the Google Play Store.

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. North Carolina developed isolation/quarantine supports to help people be successful in following control measures and to promote equity. These include:

- Non-Congregate Sheltering and Housing Support to ensure access to non-congregate shelters for people who need to isolate. 72 counties with NCS have sheltered over 7,500 people
- \$26 million to Community Action Agencies to help low-income individuals and families meet needs, including preventing evictions, caused by the economic disruption of the COVID-19 pandemic
- Employed over 400 community health workers to connect over 180,000 North Carolinians to medical, behavioral, and social supports (over 100 are Spanish speaking)
- Delivered services such as food, relief payments, or primary medical care to over 35,000 households who needed to isolate or quarantine

## **Vaccination**

Safe and effective vaccines for COVID-19 are our path out of the pandemic. More than 11 million doses of COVID-19 vaccines have been administered in North Carolina since the end of December 2020 with more than 3400 sites with vaccine doses available. As of October 5th, 54% of the NC population, 65% of people 18 and older, 88% of people 65 and older had been fully vaccinated. A State Health Director Standing Order was executed to expand access to vaccination, especially for those people not connected to a medical provider.

### ***COVID-19 Vaccination Management System***

Based on CDC requirements for data entry, the increased user volume, system capacity issues, and the need for vendor managed adjustments, NC implemented a new web-based system, provided to all COVID-19 enrolled providers at no charge. The new system is the NC DHHS cloud-based COVID-19 Vaccine Management System (CVMS). It allows healthcare providers to enroll as vaccine providers, record and manage vaccine administrations, and manage and transfer vaccine inventory. CVMS provides recipients access to their vaccine information through a unique portal.

Providers use CVMS to manage vaccine recipients, record administrations, and grant immediate access to new users at their location. In addition to vaccine administration, providers also use CVMS to manage vaccine inventory and facilitate vaccine transfers across the state, helping to prevent wastage. Providers seeking additional inventory can request transfers using the marketplace.

The COVID-19 Vaccine Portal is a free and secure website that empowers vaccine recipients to view and update their contact information, as well as download their own vaccine information. Program Managers access CVMS using the back-end portal. This allows the State of North Carolina to efficiently approve and enroll new providers, manage vaccine inventory shipments and usage, and analyze real-time data reports across the state.

Providers have options when deciding how to send information into CVMS. They can choose manual entry or CVMS Direct. Federal Pharmacy partners leverage a unique data exchange. Frontline essential organizations use the CVMS Organization Portal to quickly invite all eligible employees to register for the COVID-19 Vaccine, expediting the administration process.

## ***Equity in COVID-19 Vaccination Efforts***

NC DHHS continues to be devoted to ensuring that everyone is included in North Carolina's COVID-19 Vaccination effort. NC DHHS is committed to making sure that all communities have accurate information about and equal access to COVID-19 vaccines. Racism runs throughout our social, economic, and health care systems, causing unequal access to care, maltreatment, and neglect for historically marginalized communities. These longstanding and continuing racial and ethnic injustices in our health care system contribute to lack of trust in vaccines. North Carolina is drawing upon the experience and expertise of leaders from historically marginalized communities to develop and implement its vaccine plan and the agency has committed itself to these guiding principles:

- Everyone has access
  - *All North Carolinians have equitable access to vaccines*
- Inclusion and respect
  - *Vaccine planning and distribution is inclusive and draws upon the experience and expertise of leaders from HMPs*
- Keeping you informed
  - *Transparent, accurate, and frequent public communications is essential to building trust*
- Informed decision-making
  - *Data is used to promote equity, track progress and guide decision-making*
- Continuous improvement
  - *Appropriate stewardship of resources and continuous evaluation and improvement drive successful implementation*



As shown in the graphic above, NC DHHS is using a systematic approach to embedding equity into all aspects of COVID-19 operations. These strategies include:

- Using data to promote equity, track progress and guide decision-making.

- Engage leaders from HMPs to inform how to earn trust
- Identify and work with trusted messengers to share information about vaccines with people in historically marginalized communities.
- Host Fireside Chats and Cafecitos to address concerns
- Produce PSAs featuring trusted messengers
- Invest in media trusted by historically marginalized communities
- Leverage Community Health Workers to educate communities about the vaccines and address hesitancy through Town Halls, Q&A sessions, and Facebook live events and support for vaccine events and clinics, including calling registered patients & providing interpretation
- Leverage the Healthier Together initiative to deploy regional health equity teams to work with individuals, CBOs, and vaccine providers to identify and eliminate barriers to vaccination among HMPs

To provide data transparency on the COVID-19 vaccination efforts, NC DHHS launched "[Promoting COVID-19 Vaccine Equity in North Carolina](#)" which provides updates to the public every two weeks. This report details the share of vaccinations going to Black/African American, Hispanic/Latinx, and American Indian or Alaskan Native populations. This reports also highlights best practices to promote equitable access to vaccinations and key metrics for earning trust, embedding equity in vaccine operations, and promoting accountability through data transparency.

As described earlier in this report, Healthier Together is a public-private partnership between NC DHHS and [NC Counts Coalition](#) to increase COVID-19 vaccinations among BIPOC populations and provide a foundation for a longer-term framework for health equity.

- Healthier Together provided a first round of funding from June to August 2021 to 27 CBOs across all six Medicaid regions, who collectively reached over 400,000 individuals through door-to-door and site-based canvassing, phone and text message outreach, and educational events about COVID-19 vaccines.
- Healthier Together is providing a second round of funding of up to \$500,000 in grants to CBOs through a Request for Proposals during Fall 2021.
- CBOs can apply for grants for short-term vaccine equity initiatives from November 2021 to February 2022 to ensure as many individuals, ages 12 and up and from HMPs, are vaccinated as possible.

While there is still more work to be done, these efforts have helped to improve the equitable distribution of vaccines across North Carolina. As of the date of this report, the American Indian/Alaskan Native population make up 2% of the North Carolina population, and have received 1% of the vaccine doses, the Asian/Pacific Islander population make up 4% of the North Carolina population, and have received 4% of the vaccine doses, the Black/African American population make up 23% of the North Carolina population, and have received 18% of the vaccine doses, the White/Caucasian population make up 72% of the North Carolina population, and have received 63% of the vaccine doses, the Latinx/Hispanic population make up 9% of the North Carolina population, and have received 10% of the vaccine doses.

While efforts to drive vaccination among HMPs have had an impact, a gap remains among lower

socio-economic populations. North Carolina is working to close the gap by providing more information on vaccine safety and effectiveness and, most importantly, greater access and support for making an appointment.

North Carolina's equity work in vaccines has been nationally recognized. CDC Highlighted North Carolina's [Success in Vaccine Equity in a report](#) that shows that the state's outreach and data strategies led to substantial increases in vaccination rates among Black and Hispanic people. North Carolina's equity work is highlighted in a [Policy Brief](#) from the National Governor's Association and Duke-Margolis Center for Health Policy on reducing racial and ethnic disparities. North Carolina [was named the only state](#) to collect and publicly report race and ethnicity data for nearly 100% of vaccinations from early on in the vaccination efforts.

### ***Helping the Public Locate COVID-19 Vaccine Providers in North Carolina***

In December 2020, NC DHHS launched "[You Have a Spot. Take Your Shot.](#)" the state's ongoing community outreach and engagement initiative to help people locate and make appointments with participating COVID-19 vaccine providers in North Carolina. In addition to public opinion research, the program is also informed by community groups, faith-based leaders, and others who support the state's Black, Latinx, American Indian, and other HMPs, as well as rural communities. Findings from the research show that the top sources used to find information about getting a COVID-19 vaccine are NC DHHS, followed by friends and family, medical professionals, and the county health department.

### ***Research on Vaccine Adoption and Public Perception***

North Carolina was among one of the first states in the nation to conduct market research across all populations to inform its COVID-19 vaccine outreach and education. That research informed many of the state's outreach and engagement strategies, including its focus on the importance of trusted messengers to provide reliable and accurate information about COVID-19 vaccines. To date, the state has partnered with more than one thousand faith-based organizations, community leaders, groups, and organizations.

Findings from [recent public opinion research](#) on COVID-19 vaccine risks, rewards, and vaccination motivations across the state show a clear and welcome improvement in North Carolinians' attitudes related to COVID-19 vaccines underscoring the positive impact of messaging, mandates and people's positive experience with vaccines. When compared with the same survey conducted last fall, vaccine risk perceptions have dropped significantly overall, while the perceived rewards of being vaccinated have risen. In fact, there has been a sizeable shift in the overall intent to vaccinate since May 2021 rising from 70% to 79% of North Carolinians surveyed saying they have already, definitely will or probably will be vaccinated. Even more encouraging is that those saying they don't know if they will, or probably/definitely won't has decreased from 25% in November 2020 to only 15% in September 2021. The number of people who would recommend COVID-19 vaccination to family and friends has more than doubled from 30% in November 2020 to 70% in September 2021.

The most widely shared motivations to get vaccinated were the desire to prevent serious health

problem and hospitalizations that could come from getting COVID-19 as well as wanting to spend time with family, friends and to feel better protected from COVID-19. Additionally, six in ten North Carolinians say they are likely to get a booster when it is available to them—with 80% saying they definitely or probably will.

As North Carolina continues to vaccinate teens and young adults, research is also showing positive trends among parents' intent to vaccinate their children. Two-thirds of parents with 12-15 year-olds and nearly seven in ten parents of 16-17 year-olds have either vaccinated their child, have an appointment, or are likely to get them vaccinated. The number of parents who intend to vaccinate their children age 12-15 has risen from 50% in May 2021 to 68% in August 2021. Similarly, one-third of parents with children ages 2-11 say they will definitely get their child vaccinated when they are eligible—the total number rising from 51% in May 2021 to 58% in August 2021.

### ***Incentives to Promote Vaccine Uptake***

***Summer Card Program*** . As part of its ongoing effort to get more North Carolinians vaccinated and safely bring summer back, the NC DHHS offered incentives in the form of cash cards to increase vaccine uptake. The [Summer Card program](#) has been an overall success, most notably so after the increase in the allotment to \$100, which led to several vaccine providers seeing a noticeable increase in demand, and many ran out of their card allotments in a single day. Providers also saw increases of up to 98% in the number of Summer Card recipients compared to the week before the increase.

Prior to the end date, anyone 18 and older who got their first dose of a COVID-19 vaccine could receive a \$100 card after vaccination. Those who drove others to get vaccinated could receive a \$25 Summer Card each time they drive someone to an appointment at the completion of the vaccination. The cards were distributed to offset the time and transportation costs of getting vaccinated.

***Summer Cash Drawings***. As part of North Carolina's effort to bring summer back with safe, effective, and free COVID-19 vaccines, Governor Cooper announced the \$4 Million Summer Cash and \$125,000 scholarship drawings to motivate those who have not yet been vaccinated. Four North Carolinians from the 18 and older age group won \$1 million each and four North Carolinians from the 12 to 17 age group won a scholarship in the amount of \$125,000.

