

Transcript for Friday Open House for Providers  
August 14, 2020  
12:30-1:30 pm

Presenters:

Betsey Tilson, MD, MPH, State Health Director, Chief Medical Officer, NC DHHS  
Zack Moore, MD, MPH, State Epidemiologist and Epidemiology Section Chief, DPH, NC DHHS

Hugh Tilson

Looks like it's 1230 so why don't we go ahead and get started. To make sure that he can hear me. Good afternoon everybody and thank you for participating in our office hours for providers or as Elizabeth says the ever popular office hours for providers. Want to thank everybody for making time for this new approach office hours so that the DHHS leaders and providers can communicate about what's going on with COVID-19 and how to respond to these challenges. We've got another one of these scheduled at the end of the month. We'll reassess that point if they continue to be valuable so welcome any of your feedback as we make that assessment. My name is Hugh Tilson I'm the director of the North Carolina AHEC program I'm moderating today I think everybody knows who our panelists are and if you can go to the next slide. There are Dr. Betsy Tilson who is our State Health Director and Chief Medical Officer. And Dr Zach Moore, who is the state epidemiologist and Epidemiologist Section Chief, really, really appreciate y'all making time for us, we know busy you are, and how crazy your schedules are really appreciate you making time as do all of the participants.

I'll turn it over to Dr. Moore next for opening comments, but also want to thank everybody who's participating for making time in your schedules to get this information, we really know how important your work is and how busy you are, and hope that the information today will help you do your important work better and make navigating these trying times little easier. After you hear from Drs. Tilson and Moore we will turn to your questions. Everybody is muted, there are two ways to submit questions. One is using the q&a feature on the black bar at the bottom of the screen. And then the other is by sending us an email that email address is [questionscovid19forum@gmail.com](mailto:questionscovid19forum@gmail.com), and we will process those questions and turn them over to doctors Moore and Tilson. So, Zack let me turn it over to you now.

Dr. Zack Moore

Okay, great. Thank you. Can you hear me okay. Yep. Wonderful. Thanks everybody for joining. I'm not going to take much time because we're here for the office hours and questions but I do want to just briefly give some context for where we think we are in this pandemic. We do have some, you know, signs of improvement over the past few weeks in North Carolina, certainly still in a period of extremely widespread transmission. So, you know, lots of qualifications around the, the good news but we we did see a peak in cases around July 7 and we have had a downward trend in our reported lab confirmed cases since that time, knock on wood. You know, of course, there's no perfect data out there for tracking this and but we are somewhat. You know, I guess it's reassured that along with our lab

confirmed cases we've seen similar decreases and similar timing in some of our other metrics including our syndromic surveillance, in all of our emergency departments where we've seen declines in COVID like illness visits. And we have seen pretty stable hospitalizations but but some decreases there as well.

So this is a pattern that's actually been seen with different variations, all across the southeast so this very large spike as you're all aware, with some decreasing across the region. And then, you know, on a national level, less of a compelling downward trend there's been upticks in different areas, particularly at this particular moment in sort of the upper Midwest and upper central portions of the country. So, we will see i mean i think you know we all are aware that with schools starting and colleges and universities we're coming into a period where we have venues where there are opportunities for transmission, that have not been present before so we are certainly watching very closely, and a lot of work has gone in from a lot of different sources to making sure that transmission will be mitigated and minimized in those settings. That's something that's going to be tracked really closely, you know, as I've probably said on here before personally. You know, I, I would really like to see us get our rates down as low as possible coming into the influenza and respiratory virus season. It's been interesting that it's been a very light flu season in the southern hemisphere so far this year, which, again, very tepid encouragement there. You know we're working to make sure that our surveillance is ready to encompass, both of those things here in the coming weeks and months. And I think that's probably it for a big picture update, so maybe I'll turn it over to Betsey for any opening remarks. Thank you.

Dr. Betsey Tilson

And just two kind of updates or hot topics that have happened to this week, and then we'll get into your questions some that were submitted proactively that I think will get a bunch of hot topics as well but but two things and if those of you who are on there was a big Medicaid call last night that came through some of the quality improvement things within Medicaid but these two topics were briefly mentioned there last night so just wanted to reiterate them for the different audience today. One was specifically around there's been a fair amount of activity around physicians being asked notes, medical notes or doctor's notes for people to go to gyms. And so I just wanted to clarify that a little bit and give you some guidance and give you some background on that.

