Transcript for NC DHHS Update on COVID-19 Vaccines

August 31, 2021

5:30 – 6:30 p.m.

Presenters:

Dr. Betsey Tilson

Dr. Shannon Dowler

Dr. Amanda Fuller Moore

Ryan Jury

Hugh Tilson

All righty, six o'clock so let's get started. Good evening everyone and thank you so much for participating in tonight's webinar, but an update on COVID-19 vaccines and other related topics. Webinars put on by the North County Department Health and Human Services and supported by North Carolina AHEC, who will discuss updates on vaccines treatment testing, and at the end we'll provide an opportunity for you to ask questions of DHHS leaders, and then to close and I'll be moderating this evening. There's a lot of great content so I'll be brief. Before I turn it over to the state health officer and the DHHS team. Before I do thank you everybody, panelists and participants for making time this evening to participate. You know how busy you are and we hope the information presented today will help you as you do your really important work. A couple of logistics. You can adjust the proportions of the slides in the speaker by clicking on the two white bars just to the right of the slide, and dragging it to either side, and that will help you adjust the size of the slide. And we also have a lot of panels tonight so you can adjust your video settings to hide people who aren't speaking. To do so click on the View button on the top of your screen. Then select side by side speaker, and then you'll just see the slides and the speaker. I will put these instructions in the q&a For your convenience, after you hear from the presenters, then you will have a chance for questions and comments as a reminder, everybody is updating except for our presenters. So, the way to submit a question or comment is using the q&a function on the black bar on the bottom of the screen. Next slide please. As you can see there's a lot on our agenda for tonight. We've learned in the past that the presenters will often address your questions during their presentations you can see we're going to cover, you have a question about one of the topics on the agenda, I encourage you to wait till the presenters are through their presentation. Before submitting a question. We hope to be able to get to all the questions tonight, either by responding in writing, or in the q&a but please know that will forward all the questions and comments submitted tonight to DHHS for their consideration future future communications or updates. Please also know that the slides are posted on the AHEC website and we'll put a link to those slides in the q&a for your convenience, so you can follow along with them. We'll also post a recording of the webinar with the slides, tomorrow on our website. Now I'll turn it over to our State Health Director and Chief Medical Officer Dr Betsey Tilson.

Dr. Betsey Tilson

Great, thank you you and thank you, really appreciate you and AHEC facilitating this also really want to thank our professional societies, medical side of the Peds society family medicine or community health centers our State Medical Society, free clinics, all of our professional sighs it really helped to get the word out, we really really appreciate that and that and the partnership throughout the pandemic. So thank you for that also really want to thank all of you who are joining in, I know, listening on a content packed webinar at the end of the evening is not always the most fun, but I really really appreciate you joining us for this webinar, there is, as he alluded to, we have a lot of information, there's been a lot of changes a lot of our updates have happened in the past couple of weeks. So, so hold on because we definitely have a content rich webinar tonight and as you'll notice we actually scheduled it for 90 minutes, just because we knew there was a lot of content that we want to be sure we share with you but also to allow for times for q&a So, we are planning for 90 minutes to allow for that. I also want to thank you for day in and day out in weathering this pandemic with us with your patients with your communities, I know that you are on the front line, day in and day out is so grateful for continuing to step up and serve our patients serve our community serve each other so thank you thank you thank you we have had a huge amount of progress which we'll highlight, but we still have work to do. And so really appreciative, again your partnership, your efforts and to work with you. Also really grateful for our DHHS team. I will be leading off on talk a little bit about some of our COVID and vaccine trends and some provider resources, and I'll be handing off to Dr Kelly Kimpall who many of you I hope are well acquainted with she has our women and children section, and there's a little bit of a formatting issue on the agenda, my, my bad, but she'll be covering vaccine updates I will talk about the approval consent laws incentives all sorts of updates within vaccine policy. And then she'll turn it over to Ryan Jury who is really gonna talk through some of our operational pieces as part of our vaccine efforts that can go up storage and ordering and also looking ahead to boost your plant and I know there's lots of questions about future planning. And so, looking ahead to that. Then I'm going to turn it over to Dr. Amanda Fuller-Moore many of you are very familiar with her. She is going to talk through some of the treatment options and we'll spend a little time on ivermectin but mostly on monoclonal antibodies. There's lots of questions about that, so making sure you have that in ways that we're trying to get that out more and more talk providers. Also, Dr. Shannon Dowler who is the medical director chief medical officer for Medicaid is also on the line, she's going to talk through some of our Medicaid policies as well and fixes support and maybe, and then flip back to me we have some questions come in about testing so we have a quick little q&a about testing. So, lots of content, grateful for everybody in this partnership as we move forward. So with that, Nevin. Please turn to the next slide right in the next slide.