### ***Additional Doses of COVID-19 Vaccine Authorized For Immunocompromised People***

The Food and Drug Administration (FDA) authorized and the CDC recommends additional doses of mRNA vaccines for individuals with moderately to severely compromised immune systems who may not have mounted the same level of immunity after the initial series of vaccination. [These additional doses are authorized and currently for those who qualify.](#)

### ***COVID-19 Vaccine Boosters***

The FDA authorized and the CDC have a recommended ["booster" vaccine shots](#) to strengthen and extend protections against severe illness for adults at high risk for serious illness or exposure. Individuals who received Pfizer vaccine for their initial 2 dose series can now get a Pfizer

BioNTech booster if it has been at least 6 months since their second Pfizer shot, and if one of the following is true:

- The person is 65 or older.
- The person is 18 and older and:
  - You live or work in a nursing home or other long-term care residential facility.
  - You have a medical condition that puts you at high risk for severe illness, for example obesity, asthma, heart disease, high blood pressure, and diabetes.
  - You work in a high-risk profession, meaning you come into contact with a lot of people, and you don't know their vaccination status, for example, health care workers, first responders, teachers, food processing workers, retail and restaurant workers, and public transportation workers.
  - You live or work in a place where many people live together, for example, homeless shelters, correctional facilities, migrant farm housing, dormitories or other group living settings in colleges or universities.

As of the date of this report, the FDA's Vaccines and Related Biological Products Advisory Committee are scheduled to meet October 14th and 15th to evaluate data on boosters for Moderna, Johnson and Johnson Vaccines and heterologous series of vaccines.

### ***Vaccines for Younger Children***

As of the date of this report, the Food and Drug Administration's Vaccines and Related Biological Products Advisory Committee are scheduled to meet October 26th to evaluate data on boosters for Moderna, Johnson and Johnson Vaccines and heterologous series of vaccines.

[More information is available from the CDC.](#)

### **COVID-19 Treatments**

The FDA has issued [Emergency Use Authorization \(EUA\)](#) to allow the use of monoclonal antibody therapies for the treatment of mild to moderate COVID-19 within 10 days of symptom onset for patients at high risk of progression to severe disease. There are more than 200 sites across North Carolina administering monoclonal antibodies, including four sites established with FEMA, with almost 50,000 doses administered. A State Health Director Standing Order was executed to promote access to monoclonal antibody treatment.

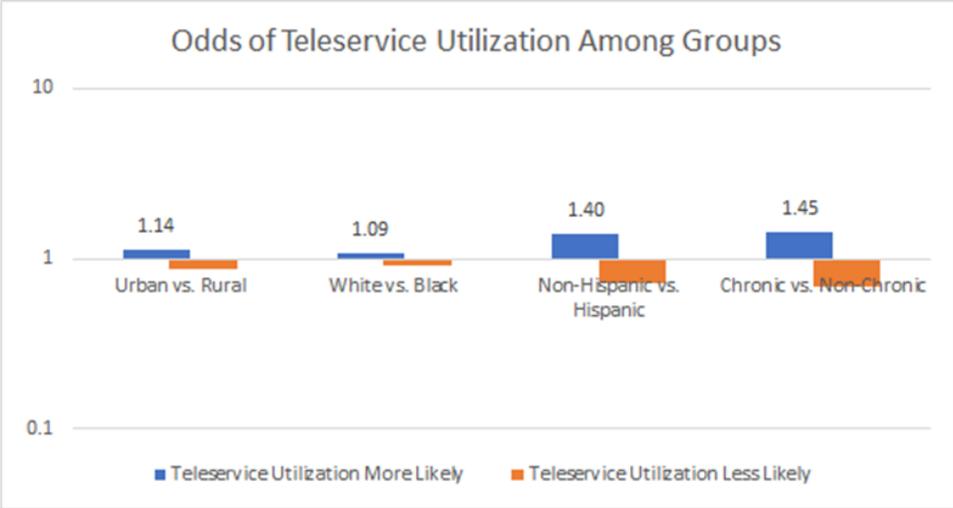
This treatment must be administered early in order to work. If people test positive for COVID-19, they can call [1-877-332-6585](tel:1-877-332-6585) (English) or [1-877-366-0310](tel:1-877-366-0310) (Spanish) to find out more about monoclonal antibody treatment. More information, including answers to frequently asked questions about monoclonal antibody treatments, is provided at [covid19.ncdhhs.gov/treatment](https://covid19.ncdhhs.gov/treatment).

### **Increasing Prevalence of Telehealth**

Telehealth became an important tool in providing access to healthcare for all North Carolinians, during the COVID-19 pandemic, and especially in rural and medically underserved areas and for people with chronic disease. NC DHHS invested in providing resources to health care providers

and consumers to increase equitable access to care and utilization of telehealth across the state. For health care providers there are technical assistance, education, and resources available to support telehealth implementation and utilization within their organization. In partnership with AHEC, practice support was deployed to engage practices who were less advanced in their telehealth offerings. For consumers, NC DHHS provides resources on how and when to use telehealth and its benefits including providing a “Telehealth Playbook” on its website.

Using technology like telehealth to deliver care is a critical strategy in NC Medicaid’s COVID-19 response efforts. With the emergence of COVID-19, there was an urgency to expand the use of technology to help people who need routine care and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. As a result, NC Medicaid temporarily approved telehealth as a modality for a larger variety of services and beneficiaries and in the past year has made many of these modalities permanent. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members by using telehealth, has and will continue to slow viral spread of COVID-19. In an evaluation of utilization, the Division of Health Benefits (DHB) measured access to care through utilization of telehealth for Medicaid beneficiaries as a function of race, ethnicity, rurality and chronic disease. Utilization of telehealth was similar for white and black populations. However, non-Hispanic populations were 1.4 times more likely to use telehealth than Hispanic populations and people with chronic disease were 1.45 times more likely to use telehealth than people without chronic disease. Despite concerns about access to broadband, those in urban areas were only 1.14 times more likely to use telehealth, a testament to the investments made in broadband expansion in recent years.



**Oral Health and COVID-19**

As North Carolina reopened from the spring 2020 shutdown, private practice dentistry quickly rebounded. However, this was not the case for the dental safety net. Although most clinics remained open for emergency services throughout the pandemic, patient volume in public health dental clinics held steady at a fraction of pre-pandemic levels for months longer than private dental offices. In many instances, dental staff were pulled to support their facilities’ COVID-19 testing and vaccination needs.

To counter the financial impacts for safety net providers, NC Medicaid implemented rate increases for Local Health Departments, Federally Qualified Health Centers, and Rural Health Centers. Oral Health Section leadership within the DPH worked closely with NC Medicaid to keep public health dental providers informed by promoting and sharing North Carolina Medicaid updates and national guidance from the [Occupational Safety and Health Administration](#), [CDC](#), and [ADA](#) with our stakeholder group. Dental recommendations created challenges, namely the increased cost of PPE for dentists treating underserved populations. From early on, this increased expenditure was offset by a 5% rate increase for dentists enrolled as Medicaid and the Children’s Health Insurance Program providers.

The Oral Health Section worked with the University of North Carolina (UNC) Gillings School of Global Public Health to create 3 training modules for school administrators and nurses on the impact of COVID-19 on K-12 Students. In addition to updating our provider community, there was a great need this year to provide COVID-19 oral health resources for North Carolina’s families and our community caregivers—those employed in early childhood or elderly residential facilities. Our program managers created and released [Guidance for Early Childhood Oral Health Care During COVID-19](#) and [Guidance for Geriatric Oral Health Care During COVID-19](#) to stakeholders across the state.

In response to national COVID-19 guidance for dentists to limit aerosolizing procedures, dentists have embraced a more preventive-focus and the use of tele-dental appointments. The broader dental community now supports dental public health concepts of increasing access to dental services. Changes to the Dental Practice Act this past year reflect this new momentum, specifically the increased scope of practice for dental hygienists and regulations that outline how dental providers can implement tele-dentistry. In fact, expanding the use of tele-dentistry and its use in community sites has the potential to correct some disparities of care.

## **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. 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). The gap is even larger among those with 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. However, eight out of nine (over 500,000 of them) did not receive this service. 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. 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. Additionally,

periods of economic downturn are linked to increased rates of depression, anxiety, substance use, and other behavioral health conditions.

### ***Indicators of Behavioral Health Outcomes***

- a. 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. This suggests a tripling of the 11% who reported symptoms in the first half of 2019. 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). 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.
- b. 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).
- c. 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). We are only experiencing the beginning of the long-term 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 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.<sup>19</sup>

### ***Increasing Access***

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

North Carolina applied and was approved for an [1135 waiver and an Appendix K waiver](#) from the Centers for Medicare and Medicaid Services 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. In collaboration with NC Medicaid, the Chief Medical Office for Behavioral Health and IDD determined roles and responsibilities for telehealth and other service policy changes and implementation including the single department-wide executive lead, policy and divisional subject matter experts, project management, liaison with federal authorities, legal consultation, communications lead, stakeholder coordinator lead, and operational leads for IT/payment system changes including liaisons to health plans. There were regular and early external stakeholder engagements that included engagement around payer/provider service provision flexibility priorities, member and family access gaps and needs, education around implementation of new flexibilities and best practices.

### *Awareness and Crisis Management*

NC 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.

**Hope4NC: Crisis Counseling Program**

- 24/7 resilience and referral resource for all North Carolinians
- Call/text/chat option for referral to local LME/MCO for one or more intensive counseling
- Nearly 1.9M received behavioral health primary and secondary services for resilience
- As of 9/24/21 total number of calls: 8,892, with 10% referred for more intensive community-based services
- Callers report:
  - Callers ages range from 12 to 86; nearly half identify as a person of color
  - Over 60% caring for a child, older adult, person with disabilities while unemployed due to COVID-19
  - High levels of anxiety, depression, fear, difficulty sleeping/concentrating
  - Primary concerns: risk of exposure for self/others, COVID-19 resources and community supports/referrals, housing
- Helpline call responders report callers’ needs have been more intense and acute during the pandemic, especially with rise of COVID-19 Delta variant
  - **Number of calls increased 30% between July and August of 2021**

**Hope4Healers Helpline (919-226-2002)** is a partnership with the North Carolina Psychological Foundation. This initiative provides additional mental health and resilience supports for health care

professionals and other staff who work in health care settings, emergency medical specialists, first responders, childcare professionals, and educators 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.

## Hope4Healers

- Collaboration with the NC Psychological Foundation
- Additional 24/7 support for Health Care providers, Educators, Child Care Professionals, First Responders, and Disaster Responders on the front lines of the COVID response
- As of September 15, 2021 calls for 2021: 185, with 32 referred for free phone sessions with a Licensed Therapist.
- Primary caller concerns:
  - Fear, risk of exposure, prevention, and for information & resources



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

## The SCOOP on Managing Stress

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

**HOPE  4 NC HELPLINE 1-855-587-3463**

Also, there was the development of the [Mental Health COVID Toolkit](#) as part of the Behavioral

Health/IDD HMP workstream.