So, we have from a policy standpoint we have kept gyms closed statewide for a number of reasons one that they overall are pretty high risk environment when we think of what makes an environment high risk for viral transmission, gyms, check a lot of the boxes so indoors higher risk than outdoor. And that people with gyms may hard, it may be hard for people to social distance from each other if the equipment is close to each other so make social distancing a little bit difficult. Third, anything that increases respiratory efforts or breathing heavily launching more territory droplets so heavy exercise can increase that respiratory spread. Also, people are exercising it's harder for them to wear face covering because they're exercising and so they have less people wearing face coverings and then the fomite spread there's just a lot of surfaces that a virus can be on. So for a lot of those reasons oh and then there's been studies about outbreaks especially from like Zumba classes and so there's data on

outbreaks associated with fitness facilities so for all those reasons from a policy decision we have kept gyms closed we also look at some other states that had an open. And then as part of their surges in their cases, they have gone back and close some of those gyms. So for right now and just as Zack was saying we want to kind of make sure that we are in a good position, as much as possible especially knowing kids are going back to school and knowing that flu is on its way we're being very cautious in opening up some of our higher risk settings.

So that's the intention is that overall indoor fitness facilities are closed for the majority of people. Now outdoor facilities are great and we've allowed that and we want people to be exercising. Of course exercise is great and outdoor fitness is okay, but as part of some of the legal proceedings, there was an exception because we have not closed medical facilities. Obviously our doctor's offices are open, and that the thought was if somebody is really utilizing fitness equipment as part of their, their medical treatment plan, kind of, as in a medical facility that if people didn't have access to that equipment in their medical facility and they had to have access to that equipment in the gym. Could that be allowed. So for example the example was somebody who's doing rehab or someone is doing PT and that maybe the rehab or the PT facility, doesn't have the proper equipment they need for that that prescribed PT or rehab. And the only way they could do that is through a gym could there be a medical exemption for those people to be able to use to use the equipment in the gym.

So that is the intent of the exception that somebody use the gym for a very prescribed medical treatment plan that they couldn't they can't do in a medical facility. The intention is meant to be very limited, small number of people still adherent to the mass gathering limits indoor mass gathering limits. So, it was meant to be a very specific medical exemption that has been somewhat flexibly interpreted. And what we're hearing is a lot of providers are being asked by people to say can I have a doctor's note to use the gym, you know, of course gym is good, maybe I have a chronic condition or BMI, and, but that is not the intention and if we think about it to a lot of those folks have underlying health conditions they're at higher risk for complications with COVID so we really don't want to put them in a really high risk setting. So, the intention is very very limited. Someone who has a pretty prescribed medical treatment plan. And that's the intention of that. So I hope that helps you a little bit. If you are being asked by your patients for a note to use a gym that is not what we're encouraging and that's not the intention of the exception.

Second thing that came out, I guess on Wednesday now was, we were hearing from a lot of different stakeholders concerned about kids, not being up to date on their immunizations and then were concerned that then they would be excluded from learning environments. What we were hearing, a couple different things that one, you know there was some changes in the adolescent immunization with a new Meningococcal coming out in the spring is when we do a lot of that, the schools do a lot of education around that schools obviously disrupted in the spring. So we didn't get a lot of that education out. We know that well child visits, have been down and vaccination levels are down we're working hard to get folks back into primary care but we know we're below where we were last year. We also know our local health departments who, who obviously are do a big chunk, and help a lot with getting

kindergarten clinics and vaccination clinics. They have obviously been very strained in responding to covid. They also do a lot of mass vaccination clinics and clearly that's not a great idea to get bring a lot of people together so they're going to not be able to do kind of the big vaccination clinics that have to break it up, and then also we know that if kids go back to school use that first month of school kind of it's all hands on deck with our school folks, to be able to really work on getting the health assessments of immunizations and schools, especially those that are going to be in person, they're really going to be grappling in this first month just trying to operationalize all the new COVID health and safety protocols.

So for all those different reasons. What we decided to do was the same thing that we did with Florence was to give basically an extra 30 days, a suspension of a 30 day grace period to get the vaccinations on the school assessment. So not a waiving but just an extension of that of the deadline. And so I just to make it easier that the rule is that it's 30 days from the child's first day of attendance, that child's first day of attendance might be different for each child. So just to make it easier and cleaner that in that the clock will start October 1, and then everybody will need to get it in by November 1. So typically, if a kid goes to school on the first day of the October 25, which means it would be due September 25, we just move that kind of five days a little bit and then instead of starting October 25 it starts or August 25 it starts October 1. So that came out, I hope that you saw, we tried to push out through all of our channels. Again, very similar to what we did with with Florence and it applies. And then once kids, after November 1, they need to be exempted excluded from school and that includes both in person and if they are doing remote learning, so it holds to both. So, that's all I wanted to do proactively and then we can get into the questions.