Wonderful. Great, I'm just going to talk a little bit about where we are, again, I hope you follow along with us on our dashboard on the bottom left is the link to our data dashboard so please please do frequently frequent it as often as I do, which is, multiple times a day. The bad news and I'm sure you all aware of this but we are searching, again, all four of our key metrics that looks at our, our number of diagnosed cases, the percent of our tests that come back positive, people who are hospitalized with COVID and people come into the emergency partner with COVID like illness. Those are our four key metrics, not one metric by itself is perfect, we look at those four together. And unfortunately, all of them are up across the state. We are especially concerned about the hospitalizations and the ICU beds and those of you who work in health systems are communicating with our systems now, those test

systems are really starting to feel very, very tight so we're really, really trying to work hard to get key people out of the hospital.

Next slide please. Also wanted to point out that this, we're increasing and we're increasing across the whole state. Many of you maybe a couple of weeks ago, maybe heard the Guidance from the CDC that they had some differential guidance for states or counties that were considered moderate or high transmission. Unfortunately, according to CDC, CDC, all of North Carolina is in that category of high transmission is that red so we are seeing this high level spread statewide the top left is that CDC map on the bottom right, amongst those red counties. This is our own data that segmenting out and you can see the darker the blue, the higher the viral spread so although we are really high across the whole state, you can see those areas that are even higher. And then for those of you who are practicing there or caring for communities they're knowing we're having this really really high rates of viral spread. Next slide please. We also are seeing spread across all of our age groups. We are seeing it amongst our young adults, and amongst our children's children as well. The one little glimmer of good news and rest is this the royal blue line. That's the lowest rate of case increase that is our 65 and over, they have that highest rate of vaccination rates so we are seeing some protection in there over over hp but all the other age groups we are we are increasing pretty rapidly. Next slide please. We unfortunately are also seeing a widening of disparity, amongst our racial groups so we're seeing once again our Native Americans that are African Americans having a higher rate of transmission than our white and our Asian populations. Next time, and also seeing the same thing with our Latin X and non Latin X population we are seeing a widening of that disparity again with this search. And this has been consistent throughout the pandemic that our communities of color have really borne the burden of this pandemic disproportionately, a couple of reasons for the for the surges one, there was somewhat of a relaxing of our public health measures, and to the spread of the Delta variant. So the Delta variant is about twice as transmissible as the alpha variant which was that UK variant that we saw, we spread that spread in the spring you can see that little bump we had in the spring that was the UK variant, and that variant was about twice as transmissible as our original variant, So that delta variant is just much, much, much more transmissible than prior variances original variant one person being infected may be spread to two other people with Delta it's more on the order of every person in fact it can spread to about six or eight other people so much more transmissible and what we are finding, we don't. We have a series of labs and networks across the state, and in the country that does sero sequencing of our viral samples and so what we know in North Carolina is about 98.5% or so of the viruses that are sequenced to our delta so it's pretty much all delta that we're seeing in North Carolina.