### ***Expanding Services***

North Carolina 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. CARES II and ARPA funding will further this reach.

### ***Unique Role of Division of State Operated Healthcare Facilities***

The 14 facilities of the Division of State Operated Healthcare Facilities (DSOHF) were instrumental in the management of COVID-19 among BH/IDD populations. Communication was the cornerstone to education, awareness, and compliance with policy mandates for COVID-19. DSOHF medical directors/infection control/employee health and the Chief Medical Office for BHIDD collaborated to design policy and implement the response to the pandemic. Frequent meetings addressed national/NC COVID-19 infection trends/updates, new CDC and NC DHHS guidance and/or procedures, review of new and proposed DSOHF policies and procedures and other topics. To maintain safe and effective state facilities, there was extensive COVID-19 policy development in areas such as, DSOHF staff and visitor screening, employee health requirements, infection control, PPE, staff testing, pharmacy accountability, and vaccine rollout.

DSOHF launched a comprehensive vaccination campaign for its patients/residents and staff. Specifically, CDC guidelines were leveraged to offer allowances to vaccinated staff such as exemption from DSOHF's universal eye protection policy and allowance for gathering during breaks without face masks, reduced testing schedule for vaccinated staff, no quarantine for vaccinated staff after out-of-state travel, and use of procedure mask without knot and tuck or fitter, if fully vaccinated. Core campaign components included education with a focus on equity, universal access, outreach with repeat communication, and reinforcing the benefits of vaccination.

With this campaign, DSOHF achieved a greater than 75% vaccination rate among staff and greater than 90% vaccination among long-term care residents. Then, in concert with other major health systems, DSOHF implemented a vaccine mandate at the end of July 2021 with a deadline of September 30, 2021. It is anticipated that fewer than 20 staff will be dismissed, demonstrating how vaccine mandates can preserve staff and save lives.

### **Chronic Disease Health Debt**

The COVID-19 pandemic has created a large "health debt" for North Carolinians from missed or delayed preventive health screenings and delayed care for chronic disease. Many providers have had to shift priorities to address urgent care visits and COVID-19-related health care needs. In addition, patients have forgone routine screenings to decrease their risk of COVID-19 transmission. As a result, panel management and supporting patients with their routine screening needs, e.g., colorectal cancer screening, breast cancer screening, diabetes care etc., are important priorities as we emerge from the current wave. Some priorities in chronic disease care including

addressing tobacco, including e-cigarette use, preventing diabetes, and increasing cancer screenings.

### ***Addressing the E-cigarette Epidemic Among Youth***

- a. After nearly two decades of success in lowering NC youth cigarette smoking rates to historic lows, progress is eroding due to what the US Surgeon General recently called “the e-cigarette epidemic among youth.”
- b. The 2017 NC Youth Tobacco Survey found e-cigarette use increased 894% between 2011 and 2017. E-cigarettes are the most commonly used tobacco product among youth, with 16.9% of high school students currently using them, and even more (23.3%) saying they plan to use them in the next year.
- c. Most e-cigarettes contain nicotine, which is highly addictive and harmful to the developing brain. E-cigarette aerosol contains harmful substances, including nicotine, cancer-causing chemicals, volatile organic compounds, ultrafine particles, and flavorings that have been linked to lung disease and heavy metals.
- d. Currently the CDC reports that the most popular e-cigarette among young people is JUUL, which is available in many flavors, is shaped like a USB flash drive, and contains as much nicotine as a pack of cigarettes. DPH is working aggressively across the state to effectively protect our kids from all forms of tobacco product use, including e-cigarettes.
- e. It is recommended that health care providers ask about e-cigarettes and vaping when screening patients for tobacco product use; educate patients about the health risks of tobacco product use, including e-cigarettes for young people; and counsel youth and young adults to quit. Patients can utilize free cessation services through referrals to QuitlineNC at 1-800-QUIT-NOW.

### ***Screen, Test, and Refer North Carolinians to Help Prevent Diabetes***

- a. As evidenced by the HNC 2020 data in Appendix A, diabetes rates among adults in NC have not improved in recent years and new strategies need to be employed. DPH is now hosting diabetesfreenc.com, a portal for CDC-recognized Diabetes Prevention Programs (DPPs) throughout North Carolina. DPPs are evidence-based year-long programs led by a trained lifestyle coach that provide a group learning environment. The lifestyle coach helps participants develop strategies for healthy eating and physical activity and connects participants with others working on similar goals to prevent type 2 diabetes
- b. DPPs are offered to North Carolinians in both in-person and online formats with various start dates and times. In conjunction with DPPs, a new service is now being offered by DPH, called the DPP Navigator. DPP Navigators are available to locate DPPs to coordinate enrollment for participants throughout the state. DPP Navigators also receive and coordinate referrals from health care providers, practice referral coordinators, and CBOs. DPP Navigators provide bi-directional feedback to referring providers and organizations to include participant enrollment and program completion status.
- c. DPP Navigators are available to assist and receive referrals Monday through Friday from 7am to 7pm via phone 1.844.328.0021; Fax 1.866.336.2329; email: [dppreferral@dhhs.nc.gov](mailto:dppreferral@dhhs.nc.gov), and [NCCARE360.org](mailto:NCCARE360.org). To learn more about the DPP Navigator

and to make a referral, contact [thenavigator@diabetesfreenc.com](mailto:thenavigator@diabetesfreenc.com).

- d. NC DHHS also sponsors, through the Office of Minority Health and Health Disparities, the Minority Diabetes Prevention Program, which focuses on preventing prediabetes in our state's minority populations.

### ***Breast and Cervical Cancer Screening Programs***

The North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) provides free or low-cost breast and cervical cancer screenings and follow-up to eligible women in North Carolina. Each year, NC BCCCP strives to provide services to over 12,000 women. NC BCCCP services are offered at most local health departments as well as some community health centers, hospitals and private physicians' offices across the state for eligible North Carolina women.

A person is eligible if they:

- are uninsured or underinsured;
- are without Medicare Part B or Medicaid;
- are between ages 40 - 64 for breast screening services and 21 - 64 for cervical screening services; and
- have a household income below 250% of the federal poverty level.

BCCCP eligible women may also be eligible for NC WISEWOMAN, which provides cardiovascular disease screening, and helps women to improve their diet, physical activity, and other life habits to prevent, delay, or control cardiovascular and other chronic diseases. The Breast and Cervical Cancer Medicaid provides funding for treatment to women who are diagnosed with breast or cervical cancer and who meet NC BCCCP eligibility requirements. Visit <https://bcccp.ncdhhs.gov/> for more information.

### **Goal 3: Build an innovative, coordinated, and whole-person – physical, mental and social health- centered system that addresses both medical and non-medical drivers of health.**

NC DHHS believes that all North Carolinians should have the opportunity for good health. Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social and environmental factors and the behaviors that emerge as a result. Therefore, NC DHHS is focusing on tackling these fundamental drivers of health to improve health outcomes.

To meet its [mission](#) of improving the health, safety and well-being of all North Carolinians while being good stewards of resources, NC DHHS is addressing the conditions in which people live that directly impact health, known as social determinants of health (SDOH). These are shown in the figure below:



Our initial focus is on housing stability, food security, transportation access and interpersonal safety. Strategies include:

- Creating an interactive [statewide map](#) of SDOH indicators that can guide community investment and prioritize resources.
- Developing a set of standardized [screening questions](#) to identify and assist patients with unmet health-related resource needs.
- Building a [statewide coordinated care network](#) (NCCARE360) to electronically connect those with identified needs with community resources – and allow for a feedback loop on the outcome of that connection.
- Incorporating SDOH strategies throughout the [Medicaid 1115 waiver](#).
- Developing [Healthy Opportunities Pilots](#) to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation and interpersonal safety to high-needs Medicaid enrollees.
- Building an infrastructure to develop and support a [Community Health Worker Initiative](#).
- Coordinating NC DHHS housing services to improve outcome for people at risk of or experiencing homelessness.

Below is more detail on some of these strategies

### **SDOH Hot Spot Map**

The NC DHHS State Center for Health Statistics has created a [Geographic Information Services \(GIS\) interactive map](#) with a series of overlays showing SDOH indicators in North Carolina,

including the economic, social and neighborhood, and housing and transportation status of residents across the state. The map is organized by local health department region and is tabulated at the census-tract level. Data comes from the U.S. Census Bureau's 2016 American Community Survey 5-year Estimates and the U.S. Department of Agriculture's FNS.

Economic conditions are described in the map using several metrics, including median household income, percent of people living below poverty and percent of people who are uninsured. Housing and transportation conditions are described by metrics such as percent of households spending more than 30 percent of income on housing, percent of people living in an overcrowded household and percent of households without a vehicle. Social and neighborhood conditions are described by metrics that include education level, percent of households with low access to healthy foods and areas identified as food deserts. A cumulative index is calculated from the metrics to provide an overall measure of SDOH indicators.

### **Standardized Screening Questions**

Many leading medical practices and providers in North Carolina were interested in identifying unmet resource needs using standardized screening questions. In 2019, NC DHHS, in partnership with a diverse set of stakeholders from across the state, developed a [standardized set of SDOH screening questions](#).

The standardized set of screening questions were created to be able to be used in a variety of settings and across populations. Many North Carolina health practices are currently using the questions as part of their intake and assessment processes. While NC DHHS is not currently collecting data on all screening utilizing these questions statewide, it is collecting screening performed in Medicaid, through Phreesia and through NCCARE360.

- Medicaid Managed Care (MMC): While the screening questions are meant to be used across populations, not just within Medicaid, all Medicaid Pre-Paid Health Plans (PHPs) are required to screen all Medicaid beneficiaries using the SDOH Screening questions within 90 days on enrollment.
- Phreesia: Phreesia is a software-as-a-service platform that some North Carolina practices use as part of patient intake. Phreesia has embedded the North Carolina SDOH Screening Questions in their tool giving North Carolina practices that use Phreesia's platform the option to include the questions as part of their patient intake processes. All screening data captured through Phreesia platform is shared with NC DHHS.
- NCCARE360: North Carolina's SDOH Screening Questions are embedded in NCCARE360. Individuals using NCCARE360 can screen any client using the screening questions. NCCARE360 prompts organizations to refer clients to services based on their responses to the screening questions. All NCCARE360 screening data is shared with NC DHHS.

NC DHHS will use all screening data to inform policy, investment, and options for intervention. All data is governed under a Data Governance Group.

### **NCCARE360**

[NCCARE360](#) is the first statewide coordinated care network in the United States to electronically

connect those with identified needs to community resources and allow for a feedback loop on the outcome of that connection. NCCARE360 is a result of a public-private partnership between the NC Department of Health and Human Services and the [Foundation for Health Leadership and Innovation \(FHLI\)](#). The NCCARE360 implementation partners are United Way of NC/211, Expound Decision Systems and Unite Us.