Hugh Tilson

Great. Thank you guys. We got questions in three general areas, testing and reporting, PPE and vaccines which don't want to go to first

Dr. Zack Moore

It's like Jeopardy, I'll take testing and reporting for 500.

Hugh Tilson

500 okay I gotta figure out a question. For figuring out when to test a child how do you determine the symptom onset date for kids who may frequently have a runny nose for example.

Dr. Zack Moore

That is the hard one. Because I and Betsey please jump in, but I don't think there's this is where we get into the art versus the science and it just is going to be a matter of clinical judgment, if there was a specific discrete onset that can be identified as a change in symptoms, or, or not, but I don't think

there's anything that we could point to, you know, I think that would really be a matter of clinical judgment determining if there was something, a discrete date there are no best if you have other thoughts on that.

Dr. Betsey Tilson

Nope, that was my response.

Hugh Tilson

Great. Next question is last webinar on July, it was stated that physicians must report any positive cases, but not negative cases, the labs must report positive and negative cases are the positive cases being counted twice or is there a way to identify duplicate reporting.

Dr. Zack Moore

Yeah, so they're not counted twice. So, every lab result that's received is, you know, matched being duplicated so that it's, you know, only. They're all linked to one particular person so any repeat positives that are done for any reason, and as I think the question alludes to hopefully there's less of that going on with the new guidance. That really de-emphasizes virologic testing for ending isolation and risk really suggest that just time and symptom based strategies should be used but but we still know there's a lot of people who will get repeat testing and those are not counted as additional cases they just link on to that existing case so we don't count them twice.

Hugh Tilson

The questions about the Panthers now the Panthers returning to Charlotte.

Dr. Betsey Tilson

Excuse me, I just want the one thing I wanted to clarify, in terms of reporting. So I know that some of the reporting requirements is a little bit convoluted so I just want to be clear about one thing so there are a couple different levels to reporting requirements. So, and physicians are different than other health care providers rules are different because there's a long standing rule that physicians specifically have to report, positive. That's a, that's an existing statute that we need to respect, we added other reporting requirements for other health care providers so I want to go over those reporting requirements one more, one more time. So, health care providers, other than physicians and nurse practitioners, PAs, if they can affirm that they are if they're sending their lab out to a lab, and they know that lab is submitting results to the state positives and negatives that meets their requirement for reporting. If other healthcare providers though are doing it kind of in house so they're doing rapid

maybe their antigen tests are in house, they need to either they or their in house lab needs to be reporting their positives, and they're negatives.

Physicians again, physicians are ordering through an outside lab, and that outside lab again is reporting their positives and negatives, then physicians, don't need to be reporting their negatives if they can confirm the outside lab is the negative, however, physicians do need to report their positives to the local health departments. And then if physicians are doing in house same thing if they're doing in house they have a CLIA lab they're doing maybe rapid antigen tests. They need to be sure that those positives and negatives are being reported. So just wanted to clarify that that physicians do need to be reporting their negative, but they can either do it through, if the lab is reporting it they don't have to have to report their negatives if the lab is reporting. I know that's confusing, so I want to clarify that.

Okay, now we'll get to the Panthers. I'll take this one. So the case is really affiliated with the County of residence of the person. So, like if a Marlin if an out of state team were to come and test positive it would be going back to that, that state or and of Panthers, they don't live in Mecklenburg County, it should be going back to the, it goes back to the person in the, the place of residence of the person. Zack correct me if I'm wrong, but I think a right.

Dr. Zack Moore

Yeah it's the concept a usual residence. So we look at where the person has been, basically boils down to you know where they're at most of their nights over the past three weeks and so for, you know, college students. People who are here for extended periods, they would be counted here.

Hugh Tilson

What's the current turnaround for covid test results.

Dr. Betsey Tilson

So there's a lot of different labs of doing testing, there's not. So, the question is multiple, multiple answers. So, again, lots of different labs doing testing and they're having different turnaround times. However, the average although the average had been a lot longer a couple weeks ago. overall the average is now back down to about two to three days if we're averaging all of our labs, but there's a lot of different labs, so I would be checking if you are sending to an end of a specific lab I would check with that specific lab. But overall, the turnaround time has decreased back down to two to three days. Overall, and in our, in our state lab that's the turnaround time. And LabCorp has gotten down as well, which is good news.