Okay then turning a little bit to vaccination status so we are making progress, we still have work to do for sure but we are making progress and the good news is we've been seeing an uptick in vaccinations, especially over the past month or so which is really nice. We're seeing it accelerate again. But we have definitely more work to do. Looking at it adults have almost two thirds of adults who've had at least one dose and we know there's a very high rate of completion if you've had your first dose getting on to your second dose. So that was good. We really need that higher but we have at least two thirds or adults. on the right hand side you can also see vaccination made by age and as I alluded to our older population 65 And up really really high rates of vaccination, which is great and we are seeing that protective effect.

And then the younger you get, the lower the percentage of the population that is vaccinated, so we really need to work, and encourage and facilitate younger people from getting vaccinated and then you see those rates of viral spread higher when it correlates with the percent of that population that is lower, and then it's just as a reminder, nobody is actually zero to 11. No one's zero and 11 is vaccinated because currently the vaccines are not authorized or recommended for anybody. Next slide please.

We also get a lot of questions about the effectiveness of these vaccines, especially with the Delta variant, spreading so I wanted to make sure you knew of data we did push this out publicly last week and we will be updating it, but our epi team has done a really nice job looking at our own data. For the past four weeks, when we knew Delta variant was really the predominant one spreading in North Carolina so looking at what happened in North Carolina the past four weeks. This looks at the, the attack rate or the risk of getting infected. Vaccinated people versus unvaccinated people and we found that if you are unvaccinated you're four and a half times more likely than a fully vaccinated person to get infected. So still good protection of getting of actually getting infected by these vaccines, but even more powerful. On the next slide please. What we found is that your risk of death. If you are unvaccinated you are 15 times more likely to die from COVID, than if you are not vaccinated. And so really still high level of protection against severe illness hospitalizations and death, and this is correlating with a lot of data we're getting from other states as well, looking at somewhere on the average of 15 or 20 times more likely likelihood of mortality, 17% likelihood of hospitalization so we our data is very consistent with what we're seeing across the country so still really really high rates of protection, especially for severe disease and hospitalization. That's fine. The other question we also get is around natural immunity and how much will the natural immunity protect you. And so a couple things that we know and a couple things that we are learning one about 90 days after you've had a natural infection, it does seem you have a very very low risk of getting reinfection and that is that 90 days so that's why you'll see that that correlates with. If you have a close contact 90 days within a diagnose infection, you don't need to quarantine, that there is a suggestion you could you could delay vaccines for 90 days after your natural infection because there does seem to be a good strong protection for 90 days, how long that protection and how strong that protection is beyond that 90 days I still think we're learning. We are seeing some data that some of that natural infection might give you some infection, infection, protection, but we're still learning that, but this is a interesting study that just, that just was released a couple weeks ago from Kentucky, it looked at people that all had a natural infection, and then compared people who had a vaccine after their natural infection for those that did not have a vaccine after your natural infection. And what they found was those people who were not vaccinated after their natural infection, were two and a half times more likely to be reinfected than those who were vaccinated. so still, the recommendation is to get vaccinated, even if you've had an actual infection, there, there is no safety concerns in vitro it shows a really really really nice immune response. And then in vivo we're also seeing this protection against reinfection. So we get that question a lot so wanted to be sure that you had that data. Okay, next slide please.

Wonderful. So we've done a lot of work in trying to get our primary care providers on boarded thank you thank you thank you thank you for all the, all of you who have are on boarded onto CVMS and being COVID vaccinators we are incredibly grateful. We're working hard, really really grateful for the

partnership with our professional societies for doing this, and this red line you'll see is the cumulative number of our PCPs primary care providers who are on board and we're still seeing continuing increase in that so thank you. We're excited we want to get more and more and more of our primary care on but we're excited about the progress that you all have made so far. Next slide. And we do have a series of provider tools to try to make it as easy for you as possible we know that it has been cumbersome and complex to become a COVID vaccinator so we do have a whole library a provider tools get one pagers, we have ta we have, we're trying to get as much support as, as people need to get them on board as we want to be sure you had all these provider tools in one place.