The platform provides infrastructure for connecting individuals to COVID-related resources and other resources in their communities. The statewide reach of NCCARE360 was accelerated to respond to the increased need among our populations and is now operational in all 100 NC counties. Since its launch in 2019, health and human service providers across all 100 North Carolina counties have collectively made more than 140,000 electronic referrals for nearly 200,000 services to connect over 70,000 individuals and families to the resources they need to stay healthy and well. The statewide NCCARE360 network includes over 2,500 organizations with over 4,600 programs. The statewide NCCARE360 network includes all five Medicaid PHPs, seven Local Management Entity – Managed Care Organizations (LME-MCOs), and 6 large health systems including Cone Health, WakeMed, Vidant Health, UNC Health, Duke Health, and Mission Health. Community members can search NCCARE360’s repository of more than 10,000 local services at [nccare360.org/resources](https://nccare360.org/resources).

## **NC Medicaid Transformation to Managed Care**

Since the passage of legislation in 2015 that began the state’s transition to managed care, NC DHHS has worked closely with health plans, providers, beneficiaries, and community-based organizations to design and prepare for implementation. Throughout this process, our vision has remained the same: to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.

NC DHHS leveraged the move to managed care to build an innovative health care delivery system that puts the health of beneficiaries at the forefront. Broad aspects of the move to manage care include:

- Creating an innovative, integrated, and well-coordinated system of care
- Supporting providers and beneficiaries during the transition
- Promoting access to care
- Promoting quality and value
- Setting up relationships for success

Features of the program include:

- Establishing a payment structure that rewards better health outcomes
  - Requiring health plans to increase participation in value-based payments over time
- Caring for the whole-person
  - Using a payment and delivery model that integrates physical and behavioral health to improve outcomes
  - Addressing unmet social needs that drive health outcomes and may reduce costs through Healthy Opportunities and NCCARE360
- Helping people manage their health through care management
  - Creating an Advanced Medical Home Program to provide local care management

- o Providing integrated care through Behavioral Health Home and Care Management
- Implementing a quality strategy to promote health plan accountability
  - o Focus on rigorous outcome measurement compared to relevant targets and benchmarks

Throughout this process, NC DHHS has prioritized stakeholder engagement and transparent communication to ensure those most impacted by this change have an opportunity to share input and are informed at each step of the process.

### ***Managed Care Launch***

On July 1, 2021, North Carolina launched the first phase in MMC: Standard Plans. More than 1.6 million Medicaid beneficiaries transitioned from fee-for-service (FFS) Medicaid to five PHPs. Beneficiaries were able to choose from five Health Plans:

- AmeriHealth Caritas
- Healthy Blue
- United HealthCare Community Plan
- WellCare
- Carolina Complete Health(limited to 3 regions of NC)

At the same time, NC deployed a nationally unique model of Primary Care Case Management with The Eastern Band of Cherokee Indians (EBCI) in a Tribal Option that manages health care for North Carolina’s approximate 4,000 Tribal Medicaid beneficiaries primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties.

To ensure continuity for beneficiaries who transitioned between Medicaid Direct and MMC delivery systems, NC Medicaid developed a comprehensive Transition of Care approach and policy. The Transition of Care design intends to maintain continuity of care for each beneficiary and minimize the administrative burden on providers during transition.

This policy governs the PHP practices related to Transition of Care and covers four broad Transition of Care topics:

- Transition of Care at Managed Care Launch
- Ongoing Transition of Care
- Preliminary requirements for assisting Standard Plan PHP Members who may be eligible for Tailored Plans.
- Transitional Care Management Requirements

Prior to launch, NC DHHS identified a group of high need beneficiaries and targeted them for ‘warm hand-off transitions.’ Over 50% of those members engaged in the warm hand-off process that focused on ensuring members understood the transition to their new plan and maintained their services and supports. To support minimal disruption to beneficiaries, the State provided each PHP with 2 years of their beneficiaries’ historical claims and enrollment data. After enrollment in the PHPs was completed, 95% of beneficiaries were assigned to plans that had the respective beneficiary’s primary care provider in-network. All members were assigned to a primary care practice and over 80% of beneficiaries were enrolled in an Advanced Medical Home. The Advanced Medical Home model is another unique feature of the NC Managed Medicaid model,

and it supports primary care management services to be provided on the ground, in the community, and in a member's medical home.

### ***Addressing Issues After Launch***

The launch of managed care was generally successful. With any transition this large, challenges were expected but the Department monitored reports of incidents for risks of potential member harm so that issues were addressed and resolved rapidly. The State worked with partners to quickly mitigate and resolve initial challenges including:

- Non-Emergency Medical Transportation in MMC that impacted beneficiaries' transportation to medical appointments
- Providers' claims payment/processing concerns were dealt with through a Provider Ombudsman
- The provision of hardship payment processes with the PHPs should the need arises.
- Monthly provider-facing interactive webinars that included the PHP medical leaders in partnership with the Medicaid team

The Department recognizes that ongoing engagement with stakeholders is crucial not only in preparation for the launch of MMC but also for ongoing operations and to help quickly identify and resolve issues affecting either providers or beneficiaries. Stakeholders include, but are not limited to, Medicaid beneficiaries, their families, and caregivers; members of tribal populations; rural and urban providers and hospitals; medical such as the North Carolina Medical Society, The North Carolina Academy of Family Physicians, and The North Carolina Pediatric Society; health care associations; advisory committees; health plans; community-based and advocacy organizations; local and county agencies and officials; and members of the public.

### ***Ongoing Support of Beneficiaries and Providers and Ensuring High Quality Care***

On June 16, 2021, the State published the updated Medicaid Managed Care Quality Strategy. Dozens of metrics are being monitored related to outcomes of care, quality of care, cost of care, access to care, results of beneficiary satisfaction surveys, and member and provider grievances and appeals. Over time the Department may offer financial incentives to the health plans for improving health outcomes on particular Quality measures. The Medicaid team has also developed an Equity strategy related to clinical measures that ensure aggressive improvements where health disparities appear in the data.

Beginning in April 2021, the State launched the NC Medicaid Beneficiary Ombudsman program, which equips each beneficiary with knowledge and resources to understand the new Medicaid program. The Ombudsman offers help if beneficiaries have trouble getting access to health care and connects people to resources like social services, housing resources, food assistance, legal aid, and other programs. In addition, DHB has created a Provider Ombudsman which addresses questions from providers and represents the interests of the provider community by responding to inquiries and complaints regarding PHPs. The Provider Ombudsman provides resources and assists providers if the health plans are unable to appropriately address the provider question or issue. Key processes were established to enable both providers and beneficiaries to escalate concerns related to managed care and to ensure that those concerns are delivered to key vendors and other

responsible parties.

Key Provider and Community Partner Engagement & Communications Activities include:

- 106 Medicaid Bulletins developed to educate providers about managed care changes
- 97 NCTracks messages sent to NC Medicaid providers related to managed care
- 615 Knowledge Articles made available to answer provider questions
- 31 Virtual Webinars, Meet & Greets, and Office Hours with over 14,000 total attendees communicated Managed Care updates and information to providers between October and June
- Over 4,600 stakeholders attended community partner webinars on managed care activities between January and June
- 47 Fact Sheets developed for the Provider and County Playbooks; other resources include links to Provider Trainings/Webinars, County Instructional Guides, and Sample Beneficiary Notices
- Ongoing collaboration and engagement with more than 80 stakeholder groups and associations

### ***Healthy Opportunities within Medicaid***

In pursuit of the mission to improve the health, safety, and well-being of all North Carolinians, NC DHHS is weaving strategies to address non-medical needs and promote “healthy opportunities” into the MMC program that will benefit all Medicaid enrollees. Social and economic factors have a significant impact on individuals’ and communities’ health—driving as much as 80% of health outcomes. In light of this, NC DHHS is fundamentally shifting its approach from “buying healthcare” to “buying health”. Scalable efforts to address healthy opportunities are challenged by existing health care and social service silos and a lack of sufficient funding and standardization (e.g., how to define non-medical services). Elements of whole person care that have been incorporated into statewide Managed Care Plans include: 1) Requirement to incorporate standardized screening questions in Comprehensive Health Assessment; 2) Utilization of NCCARE360 for closed looped referrals for social needs; 3) Initiatives that address non-medical drivers of health qualify as Quality Improvement Initiatives as part of numerator of Medical Loss Ratio; 4) Expectation of multi-disciplinary care management addressing holistic needs; 5) Elements of the Quality Plan addressing non-medical drivers of health. In addition, in three regions in the state, the Healthy Opportunities Pilots seek to create new infrastructure and payment vehicles that bridge these gaps and provide a pathway to sustainable partnerships and the delivery of high-quality, impactful care—ultimately across all of North Carolina.

### ***Pilot Awards***

In May 2021, North Carolina awarded contracts to three organizations that will act as Healthy Opportunities Network Leads (formerly known as Lead Pilot Entities). The Healthy Opportunities Pilot will integrate the services that address these non-medical drivers of health and build the evidence base to identify which services are most effective at improving a person’s health and lowering their health care costs.

The department will work with the Healthy Opportunities Network Leads, PHPs, care management

entities and Human Service Organizations to implement the pilot program. Following a competitive selection process, the following organizations will reach three regions, two in eastern North Carolina and one in western North Carolina.

- Access East Inc.: Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt
- Community Care of the Lower Cape Fear: Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender
- Dogwood Health Trust: Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Healthy Opportunities Network Leads will spend the upcoming months building their network of Human Service Organizations and assist in developing their capacity and that of their HSOs to participate in the program. The Department anticipates that pilot service delivery will begin in the spring of 2022. Pilot-participating HSOs will use NCCARE360 to accept referrals for Pilot services, invoice for Pilot services, and track enrollee progress over time

### ***Tailored Plans***

In 2022 the department plans to move the majority of the remaining members in Medicaid Direct into a Tailored Plan. The Tailored Plans will provide the same services as Standard Plans, in addition to specialized services for individuals with significant behavioral health conditions, I/DDs and traumatic brain injury, and people using state-funded and waiver services. The integration of physical and behavioral health is a key tenet of NC Managed Medical model of care.

Following a competitive selection process, the following organizations were awarded a contract to serve as regional Behavioral Health I/DD Tailored Plans when they launch July 1, 2022:

- Alliance Health
- Eastpointe
- Partners Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health
- Cardinal Innovations Healthcare

NC Medicaid is working in partnership with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to support this effort. LME-MCOs will remain in place until Tailored Plans are launched, and State and Regional Consumer and Family Advisory Committees (CFAC) will retain their role in advising Tailored Plans and NC DHHS.

NC Medicaid looks forward to continuing to work with our partners including beneficiaries and providers, and other stakeholders to continue the implementation of managed care with a focus on improving the health and wellbeing of North Carolinians.