Hugh Tilson

Is there a master list of places to be tested.

Dr. Betsey Tilson

Yes at our state lab on our website, there's a there's a website that says find my testing site, and you can search by zip code. And yeah, it's right there on our on our website if you click under testing. We have find my testing site. I think there's more than 600 testing sites across the state, if not more.

Hugh Tilson

How accurate is the current data on positive tests and tests provided.

Dr. Zack Moore

I'm guessing that's referring to the data, like our state level data, or not to how accurate are the tests themselves, because those are both good questions. But as far as the data that we have. So we post all the positive laboratory laboratory confirmed cases that are reported to us, either by electronically hopefully which is how we're hoping everything moves in that direction or back to us. If not, so, you know, everything that that we get is reflected on our daily updates. The data on total lab volume, how many tests in the state, as maybe some of you saw earlier this week there was a change in the numbers that were reflected there because there was an issue where labcorp was sending total volume numbers, every day that included some people from out of state. And they fixed that so we had to go back and change those numbers. Those numbers I would say are less are a little trickier than the numbers of cases, because we are getting some of that data reported by labs that aren't submitting electronically, where they just send us the number of the number of tests done. So there's, you know, it's kind of hard to know, verify exactly, all those numbers so the testing volume numbe, the number of total tests we you know we present what we have there. We don't use that to calculate our percent of positive tests, or to do anything else. We only for those calculations we only use the data that we get reported electronically into our system so that we won't have any issues there so for example this past week when we had to go back and make those changes. We didn't have to do any updates or changes to the percent positive or to our case counts or anything else. But, yeah, I'd say keeping up with the total number of tests being done across the state is a major undertaking and challenge that we're wrestling with particularly as point of care testing expands across the state. So that's definitely an ongoing challenge for all health departments that are trying to track that.

Dr. Betsey Tilson

Yeah. The only thing I would add is what is Zack said that the, all the current data that we're using to make those policy decisions so the number of cases a percent positive, all that is very accurate. The challenge is really basically trying to collect all the total number of tests, just as we were kind of talking

about that's part of the reason of the statute and then that reporting guidance is really understanding especially all the negatives. That steps been a challenge and trying to get all the negatives reported so that the total number of tests we're working on but everything that we're using to make policy decisions the total number of positives, percent positive all that has been accurate. Thank you.

Hugh Tilson

Is the inventory of testing supplies adequate to meet the current demand.

Dr. Zack Moore

That is a constantly moving target. I guess I would say as far as I'm aware there's no acute issues in the testing reagent or testing supply chain. But as we've seen throughout this pandemic, you know, it's, it's, again, sort of a whack a mole you know we keep finding problems that can crop up in unexpected places in that supply chain so I would say right now, you know, we've seen overall as was mentioned a decrease in testing turnaround times and no real acute issues on the supply side but that won't necessarily be true tomorrow.

Dr. Betsey Tilson

Yeah. This has been a whack a mole of supply chain I never have been so acutely aware of supply chain, it changes a lot.

Hugh Tilson

A couple of questions in the q and a college students are going to New England and are required to have negative COVID-19 tests at least 72 hours prior to arriving in New England with testing results being prioritized in labs, what would you suggest to get this accomplished.

Dr. Zack Moore

Well like has been mentioned. It's a hard question because you know, obviously we can't speak to what the turnaround time might be at any given place overall there's been a decrease. So it's, you know, it should be possible to get a result in a timely way, even for a sort of non urgent indication like that. I, some of the labs that were relying more heavily on these prioritization schemes. You know, I think are able to get to everything that they're receiving more quickly. So I don't know what to say specifically I guess it brings to my mind, an issue that we get a lot with point of care testing and use of, like, rapid antigen tests, which obviously will get you a faster result. You know whether or not it's acceptable for this purpose I don't know but it's, there's a big problem with that in that the, those antigen tests are indicated for people with symptoms within five days of onset so although they have the appeal of being



faster, using them for that type of thing would not be consistent with, with their indications from their FDA emergency use authorization.

Hugh Tilson

Can of a related question, LabCorp turnaround remains reasonable is there any clinical utility of using a rapid covid test like the Abbott ID now?