More information can be found at <https://medicaid.ncdhhs.gov/transformation>

## Community Health Workers

A community health worker is a frontline public health worker who is a trusted member of the community or who has a close understanding of the community. This trusting relationship enables CHWs to serve as a link between health, social services, and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

[The COVID-19 CHW program](#) initially supported community health workers in [55 counties](#) to connect North Carolinians with medical and social supports such as food and financial relief, diagnostic testing, behavioral health services, and education about vaccines. To date, the COVID-19 CHW Program has connected more than 112,000 people to social supports, provided vaccine education to more than 420,000 people, and scheduled more than 33,000 COVID-19 vaccine appointments. CHWs also use technology to connect people with resources and have created more than 350,000 telehealth appointments. In addition to the CHW Program, support also continues to be available to North Carolinians through the NCCARE 360 platform.

The NC DHHS was awarded a total of \$9 million with \$3 million per year distributed over the next three years to expand the program to all 100 counties. North Carolina's Community Health Worker Initiative will expand as part of the [CDC's National Center for Chronic Disease Prevention and Health Promotion's Community Health Workers for COVID Response and Resilient Communities](#) initiative and will help the state do that by developing a sustainable infrastructure for CHWs that builds on the pandemic response.

NC DHHS plans to expand, strengthen and integrate a statewide community health worker infrastructure by integrating CHWs into the [Healthy Opportunity pilots](#) as part of the [Advanced Medical Home](#) model, Medicaid and other programs to improve health outcomes. NC DHHS will also partner with the newly created N.C. Community Health Worker Association as they create an accreditation process and work with state community colleges to develop core competency trainings.

## **Goal 4: Turn the tide of North Carolina's opioid and substance use crisis.**

### **The Opioid Action Plan (OAP) and COVID-19 Impact**

In 2020, over 8 million Americans died each day from drug overdose. To address this crisis, NC DHHS collaborated with community partners to develop North Carolina's [Opioid and Substance Use Action Plan](#). Work continues on the OAP during COVID-19. As North Carolina continues to experience an opioid epidemic and its harmful effects, NC DHHS and its partners aim to reduce expected opioid overdose deaths by 20 percent over four years by focusing on policies and practices that prevent opioid misuse, addiction, and overdose. The graphic below gives a visual representation of the strategies contained within the OAP:



Session Law 2015-241, Section 12F.16 (m) created the Prescription Drug Abuse Advisory Committee (OPDAAC) to develop and implement a statewide strategic plan to combat the problem of prescription drug use in North Carolina.

OPDAAC has evolved from its initial role of implementing NC DHHS’s opioid strategic plan to a community of practice for anyone working to address the opioid epidemic from prescribers, treatment and recovery providers, local government, CBOs, families who have lost loved ones to overdose, health systems, pharmaceutical industry, harm reduction and law enforcement. Every other year OPDAAC convenes a 2-day statewide opioid summit where national speakers and state leaders present, and skill-building breakout sessions are held. OPDAAC’s membership has grown from 80 participants to a listserv of over 750 members representing a diverse network of individuals and groups working to address the overdose epidemic.

Another valuable resource, 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 and visualize metrics at the state, regional, and county levels. The dashboard has been presented at numerous stakeholder meetings to educate partners on its availability and application. The most recent year-to-date data can be viewed on the dashboard online.

Key accomplishments in 2021 since the launch of the plan include:

- Updated the [North Carolina Opioid and Substance Use Action Plan](#) (NC OSUAP) to reflect the evolving crisis, expand beyond opioids, and center equity and lived experiences throughout the work.
  - Launched an updated [NC OSUAP data dashboard](#) to track state, regional, and county-level metrics and local actions data outlined in the NC Opioid and Substance Use Action Plan.
- NC DHHS distributed approximately 100,000 doses of naloxone to date in 2021, with additional naloxone purchases planned throughout the upcoming months (including an additional 70,000+ doses by the end of 2021).
- The NC Safer Syringe Initiative supports registered syringe services programs (SSPs) with training and technical assistance, in partnership with the North Carolina Harm Reduction Coalition, and has been able to provide supplies to programs including PPE during the COVID-19 response.
- As of the 2020-2021 North Carolina Safer Syringe Initiative Annual Report, North Carolina has 41, and growing, registered SSPs directly serving 56 counties and 1 federal tribe, with 27 additional counties and 3 states being represented in the populations accessing the services. These programs served over 26,500 unique individuals (a 73% increase from the previous reporting year) and made over 1,900 referrals to SUD treatment. Additionally, these programs provided more than 8 million sterile syringes, more than 89,500 naloxone kits, and over 116,000 fentanyl test strips in the 2020-2021 reporting year. Over 12,300 overdose reversals were reported back to programs, which is a 43% increase from last year.
- Awarded \$7,003,730 in CDC funds to local partners for the third year of the North Carolina Overdose Data to Action 4-Year Cooperative Agreement.
- Collaborated with over 20 partner organizations through 23 contracted projects including but not limited to:
  - Community-based programs, including a first-time opportunity for 7 organizations at the grassroots level who have impactful harm reduction experience, to effectively reach people who use drugs for comprehensive linkages to care, including various social and health supports, and build the capacity for harm reduction and overdose prevention in North Carolina;
  - Interdisciplinary trainings on harm reduction and community-based overdose partnerships with the UNC-CH Injury Prevention Research Center, including launching a multi-state, Appalachia-based network for practice and resource sharing; and
  - Healthcare initiatives for access to medications for opioid use disorder, treating pain safely, addressing infectious disease complications of injection drug use, and training other healthcare professionals on integrating harm reduction strategies into their practice; and
- Funded 23 local health departments for community linkages to care on overdose prevention and response focused on a combination of the following strategies from the NC OAP: developing SSPs, connecting justice-involved people to care, and expanding EMS- or peer-led post-overdose response teams.
- Expanded the North Carolina State Unintentional Drug Overdose Reporting System to capture the circumstances and details surrounding overdoses death from all drug types and to provide more timely data, launched the Rapid Overdose Death Detection pilot program

- to rapidly identify suspected overdose deaths in the state.
- Disseminated monthly surveillance reports to a network of over 4,000 partners including providers, community advocates, Local Health Directors, EMS Directors, Law Enforcement Agencies, and many others. Added new reports tracking EMS encounters for suspected opioid overdose and a report of monthly suspected overdose deaths.
- Issued a \$10.6 million RFA for local justice system projects to prevent opioid overdoses for people who are involved in the justice system.
- Deployed rapid resources, technical assistance, and flexibilities to ensure continuity of treatment and harm reduction services during COVID, as well as surged overdose response supplied which reduced the spike in overdoses seen during summer due to the pandemic.

North Carolina also participated in a historic set of settlements against opioid manufacturers and distributors. Funding from these settlements will be distributed among state and local governments pursuant to the [Memorandum of Agreement](#). The MOA lays out a menu of evidence-based Opioid and Substance Use Action Plan strategies that counties can choose to implement. The settlement funds represent an opportunity to invest in the long-term infrastructure needed to combat the opioid epidemic across North Carolina.

NC DHHS is ensuring equity in its response to the opioid epidemic by diligently employing the following strategies:

- Center lived experiences of individuals who use drugs and HMPs by hiring, contracting, and collaborating with HMPs in all phases of organizational development.
- Analyze data to identify disparities in HMPs accessing services and programs.
- Work with and support providers and HMPs to effectively address service disparities. Ensure they are leading implementation of these programs.
- Create a resource hub for service providers to provide culturally competent and linguistically appropriate services, centering and hiring individuals with lived experiences, and health equity for substance use.
- Increase access to comprehensive, culturally competent, and linguistically appropriate outreach, overdose prevention, harm reduction, and connections to care for HMPs.
- Expand prevention, harm reduction, and treatment services to include consumption modalities and substances most commonly used by HMPs.
- Improve access to outreach, overdose prevention, harm reduction and connections to care services for HMPs by implementing culturally competent and linguistically appropriate programming and prioritizing funding opportunities for programs that are doing so.

**Goal 5: Improve child and family well-being so all children have the opportunity to develop to their full potential and thrive.**

**Division of Child and Family Well-Being**

NC DHHS is launching a Division of Child and Family Well-Being that will focus on closing equity gaps across the health, social, and educational needs of children and youth. As part of this new Division, NC DHHS will employ the following strategies:

- Build upon the Department’s vision for children and families: Children are healthy and

- thrive in safe, stable, and nurturing families, schools, and communities
- Bring together complementary programs that serve children and families from social services (e.g., Supplemental Nutrition Assistance Program (SNAP), mental health (e.g., systems of care, school mental health), and public health (e.g., Supplemental Nutrition Program for Women, Infants, and Children (WIC), early intervention, children and youth programs) and enhance how children and families access programs that support their well-being.
- Coordinate increased investments to improve child health and well-being. An early focus will be on quantifying and addressing inequities in access to child and youth mental health services.
- Elevate the value of our teams supporting child and family well-being.

### **Child Care Stabilization Grants**

North Carolina has received a historic, one-time federal \$805 million investment in early care and learning child care programs. The North Carolina Child Care Stabilization Grants, made possible by funding from the 2021 ARPA, will support working families with access to high-quality, affordable child care. The grants will also help early care and learning programs with recruitment and retention, enabling them to provide better wages and benefits to teachers, and promoting equity for all—children, parents, and teachers.

### **Children with Complex Needs**

Children with Complex Needs are ages 5 and under 21, with I/DD and a mental health disorder diagnosis who are Medicaid eligible and at risk of not being able to return to or maintain placement in a community setting. The Department is developing a process to identify these children and link them to diagnostic testing and appropriate services.

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, has continued to offer virtual services, which started 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 NC ITP and service provision for families entering the program with children with developmental delays and established medical conditions. The NC ITP currently has an enrollment 14% below pre-pandemic levels. While referrals did decline significantly early in the pandemic, they have returned to pre-pandemic levels over the past several months.

Throughout the COVID-19 pandemic, services for infants, children, youth, and their families have continued, adapting as needed to meet the needs of individuals and additional safety precautions (i.e. use of masks, physical distancing). Staff have adapted to conducting outreach and training activities virtually during COVID-19. More than ever before COVID-19 has highlighted the need to partner with professionals, families, and agencies in communities across the state who care for or serve children and youth with special health care needs (CYSHCN). The engagement of families of CYSHCN has been key in providing diverse perspectives as we address physical health, dental health, disabilities, behavioral health, health care transition, and

the medical home approach for CYSHCN during COVID-19. The Governor-appointed Commission on CSHCN has provided ongoing feedback to DHB on policies and processes and issues related to Medicaid Transformation and its impact on CYSHCN. The Children with Special Needs Help Line continued to provide information about services available such as Medicaid and Health Choice, medical homes, resources to pay for medical equipment, and information about health care transitions for CYSHCN.

There have been additional efforts to partner with DSS and Fostering Health NC to address the needs of children in foster care who are CYSHCN. With the decrease in well visits and vaccines due to many reasons related to the COVID-19 pandemic, it has been important to maintain timely access to comprehensive and coordinated care in medical homes for children in foster care. These well visits need to occur on an enhanced frequency and schedule to address the increased risks of children in foster care by monitoring growth, screening for potential social, emotional and developmental concerns, building strengths and assets, and addressing acute issues as needed. The Commission, family members and other stakeholders have provided feedback on the draft of the NC Specialized Foster Care Plan developed by DHB which is planned for implementation in 2023.

### **Well Child Care and Immunizations**

During the COVID-19 pandemic, NC and the United States experienced declines in well-child visits and immunizations, with more missed well-child visits among low-income children and Black or Hispanic children. There was also a greater decline among the public sector immunization ordering. 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, and counseling. NC DHHS has continued to work with its partners, such as CCNC, NC AHEC, and providers to raise awareness among parents and caregivers across North Carolina, sharing best practices, and outreach to improve overall immunization and well child rates. Nationally, Vaccines for Children (VFC) provider orders have rebounded to similar levels as pre-pandemic, but there is still a substantial overall deficit for 2020-21 (CDC webinar).

NC DHHS will also soon launch its yearly influenza vaccine campaign in order to promote the flu vaccine during the fall with the highly contagious Delta variant of SARS-CoV2, while also highlighting the message to providers that COVID-19 vaccine and influenza vaccine can be administered at the same time. The NC Immunization Program will continue a bidirectional, streamlined borrowing process with seasonal influenza vaccine to prevent missed opportunities for both VFC-eligible and fully insured children to increase flu coverage.

To ensure that children are not excluded from school because of increased demands on health care providers amid the ongoing COVID-19 pandemic, Governor Roy Cooper issued a new [Executive Order](#) and State Health Director Dr. Elizabeth Tilson issued a [State Health Director Memo](#) that suspends but does not waive documentation deadlines for proof-of-immunization and health assessment requirements for school and child-care facilities for the 21-22 school year. The Executive Order is needed because increased case rates and viral transmission caused by the Delta variant have limited providers' ability to schedule immunization and health assessment visits.

According to the [North Carolina Pediatric Society](#), pediatricians are experiencing record levels of demand for sick visits due to viral illnesses. In typical years, proof of required immunizations and health assessments are required within 30 days of the first date of attendance of school. After 30 days, children are to be excluded from school until the family provides documentation of requirements. This year, the 30-day "grace period" for all students will begin on November 1, 2021. Extending these deadlines will allow more time for families, schools, and providers to facilitate access to needed immunizations and health assessments. Families are required to provide the school or child care facility proof of an upcoming appointment (which could include a written statement from a parent or guardian) by October 8, 2021, and are strongly encouraged to obtain the required immunizations for their children in a timely manner.

## **Child Nutrition**

Food access continues to be a central focus with the economic toll from the ongoing pandemic. NC DHHS has opted into many waivers offered by the United States Department of Agriculture, FNS to provide flexibilities in nutrition programs, including NC DHHS programs such as WIC, the Child and Adult Care Food Program (CACFP), FNS or SNAP, and to operationalize new programs like P-EBT for students, P-EBT for Childcare and implementing FNS online ordering.

The WIC Program utilized flexibilities for physical presence, food package, and remote or State assisted issuance, among others. These waivers allowed WIC participants and applicants, to receive WIC nutrition education, breastfeeding education, and food benefit issuance without requiring a clinic visit. The food package flexibilities helped address supply chain issues for participating families. Online WIC referrals remained high throughout State fiscal year 2021, with sustained WIC participation approximately 20% higher than February 2020. Most recently, North Carolina participated in the increased Cash-value Benefit for the purchase of fruits and vegetables to \$35 per month per eligible participant for four months (June through September 2021).

The CACFP utilized waivers applicable to meal pattern flexibility, lifting the congregate feeding, requirement and issuing Emergency Operation Costs reimbursement to support participating institutions that may have had to shut down during COVID-19. These flexibilities allowed child care centers, family day care homes, adult day care centers, emergency shelters, at-risk afterschool programs, and outside school hours programs to receive reimbursement for providing meals to participants.

The P-EBT programs, a collaboration between NC 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 or child care may have been impacted by COVID-19. NC DHHS implemented online ordering so that families enrolled in FNS can order food online for curbside pickup or delivery at national retailers like Walmart and Amazon, as well as some local and regional retailers using FNS benefits. With these flexibilities and new programs, recipients can continue to receive benefits and follow safety precautions.

## **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 staggering disparities. In an effort to strengthen our focus on maternal health, NC

DHHS applied for and was awarded two federal grants to improve maternal health in the state. The Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program supports the work of the Maternal Mortality Review Committee (MMRC). The MMRC is charged with reviewing all maternal deaths in the state and making recommendations for improvement. Their first report is scheduled to be released later in Fall 2021.

Using recommendations from the NCIOM Perinatal Systems of Care Task Force, the Maternal Health Innovation (MHI) Program was developed. This collaborative work led to the creation of a statewide Maternal Health Task Force, also convened by NCIOM. The Task Force is charged with moving forward several key recommendations by September 2024 in partnership with the MHI Program. MHI's work has focused on the creation of a Provider Support Network inclusive of Perinatal Nurse Champions, Family Medicine Champions, and Obstetrician Champions focused on improved transitions of care for postpartum women to primary care. This also includes Pediatric Champions as they promote screening for maternal risk factors during well-child visits. MHI also supports the 4th Trimester efforts in each of the six perinatal care regions, Centering Pregnancy and Parenting, Doula and Community Health Workers, Quality Improvement efforts, along with a focus on diversifying the workforce and providing implicit bias training opportunities. This work remained aligned with the state's updated Perinatal Health Strategic Plan that is expected to be released in Fall 2021 as well.

## **Goal 6: Support individuals with disabilities and older adults in leading safe, healthy and fulfilling lives.**

### **Older Adults**

- DPH collaborated with the Division of Aging and Adult Services (DAAS) to receive a grant from the CDC to help promote a public health approach to Alzheimer's disease and related dementias. **Building Our Largest Dementia Infrastructure for North Carolinians (BOLD NC)** was one of 16 applications to be awarded in this nationwide competitive grant program.
- DAAS receives \$200,000 per year for three years to assist the DAAS and DPH in increasing the focus on brain health and cognitive decline risk factors, as well as help to meet the needs of people with dementia and their care partners. Program activities will align with the Healthy Brain Initiative State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map and the Road Map for Indian Country.
- DPH worked with partners to launch the first five-year NC Falls Prevention Coalition Action Plan to prevent falls among older adults and adults at risk for falling due to disabilities and other conditions.
- DPH and DAAS worked with the NCIOM and partners (AARP North Carolina, LeadingAge NC, UNC Center for Aging and Health/Carolina Geriatric Workforce Enhancement Program, UNC-Asheville Center for Health and Wellness, and others) to apply for funding to develop a Healthy Aging Task Force that will focus on injury and violence prevention, nutrition and food security, mobility, and aging in place.
- NC DHHS created the Social Isolation and Loneliness Work Group to support older adults and help prevent suicide.

In addition, long term care residents have been a priority population during the pandemic. NC

DHHS's response has focused on a five-point strategy for long-term care facilities including prevention, staffing, testing, outbreak management and oversight.

Key initiatives include:

- Providing more than 3,500 long-term care facilities with PPE.
- Helping to fill 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. Over 5,000 individuals were referred for staffing needs.
- Conducted remote infection prevention and control consultation with skilled nursing and other long-term facilities across the state through a partnership with the CDC and the North Carolina Statewide Program for Infection Control and Epidemiology.
- Providing targeted funding to support nursing homes and adult care homes to provide the intensive care needed for residents with COVID-19 and limit the spread of the virus to other residents and staff.
- Providing a toolkit to support long-term care facilities in preparing for and responding to COVID-19 outbreaks in their facility. The toolkit contains an infection control assessment, infection staffing worksheet, infection prevention educational resources and other tools.
- 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 and allowing facilities to exceed the number of licensed beds if needed to provide temporary shelter and services to adequately care for residents with COVID-19. To date, 675 nurse aides have been granted reciprocity in North Carolina.
- Providing virtual training for thousands of staff working in long-term care sites.
- In partnership with local health departments, created 10 infection prevention control teams based regionally that have initiated contact with 3,273 long-term care facilities and conducted 1,274 infection prevention visits.
- In addition, this population was prioritized in the top tier for vaccination efforts and NC DHHS is continuing to focus on operational planning to ensure facilities are partnering with vaccine providers for booster doses for their residents as they become eligible.

## **Olmstead Plan**

The goal of the Olmstead Plan is to support people with disabilities to live their lives as fully included members of the community by engaging in an inclusive process to develop and implement an updated strategic plan. As part of this work, North Carolina supports serving individuals with disabilities in the most integrated settings possible, based on what is clinically appropriate as defined by the individual's person-centered planning process. We believe that individuals with disabilities should have the opportunity to live in community settings that reflect community values and standards.

Through engaging beneficiary and provider stakeholders, NC DHHS has begun work on a plan that supports individuals through a person-centered process, builds upon our already existing system and supports providers to ensure compliance with rules. The link to the [webpage](#) details goals of

the Olmstead Plan and North Carolina’s vision of Home and Community Based Services.

### **The Transitions to Community Living (TCL)**

TCL provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work, and play in North Carolina. This initiative promotes recovery through providing long-term housing, community-based services, supported employment, and community integration.

The six pillars of the Settlement are as follows and provide for:

1. Community-based supported housing - permanent, integrated, affordable housing for people who are TCL-eligible and choose to live and receive services in the community. Tenancy supports are provided to every person with a housing slot.
2. Community-based mental health services - access to the array and intensity of services and supports necessary to enable a person who is TCL-eligible to successfully transition and live in the community.
3. Supported employment (Individual Placement Supports) - supported employment services that assist the person to identify and maintain integrated, paid, competitive employment.
4. Discharge and transition process - informed decision making and assistance in transitioning from a State Psychiatric Hospital or from an Adult Care home into permanent supported housing.
5. Pre-admission screening and diversion - effective diversion from entry to an Adult Care home and movement into permanent, supported housing.
6. Quality assurance - a quality assurance and performance improvement monitoring system that ensures that a community-based placement and services are developed in accordance with the Settlement Agreement and that the person receives services and supports they need to ensure health, safety, and welfare.

Each component has settlement milestones. Implementation plans are completed during collaborative work group sessions that are open to the public.