Dr. Zack Moore

Um, I mean yes potentially I think there's definitely situations where there, there might be a need for or desire for more rapid results. I certainly wouldn't rule out their utility of perhaps having a result in less than an hour versus two days. But there's, you know, trade offs in terms of sensitivity and just keeping in mind that if you are using a point of care test and that includes the Abbott ID now, point of care molecular tests, along with the antigen test they do have lower sensitivity. So if you're testing someone in whom COVID is suspected and you get a negative result, that should be read that person should be retested using a different molecular assay, sort of like we've always preached about rapid flu tests. You can never rule out flu, with a rapid flu test and that's basically the same principle that holds for COVID with these rapid tests that are currently available you can't use them to rule out, COVID and someone in whom it's suspected.

Hugh Tilson

Thanks. Get something to add Bets?

Dr. Betsey Tilson

Well I was gonna say the same thing when we talked about with antigen is that you want to use those those where you have pretty high pretest probability just because of the lower sensitivity.

Hugh Tilson

We're getting a little bit of echo when you talk, I don't know what's going on

Dr. Betsey Tilson

Yeah I know I'm on my handheld, I'm not sure where that was coming from.

Hugh Tilson

Okay. With point of care testing is a nursing facility going to be responsible for reporting to local health department, NC DPH and HHS etc. Just as the actual lab test report, referring to all the data elements the lab must report DHHS.

Dr. Zack Moore

Well, Betsey, do you want me to start. Sure, I can. Yeah, this is a tricky topic and one that's coming up a lot so I guess I can, and maybe I will not try to speak for what's required from HHS and just from us which as Dr Tilson mentioned, is that all positive and negative results, need to be reported. But we don't have at the state level, specific requirements for, for all those elements. And we recognize that when you're talking about long term care facilities or clinical practices there may not be sort of readily accessible ways to transmit things in any kind of automated way. So it's. I'll just say that they are reporting is required. But we are still considering how to maybe routinize that or facilitate that and make sure that the specific elements that are needed are being transmitted with those results. I don't know, Betsey if you had anything.

Dr. Betsey Tilson

Yeah, I think the reporting requirements stand no matter where the testing is being done and we're working on thinking through all the different ways to actually do that and a little bit more of a, we want to get to an electronic routinized way just as Zack was saying because when we try to do things kind of more manually, you'll see you know what happened this week. And every time you have a kind of a manual out of the box process there can be inaccuracy there so yes they need to reporting and we're working on making that the most efficient as we can.

Hugh Tilson

For someone who has very mild symptoms e.g. nasal congestion mild sore throat only, and who is not at high risk of illness or complications, who is tested because we have a low threshold for testing. But who tests negative. Can we advise them to resume their usual activities as soon as they feel well. Rather than advising 10 plus one isolation.

Dr. Zack Moore

That can I, my short answer would be yes. You know, if you had tested someone in whom, COVID is not suspected, they and they have a negative result. They are not required to adhere to the isolation criteria that are specific to COVID. So, we would hear you could default back to the usual isolation guidance for the type of presenting illness that they have.

Dr. Betsey Tilson

We had that you while you're waiting for the first. Sorry I'm getting the feedback. We have a sheet that says, what do I do what now I've been tested what do I do, and one of it is, you know, while you're

waiting for the test, then you need to be in isolation but if you're if you're negative, then you just need to adhere to that typical that you should be without a fever for at least 24 hours but not the fullout code that isolation if you're negative.

Hugh Tilson

Thank you, do we increase the sensitivity of the test when we isolate people who report concerning symptoms, beginning with the day that their symptoms begin but wait to actually test them until they have already been symptomatic for a day or two.

Dr. Zack Moore

I think the question is about testing at the time of symptom onset versus waiting a couple of days. Is it more likely that you'll pick it up.

Hugh Tilson

Yes.

Dr. Zack Moore

So, No. One of the many unfortunate features of SARS CoV2 is that the period of highest viral shedding actually is from just before onset, to just after so in those couple of days before to a couple days after so there's not any benefit to waiting until a couple days into symptoms in terms of likelihood of getting a positive result. Yeah.

Dr. Betsey Tilson

I know this isn't a question but related to that is ideal testing time frame somebody who look close contact, but as asymptomatic, and our recommendation there has been if you're up for close contact asymptomatic, waiting till about five or six for a test is recommended because typically that, that's when we see that kind of mean contact to symptom onset. So that, that's a recommendation for an asymptomatic contact is about day five or six but if you're symptomatic test right away.