### **Goal 7: Achieve operational excellence by living our values- belonging, joy, people-focused, proactive communication, stewardship, teamwork, and transparency.**

#### **Enhance data driven decision making and whole person health through a modernized data and IT infrastructure.**

NC DHHS's creation of the Data Office in 2019 made a strong statement regarding the importance of data as a strategic business asset. The Data Office developed a Data Strategy Roadmap with a focus on five cross-cutting pillars. These five pillars have guided our work this year to achieve operational excellence: i) Infrastructure- the Business Intelligence Data Platform, described in Goal 2, which was initially developed for COVID-19 related data, has provided a foundation for a broader IT infrastructure needed for “data democratization” or access to data by the people who need it. This enables both transparency and proactive communication. ii) Data Governance- NC DHHS has worked with a consultant who is a national expert on data sharing across government entities to develop a Data Sharing Guidebook and legal framework to facilitate appropriate role-

based data sharing. iii) Data Connection –the Department has deepened its partnership with the Department of Information Technology Government Data Analytics Center and the State Health Information Exchange to facilitate record linkage across previously siloed data sources, thus facilitating a 360-degree view of the people we serve. This brings a people-focused lens and facilitates Goal 3- an innovative, coordinated, and whole-person centered system. iv) Data Quality- beginning with Medicaid and COVID data, DHHS has initiated proactive workstreams aimed at data quality assessment and improvement. v) Data Use- COVID provided an urgent use case through which to demonstrate the importance of actionable data insights, from tracking trends of testing, cases, and hospitalization to resource allocation for vaccine outreach to populations who need it most.

### **NC DHHS Award Ceremonies**

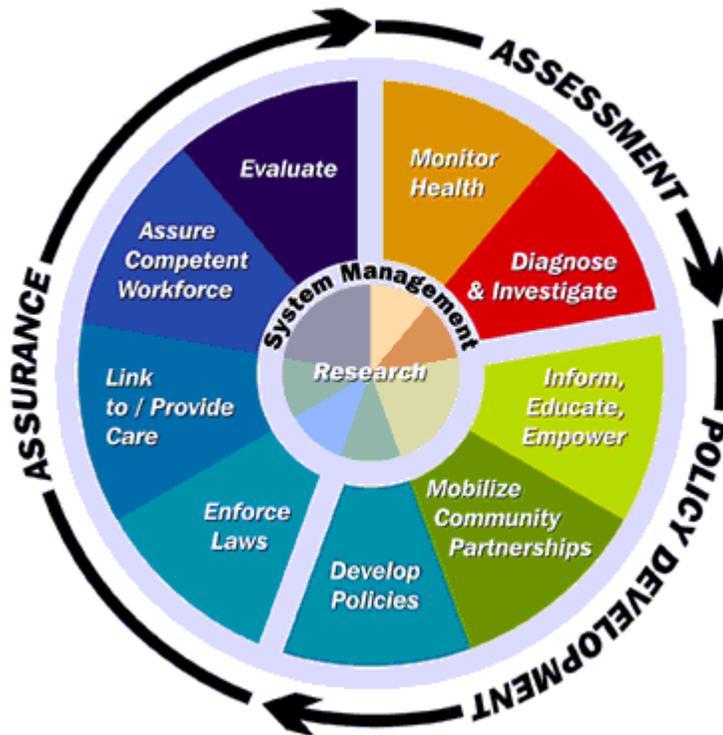
Each year, the NC DHHS awards ceremony serves as an opportunity to lift up the amazing accomplishments of the NC DHHS team and recognize how they exemplified the NC DHHS values in the prior year. On March 25, 2021, employees from across NC DHHS were honored during the annual NC DHHS Team Recognition Awards in a virtual event. The awards recognized NC DHHS teams who have gone above and beyond to further the mission of NC DHHS and how they demonstrated the NC DHHS values of belonging, joy, people-focused, proactive communication, stewardship, teamwork, and transparency during 2020.

### **Strengthening Foundational Public Health Capabilities**

According to the [2020 report from America's Health Rankings](#), which is the most current, North Carolina ranks 41<sup>st</sup> in a tie with Missouri and Pennsylvania out of 50 states for state dollars dedicated to public health and federal dollars directed to states per person by the CDC and the Health Resources & Services Administration. This places our state close to the bottom in regard to available funding for Public Health and exacerbates challenges with access to care with a disproportionately negative impact on HMPs.

Despite these challenges, North Carolina has a committed and capable public health team that works tirelessly every day to advance its critical mission of working to promote and contribute to the highest possible level of health for the people of North Carolina.

Public Health in North Carolina has three core functions, and 10 essential services of Public Health are illustrated below by the "wheel graphic".



The COVID-19 pandemic has stretched the public health workforce in North Carolina and exposed gaps in foundational public health capabilities at the state and local levels, hindering optimal public health pandemic prevention and response. The National Academies series on emerging stronger after the pandemic cites gaps in foundational capabilities as a root cause for poor pandemic response. The Foundational Capacities of Public Health are the suite of skills, programs, and activities that must be available in state and local health departments everywhere for the health system to work anywhere. They include:

- Assessment/Surveillance
- Emergency Preparedness and Response
- Policy Development and Support
- Communications
- Community Partnership Development
- Organizational Administrative Competencies
- Accountability/Performance Management.

Building on the framework designed by the Public Health Leadership Forum, North Carolina has emphasized *Health Equity* as a cross-cutting theme across all the Foundational Capacities. With anticipated financial support from the CDC, DPH will use this evidenced-based framework to identify and fill select staffing and training needs at the State and local levels for COVID-19 response and recovery and leverage the framework of the Foundational Capacities. This approach is designed to advance pandemic response and recovery, while also preparing for community-wide public health needs for the future.

## **The Future of Local Public Health in North Carolina**

The NCIOM has convened a Task Force on the Future of Local Public Health in North Carolina to develop a vision for the future of local public health in the state and recommendations to achieve that vision. This includes principles of health equity, leadership, connection between clinical services and population health, opportunities for targeted investments, public communication about the value of public health, and data integration to drive improvements in service delivery and outcomes.

The work of the task force is happening in conjunction with a special initiative of the North Carolina Association of Local Health Directors (NCALHD) to improve the visibility and influence of public health as a critical part of the state's health care safety net infrastructure, supported by a grant from the Kate B. Reynolds Charitable Trust. The NCALHD will lead future action planning to implement task force recommendations with local public health departments, and additional partners may carry forward regional and state public health action planning, including policy development for consideration by the NC General Assembly.

## **ADDRESSING OTHER COMMUNICABLE DISEASE THREATS**

### **Human Immunodeficiency Virus (HIV):**

HIV rates: Rates of newly diagnosed HIV have declined slightly since 2016 from 16.3 per 100,000 to 12.2 per 100,000 in 2020; however, caution should be used in viewing 2020 data due to the restrictions of services during COVID, including availability of HIV testing and public interest in being tested.

In June of 2021, DPH released North Carolina's "Ending the HIV Epidemic Plan." It is available [here](#): in [English](#) and [Spanish](#) along with printed copies are also available. The Plan was created after a series of community meetings were held across the state, and with the guidance of a diverse Steering Committee of members of the HIV community. Three Pillars – Engage & Embrace, Test & Treat, Policy & Promotion – were identified, with the underlying commitments to address stigma and to measure progress toward a meaningful decrease in infections and an increase in the number of people who are virally suppressed when living with HIV. Each Pillar has Strategies to achieve these goals and Action Steps to get there. These include but are not limited to expanding access to pre-exposure prophylaxis (PrEP), assuring anti-stigma education for providers, and promoting youth-serving sexual education campaigns, to name a few.

### **Viral Hepatitis**

Since 2018, North Carolina has been experiencing a state-wide person-to-person outbreak of hepatitis, primarily in men who have sex with men, people who use drugs, and persons experiencing homelessness. This outbreak is characterized by high hospitalization rates (63%) and increased rates of comorbidity with other viral hepatitises (13% hepatitis B, 48% hepatitis C). Cases associated with this outbreak have markedly increased beginning August 2020, resulting in an increased comprehensive outbreak response.

The North Carolina Viral Hepatitis Task Force (NCVHTF) is a diverse group of stakeholders in viral hepatitis who meet quarterly to identify the greatest needs and barriers addressing viral hepatitis in North Carolina. Through a series of day long meetings, the NCVHTF drafted a State Plan of recommendations on how to lower viral hepatitis transmission and increase access to viral hepatitis care in the state. This plan includes ten priority topics necessary to address viral hepatitis and highlights low-barrier and gold-standard interventions.

Hepatitis C is curable, and hepatitis A and B are preventable by vaccination. Viral Hepatitis in North Carolina continues to rise, and the following is what providers can do to help:

- a. Become HCV treatment providers by going through the North Carolina Hepatitis Academic Mentorship Program
- b. Adopt the USPSTF/CDC HCV screening guidelines
- c. Screen all adults for hep C at least once
- d. Continue to screen at risk individuals at regular intervals
- e. Screen for HCV once for each pregnancy
- f. Offer referrals for patients to substance use treatment and/or syringe access programs as requested/needed
- g. Discuss risk for viral hepatitis with patients (sexual risk, safer drug use practices, vaccinations, hand hygiene, etc.)
- h. Offer regular HCV testing for patients who report risk behaviors
- i. Offer vaccinations for Hep A and B to patients
- j. Become familiar with process for accessing hepatitis C prescription assistance for uninsured patients (specifically for HCV)
- k. Educate all staff on cultural humility and foster a welcoming environment for people who use drugs

### **Congenital Syphilis (CS) Infections**

In North Carolina, syphilis infection rates among women of reproductive age have more than doubled, going from 4.4 per 100,000 in 2014 to 10.4 per 100,000 in 2020. This increase was associated with a greater than 4-fold increase in reported CS infections during the same timeframe, increasing from 7 reported cases in 2014 to 32 reported cases in 2020. CS is a preventable infection caused by failure to diagnose and treat syphilis in pregnant women, resulting in transmission to the unborn child. CS can result in severe and life-long consequences for both mother and infant, therefore every CS infection should be treated as a sentinel event and health systems failure. Since 2017, state and local syphilis prevention staff perform quarterly reviews of every reported CS case to identify and target missed health care and public health opportunities to prevent CS. Information gathered from these reviews are routinely shared with local and state stakeholders to promote CS prevention and elimination efforts.

#### ***What Providers Can Do***

- Perform a thorough sexual health and behavioral risk assessment at every prenatal visit.
- Test every pregnant woman for syphilis at the first prenatal visit, between 28-30 weeks gestation, and at delivery. This is required by North Carolina Public Health Law.
- Treat all sex partners of pregnant women diagnosed with syphilis to prevent re-infection.

## ENVIRONMENTAL HEALTH

As our climate warms, we are seeing more short- and long-term health impacts on the residents of North Carolina. Due to pervasive systemic injustices, HMPs too often live in environments that jeopardize their health and well-being. For decades, the same policies and pollutants that we now recognize as causing climate change has been affecting communities of color, resulting in higher rates of asthma, heart disease, cancer, and other preventable diseases

### Worsening Issues with Heat, Flooding, Storms

Population growth, aging infrastructure, rural-urban divide, COVID-19, and SDOH continue to exasperate disparate climate impacts. Black communities and low-income populations in eastern North Carolina are more likely to live in low-lying flood plains and substandard housing and experience greater risk of exposure to extreme flooding events. Additionally, children can be mentally and physically impacted by intense storms, loss of home or possessions, and frequent relocation, an Adverse Childhood Experience that impacts lifelong wellness. Low-income earners and farmworkers may suffer loss of wages and difficulty finding affordable quality housing.