Hugh Tilson

Have you run across any good rules of thumb, particularly questions for how to advise people over the phone when their symptoms sound severe enough to warrant their going to the hospital for example many will say they have some shortness of breath. But is there a good way to assess whether some is severe enough to warrant ED evaluation.

Dr. Zack Moore

I don't know that I have anything particular to offer along those lines. But, you know, I will say there's been a lot of interest in increasing access to pulse oximeters, this is something that I'd say is still being looked at that as a, as a way for people to predict a little better when there might be a need for care. Because the findings with COVID have been that sometimes there can be that can actually proceed worsening of shortness of breath, and just the things that would send somebody in earlier. I guess I didn't answer the question, except to say that I don't have anything specific in terms of clinically what, what might be, you know, beyond erring on the side of if somebody has worsening symptoms, certainly, shortness of breath difficulty breathing they, those would be clear indications. Betsey did you have anything.

Dr. Betsey Tilson

Yeah, I don't know that there's anything specific to the covid other than any other dozens of respiratory distress that you would apply to other other viral infections or respiratory infections I don't know there's anything specific except Zach you were saying that if people have Pulse oximeter they do that that does potentially precede. But otherwise, I don't know there's anything specific to COVID, as opposed to other respiratory illnesses that would be a kind of a pearl.

Hugh Tilson

Great and then we got a follow up to the use of ID now point of care test, just wanted to reiterate does it make, does it have much use considering as high false negative rate in today's environment. Can you repeat your answer to that.

Dr. Betsey Tilson

Start and then let Zach come in, I think that there's a clinical utility. If you have a if there's a pretty high, you have a, you know, a high suspected or high pretest probability, you have someone who is symptomatic maybe a known contact you have a pretty high test sensitivity. Then there's I would say there's a clinical utility for it because you can trust the positive, I don't think it'd be great to do it in some of the low pretest probability because you're going to have to retest those if they're negative, but I think you could those folks who, you know, again that pre high pretest probability I think you can use that at that Abbott ID, because of a higher likelihood of a positive with them, I would not use it for like asymptomatic surveillance or where you have a lot of, you don't have much suspicion, but I think there's clinical utility if you have a high pretest probability. Zack would you say anything different.

Dr. Zack Moore

No, that's exactly how you know I like I said before I think of it like a rapid flu test although those are widely misused so maybe that's bad guidance to be giving. The way that I think about a rapid test where I wouldn't use it to rule out. But if you had someone where you suspected it and knowing that diagnosis is going to be, help you in the short term that would be the right scenario.

Hugh Tilson

Well, those are all the questions we have on testing reporting so we will move to PPE. Thoughts on face shields for school some pediatricians are being asked to write notes to excuse a child from wearing a mask and or to allow him to wear a face shield in lieu of a mask.

Dr. Betsey Tilson

Yeah, I'll take this one. It's so funny how what you don't expect to be a huge hot topic in the pandemic face shields have turned out to be this huge hot topic I would not have expected it but. So a couple things to know about face shields. So, the evidence is there is evidence to show that face shields protect the wearer. They are good protections for the wear especially good eye protection and certainly in a healthcare setting so good data of protection of the wearer. However, there is no data that it serves as good source control therefore somebody's wearing it does it prevent them from having respiratory droplets come out so there's no data on source control. The CDC specifically says it does not recommend faceshields, because there's no evidence that it's effective source control. What we have in our guidance is that face coverings are definitely preferred required. We've sometimes get confused with clear face coverings we definitely we're, we have language around if you like a clear face covering which is basically mask with a clear panel that can be really helpful for like teachers who are working with students for whom they need to see the mouth. So a student who's deaf or hard of hearing or younger students, or that need to see that mouth or kids with English as a second language or children maybe on the autism spectrum or other behavioral health issues where they really need to pick up on all those social cues that a clear face mask can be helpful. And then faceshield what we said is that, if, if, if a child absolutely cannot wear a face covering and your choice is nothing or faceshield, then. Okay, a facial is better than nothing if your choice is a child can absolutely not tolerate a face covering but it is not considered an equivalent. And it really the face covering really is, is the recommended requirement it should be a very very very small exception for that face shield where, for whatever reason, a true medical contraindication for face covering, but they really are not equivalent and there is no data that it functions as good source control. But I know you get those questions because we get them all the time.

Hugh Tilson

Let's go to vaccine. How much for 200 right. How much VFC supply has the state received thus far.

Dr. Betsey Tilson

All right. Oh, that's used for vaccines for children. It is a supply of vaccines for Medicaid kids kids who are under insured or uninsured. So it's our federal vaccine for children, supply that we that we get. So let's see. A couple things about our ordering and then update on our supply and distribution hot off the press this morning from our immunization branch. I want it to be as prepared for you as possible so the first thing is that we have already pre booked all of our pediatric seasonal flu for our VFC population which includes our Medicaid, uninsured, American Indian, Alaskan Native, under insured, and then also our supplemental adult flu doses for uninsured. So we've ordered all that. And the good news is CDC says that we can continue to request additional doses if they're needed throughout the flu season. Yay. As of today, we have received about 4.8, we have received 4.8% of our flu allocation which is a little north of 31,000 doses. So it's a little bit less than our usual initial allocation. And we have it in the state but it hasn't been distributed, it's at our CDC distributor but we haven't distributed to providers yet, but we expect provider ordering to open early next week. Yay. And then we expect the initial shipments to come out as early as the end of next week, and then kind of weekly there in and so you should start seeing some of that coming pretty soon, which is great. The other thing I know we're talking about this, but that really, really, really want to ramp up flu vaccine rates this year, for all sorts of reasons but I this year of all years we want to get our vaccine rate as high as possible. We got some extra money from the CDC, to be able to do a more intense vaccine outreach and communications and messaging plan that can actually run for six months. So we're starting to really plan that. And so we're really going to try to do as much of a big push out of vaccines, and then really going to be wanting to partner with a lot of our partners including you and really messaging out our flu vaccine

Hugh Tilson

Related question, given that it's mid August is it okay to give the flu with back to school vaccines, even if it isn't quite September 1.

Dr. Betsey Tilson

Yeah, we had a lot of conversation about this this morning, I will. I'll go and then Zack can correct me other way I think we're on the same page that we were, we were discussing this morning so officially on the CDC actually has FAQs for the 2021 flu season and officially they say, for, you know, it's, It's September and October is probably better especially for your really high risk people, because there is a potential chance of immunity waning near the end of the season, although the amount of immunity waning is a very complex dynamic really dependent upon a lot of different things including the vaccine and all that so it's not a hard and fast rule. So in general, it's better to wait probably till September, but there's also you don't want to if there's a worse, a risk of missing of a missed opportunity and so if you see someone kind of the end of August and you don't think you'll be able to get them back then it's probably better to do it. There's probably a higher risk of the missed opportunities than waning immunity. So, so that's kind of a weigh, weigh that balance on one of them to see an August, better weigh. But then if you're planning mass vaccination clinics or big vaccination clinics wait until September for those big vaccination clinics. So, that's kind of where we are Zach anything else you want to add to that.

Dr. Zack Moore

No same basic points, although I tend to worry more about the missed opportunity so you know my default is if you've got the vaccine and you've got the patient. Then, that's probably, you know, there's a strong argument to be made for going ahead, you know, unless it's someone where you have a, you know, real expectation of of a future visit or follow up with with them. And I would say that group where that would be of most concern with flu vaccine particularly is, is people over 65 where the community, unfortunately, does wane faster, where, you know, for me that that balance or sort of shifts towards deferring but I same information just maybe a different emphasis I worry a lot about missed opportunities and people not coming back.

Hugh Tilson

Thanks. And our last question is what's the process for swapping vaccine for children for private and vice versa.

Dr. Betsey Tilson

And, yeah, we've had lots of recent conversations about that, because we do want to make that as easy as possible for folks and want you to know that then immunization branch so Kelly Kimball, -- are working on making it more streamlined and easier and pushing out guidance to providers so look for that coming, coming soon but in general and I don't want to go too much in details because you'll be getting some detailed detailed guidance, but in general, there is, you need to you need to keep record and document, who's been borrowing for whom. And then what we're going to work towards is being able to batch that so you don't have to do it for every individual to batch it, and they're also trying to work through a way to be able to submit it electronically to make it easier for you instead of my understanding is that in the past, you've had to call the help desk. But we're trying to make it much more more streamlined, making it pretty clear, there's, there is some verbiage on the CDC form that we have to use that says it is not allowed. We can't change wording on the CDC form but in our memo we will acknowledge that wording is there but specifically say it's allowed in North Carolina, to make it be batched to make the system be more streamlined and more electronic. And so that will be our team is working on that now with pretty simple instructions to help you walk through that, so look for that to comment I will, I will help, ask... the word thanks to Christophe for helping us think through some of that I'm not sure if he's on the call, but he was already working on it and just brought the radar up even more to try to make this as easy and streamlined for you as possible.