Outdoor workers and those who cannot afford adequate cooling are at increased risk for heat exposures. Rising heat and poor air quality have disproportionate impact on maternal and infant mortality, young children, and older adults. The impacts of extreme heat events are higher in underserved communities, especially those living in mobile homes which are poorly insulated and those whose residents have limited means to adapt to warming temperatures and already experience disparate asthma and cardiovascular disease burden. Figure 1 from the NC Housing Coalition (2019) shows the overlap between extreme heat days and energy burden in North Carolina. [Clean energy investment](#) in communities burdened with the greatest amount of heat exposure may reduce heat-related illness among those experiencing energy poverty.

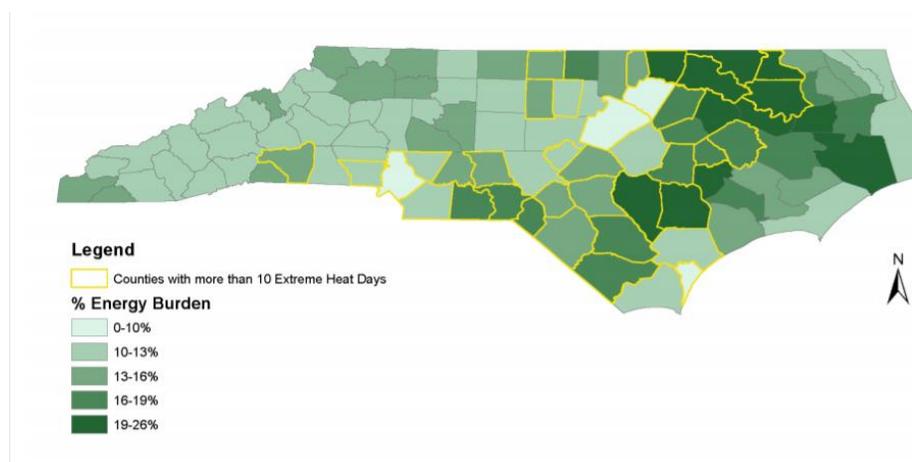


Figure 1. Energy Burden of Low-Income Homeowners by County (NC Housing Coalition)

### Focus on Environmental Justice Concerns

The NC DHHS Climate Resilience Workgroup, with leadership from the Occupational and Environmental Epidemiology Branch and the Office of Procurement, Contracts and Grants,

elevates climate and health as a priority across the department. NC DHHS works alongside the NC Department of Environmental Quality and other state agencies on the NC Climate Change Interagency Council, to implement the [NC Climate Risk Assessment and Resilience Plan](#). Climate justice goals in this plan include addressing the disparate impacts of climate change, pollution, and toxic exposures on low-income communities and communities of color, as well as funding and implementing energy projects that provide equitable access to affordable clean energy for low-income earners.

### **Expanding Efforts to Mitigate Health Effects**

In September 2021, the [DHHS Climate and Health Program](#), based in the Occupational and Environmental Epidemiology Branch, was awarded CDC funding to expand our 10-year program based on the CDC's Building Resilience Against Climate Effects (BRACE) framework. Previous funding has been used to address health effects from heat and wildfires. The next cycle will build on this adaptation work while incorporating climate justice and a focus on the health effect from flooding around the state. Activities respond to [Executive Order No. 80](#), the NC Climate Risk Assessment and Resilience Plan, and an extensive [literature](#) on the health effects of climate change.

### ***What Providers Can Do***

Clinicians can play a key role in addressing climate-related health impacts and environmental injustice among the patients and communities they serve. The following approaches can help clinicians identify sources of environmental hazards and exposures exacerbated by climate change, reduce associated health effects, and call attention to environmental injustice:

- a. Increase knowledge of environmental health** - Clinicians can support enhanced environmental health education for students and seek continuing education opportunities for themselves and their colleagues.
- b. Talk with patients, especially those from vulnerable populations, about environmental hazards** - The physical environment—air, water, and food quality—affects physical and mental health. Talking with patients about their neighborhood, work environment, and environmental stressors can increase understanding of relevant environmental influence on health and help identify potential points for intervention. Special efforts should be made to engage patients of color who are more likely to be affected by environmental injustices and the disparate health effects of climate change.
- c. Provide information about environmental injustices to advisory boards, regulatory agencies, and public health agencies** - Clinicians with knowledge of local environmental injustices that may harm health can tailor individual patient care plans and share information with entities working to improve conditions at the community level. These entities include advisory boards, environmental regulatory agencies, local and state public health departments, and federal environmental and public health agencies.

### **Environmental Health and Environmental Justice in North Carolina**

From 2010 to 2018, NC had the 4th largest population growth in the nation and our population is projected to continue to grow to 11.2 million by 2025. This rapid growth and development has

resulted in populations living near historically industrial and agricultural areas where an increasing number of people may be exposed to potentially harmful contaminants.

***Major Issues and Concerns:***

Historical injustices and ongoing racism have contributed to a disproportionate burden of pollution in communities of color and low-income communities across the state. Often marginalized communities, historically excluded from public utilities face failing on-site systems, impaired air and/or water sources, and public health concerns arising from environmental contaminants. Costs associated with addressing and mitigating environmental issues that adversely impact public health can pose a significant problem, especially in low-income communities.

***Strategy:***

Identify and address environmental occurrences adversely impacting public health associated with:

- Malfunctioning and aging private on-site septic systems
- Improperly installed and aging private drinking water wells
- Natural and anthropogenic contaminants
- Concentrated animal feeding operations
- Flooding
- Industry generated waste and waste byproducts
- Waste and chemical discharges
- Surface water impairment
- Contaminants of emerging concern
- Energy generation sector
- Coordinate with state, local and federal agencies in developing strategies to address public health inequities and reduce environmental injustices
- Provide educational materials and opportunities for septic system and well owners

***Activities (active and proposed):***

- a. The Environmental Health Section's Non-Point Source Pollution Program (NPSP) Coordinator has submitted an Environmental Protection Agency (EPA) FY2021 Multipurpose Grant Application for identification of septic systems and private wells in need of improvements, repair, or replacement for communities in three of North Carolina's forty Tier 1 designated counties.
- b. The Geospatial Strategy Advisory Committee has included septic systems in the priority use cases for geospatial data.
- c. Infrastructure needs – OSWP, OEE and OMHHD are working with the CDC regarding NC's approaches to decentralized wastewater activities and private drinking water wells including:
  - Generating new data,
  - Understanding and accessing available funding sources,
  - Identifying partners,
  - Addressing environmental justice issues, and

- Providing strategies for engaging in these priorities.
- d. NPSP Coordinator with the Private Water Supply Wells Program Wells Team Lead developed and generated three educational materials designed to assist homeowners and others utilizing septic systems: ‘Understanding and Protecting Your Septic Systems’, ‘What to Do with Your Septic Systems in Flooding Conditions’, and ‘What to Do with Your Septic Systems and Wells in Flooding Conditions’.
- e. Continue to compile and evaluate information regarding impacts of Best Management Practices on reducing septic system-derived nutrients.

### **Lead in Childcare Centers**

In the wake of Flint, Michigan, the Commission for Public Health amended administrative rule 15A NCAC 18A .2816 to require periodic testing of drinking water for lead content at all licensed child care centers effective October 2019. With funding provided that same year by the federal Water Infrastructure Improvements for the Nation Act, DPH has received a \$1.5 million grant from the U.S. EPA to test for lead in drinking water at all licensed child care centers in the state. To date, more than 22,000 water samples from nearly 4,000 licensed child care centers have been collected and analyzed.

A citizen scientist strategy was adopted, which greatly improved the efficiency of the project and made possible the widescale testing approach. Child care operators were enrolled and trained online and mailed test kits to collect the initial water samples, which were mailed back to the contract laboratory (RTI International). Thus, travel by regional and local environmental health specialists was minimized and focused on follow-up for initial samples that were elevated  $\geq 15$  ppb, which have accounted for only 503 (2.2%) samples. Mitigation has primarily focused on scheduled flushing when effective and faucet replacement. Filtration has been necessary in only a few instances due to elevated water lead levels in the plumbing and distribution system.

A summary of the results from testing water for lead in licensed child care centers is available at the following link: [www.cleanwaterforcarolinakids.org/programsummary](http://www.cleanwaterforcarolinakids.org/programsummary).

## APPENDIX

### List of Acronyms and Meanings

AHEC	Area Health Education Centers
ARPA	American Rescue Plan Act
BIPOC	Black, Indigenous, and People of Color
CACFP	Child and Adult Care Food Program
CARES	Coronavirus Aide, Relief, and Economic Security
CBOs	Community-based organizations
CDC	Centers for Disease Control and Prevention
CS	Congenital syphilis
CYSHCN	Children and youth with special health care needs
DAAS	Division of Aging and Adult Services
DEI	Diversity, Equity, and Inclusion
DHB	Division of Health Benefits
DPH	Division of Public Health
DPPs	Diabetes Prevention Programs
DSOHF	Division of State Operated Healthcare Facilities
EBCI	Eastern Band of Cherokee Indians
EPA	Environmental Protection Agency
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FFS	Fee-for-service
FHLI	Foundation for Health Leadership and Innovation
FNS	Food and Nutrition Services
HIV	Human Immunodeficiency Virus
HMP	Historically Marginalized Population
HNC	Healthy North Carolina

I/DD	Intellectual/Developmental Disabilities
LME-MCOs	Local Management Entity-Managed Care Organizations
MHI	Maternal Health Innovation
MMC	Medicaid Managed Care
MMRC	Maternal Mortality Review Committee
NC BCCCP	North Carolina Breast and Cervical Cancer Control Program
NC DHHS	North Carolina Department of Health and Human Services
NC ITP	North Carolina Infant-Toddler Program
NC OSUAP	North Carolina Opioid and Substance Use Action Plan
NC SHIP	North Carolina State Health Improvement Plan
NCALHD	North Carolina Association of Local Health Departments
NCCARE360	Statewide coordinated care network
NCIOM	North Carolina Institute of Medicine
NCVHTF	North Carolina Viral Hepatitis Task Force
NPSP	Non-Point Source Pollution Program
OAP	Opioid Action Plan
OPDAAC	Prescription Drug Abuse Advisory Committee
PHP	Prepaid Health Plans
PPE	Personal Protective Equipment
SDOH	Social Determinants of Health
SNAP	Supplemental Nutrition Assistance Program
SSPs	Syringe services programs
SUD	Substance use disorder
TCL	Transitions to Community Living
UNC	University of North Carolina
VFC	Vaccines for Children
WIC	Supplemental Nutrition Program for Women, Infants, and Children