Hugh Tilson

We have no more questions we got a comment from somebody saying how much they really appreciate your time and your thoughtful responses, which I think is a fabulous way for us to bring this to a close, from our perspective. Again we know busy, Betsey you and Zack are really appreciate your making the

time and for those of you who are participating thank you for all that you do. Betsey, let me turn it back over to you and Zack for any final comments.

Dr. Betsey Tilson

Well one thank you I think it was actually it's really good and us communicating with providers are really really important that there's a couple things that maybe I should have did it at the front, but I didn't want to take too much time away from questions. But the other big things I see on the horizon things that we are starting to gear up and plan for so obviously flu vaccine is important when we talked about that, but also thinking through what will be the clinical guidance. When we do start seeing flu. And we're working on that now we're working on that with some of our lab testing workgroup and it'd be great to bring it into this group but just the clinical guidance of when you're testing for covid and flu if you all remember in the, in the spring. We had a lot of flu but very little COVID our guidance was test for flu first and if you're flu negative then go for COVID. Now, we'll be having circulating COVID and flu and so it'll, the, the guidance will probably be test for both. And so we're, we're working through what that clinical guidance would look like and then when you do confirmatory so I just wanted you to know that that's on our radar is clinical guidance testing guidance for flu and covid when we have it and, and, and it's interesting, some of the labs are developing one test for both and actually one of our labs called the fluvid, so that you can submit one swab for both COVID and flu so that'll be really helpful. So we're working through that the testing strategy for for flu and covid together. Clearly pushing out our flu vaccine and promoting that is going to be really, really, really important.

And then the other thing that we're starting to work on and that we should have a plan, we're supposed to have a plan to the federal government by October 1 is what will be our COVID vaccination strategy. I don't know exactly when we'll get COVID vaccine. But we want to be really prepared for that as, as possible. And that one strategy will be pushing it out, the COVID vaccine through our already network of vaccinating providers. So there will probably be a process where you'll need to kind of opt in or register to be a covid provider and then we can push it out to you which would be great. And we'll also probably have to have kind of more of that mass vaccination clinics, as well so I think this will be a dichotomy of our regular providers and mass vaccination clinics. So just want you to know that's kind of on their radar we're starting to plan for that. This is a really exciting problem to have. I'm so excited to start thinking about our mass covid vaccination strategy because the more people we can get vaccinated, the better I think that'd be a really important thing.

And the other thing that I would want to put on people's radar is starting to message and really talk to your families about getting the covid vaccine when it's available what I've been hearing a lot and it makes me nervous. Is that about 50% of people say they don't, they wouldn't want the covid of vaccine once it came out. And so starting to talk to your families about that and that vaccine hesitancy around COVID I think will be really important that that worries me. So, and I think we saw, I personally saw this a fair amount during H1N1 actually specifically within our Latin x population which surprised me. Typically our Latin x population have higher immunization rates and acceptance, are kind of across the



board for all the immunizations what I found with our Latin x family is that they would be very very receptive to our regular vaccines, and the regular the seasonal flu vaccine, but were denied H1N1, which I found very interesting, and I'm a little bit worried that that will play out with COVID I don't know if it's just for newness of the vaccine and people are worried about it but I think we really need to get ahead of and really start talking about acceptance of COVID vaccine because I think it'd be really hard if we only have 50% uptake of COVID back pain so starting to set those seeds, encouraging that pic of COVID back policy will be a really important thing for all of us and then really making sure our historically marginalized populations or our populations where there's a lower uptake seeking that thinking through those those messaging and who are your trusted partners that you can work with that can be worked with those families to to help encourage uptake that is going to be a really really important thing for all of us to work on together. So, that's kind of my parting thoughts of things on the horizon that we are really trying to be thoughtful for pre planning. Zack, what else do you have for closing comments.

Dr. Zack Moore

Not much, just thank you everyone for joining and, you know, as I said at the beginning, I appreciate everything, people are doing and anything that you can do, personally, professionally and within your organizations and communities to try to increase the adherence and uptake to all these mitigation measures. This is a really key window right now, and it's, although we have a good trajectory it's not good enough to get us where we need to be so I'm hoping that we collectively can really tighten up over the next few weeks, and start off the fall from a position of strength, recognizing that it's going to be rocky. So thank you.

Hugh Tilson

Thank you, everybody. Have a great weekend. Talk to you in two weeks. Bye bye.