Next slide. I also wanted to highlight and I really want to call out Dr Dowler for her leadership and this. Many of you may know that Medicaid has a vaccine counseling code that you can actually bill for vaccine counseling because we know one of the highest value our providers bring is that trusted relationship with their patients, able to answer those questions if your patients have concerns or fears, having that conversation that is such a high, high, high value service that you deliver is that trusted relationship in that counseling so wanted to be sure that you are reimbursing, you will be reimbursed for that high value service you deliver so this is with a Medicaid vaccine counseling code. And also, Blue Cross Blue Shield just pushed out last Friday. They also have an equivalent vaccine canceling code and they clarified that as well so making sure you know that you can bill for that vaccine canceling code. Next time, it's great also wanted to be sure you're aware of this was new, from CMS especially those of you who serve Medicare patients and also we'll be modeling within Medicaid, is that people, if they're doing in home vaccination so you are traveling and going to a person's home to do in home vaccination or also traveling to smaller group homes smaller assisted living, have an enhanced administration fee for those mobile vaccinations as well, recognizing that there is a lot more time and travel time and administration time that has to happen to delete those in home vaccination so wanted to be sure you're aware of that enhanced CMS payment and Medicaid, follows Medicare as well on this next slide.

Also on the topic of in home vaccinations, so we do have a lot of our homebound folks some of our most fragile most medically at risk, folks at home. And so wanted to be sure you also knew of a new portal that was put in place probably about a month or six weeks now. But that on, when people search a vaccine provider, there's a little tab there that says need to be vaccinated at home, and that brings you to this portal where people can register their name, where they live, and that making connected to a provider who then can do an in home vaccination, so wanted to be sure you're aware of that and making sure your patients, especially those patients that you know who may be homebound. It is a way to get vaccine to them if you are not doing in home vaccinations. Okay. And that is it for my piece I'm going to turn it over to Dr Kelly Kimple, who's going to talk through some of the vaccine uptake so what happened in the past couple weeks. So, Dr Kimple.

Dr. Kelly Kimple

Good, good evening everybody and thank you so much for all that you are doing. We did want to make sure we've reviewed some vaccine updates for you all this evening. You will are likely aware that FDA

extended full approval to the Pfizer vaccines for ages 16 and over, and then that is the acrp, briefly recommended yesterday that drug is going to be marketed as Corminati, while it is difficult to say it is supposed to be a combination of COVID mRNA and community, and for the prevention of COVID-19 an individual 16 and older. Now because of the timing considerations with the process the ages of 12 to 15 years of age that continues to be under emergency use authorization. It is still available, and same with the additional dose so if there are 12 to 15, or really any 12 to 18 year old individuals that are moderately to severely immunocompromised and would warrant an additional dose that also remains under emergency use authorization. And I think it's important to point this out because of any use off label use of these outside of these indications is very discouraged, I think CDC and others have been very clear that potential liability concerns with the prep act if it's used outside of those, the COVID-19 agreement and the emergency use authorization or they approval and same with individuals with may not be able to see compensation. If there are injuries through the vaccine. The HRSA Vaccine Injury Compensation Program. As you'll see we have updated the Pfizer fact sheets for recipients and caregivers, and for healthcare providers and vaccines are going to continue to be used as opposed to the vaccine information sheets until everybody can move towards those Vaccine Information sheets and an FDA approval. Next slide.

The other thing that I wanted to make you aware of is some consent changes resources manner prove them all here in North Carolina. So, the state law was recently changed on August, August 20 now requires healthcare providers to obtain a written consent from a parent or legal guardian or minor prior to administration of any vaccine that has been granted emergency use authorization, and is not yet fully approved, so that for any minor any individual under 18 years of age. One side actually has full anyway, FDA approval that minors consent law applies but previous minors consent laws to vaccination. There's no other changes to North Carolina minors can sample I know providers were thinking about some of the other conditions or situations in which that might apply. This really is specific to vaccine under emergency use authorization. So that being said those 12 to 15 years of year olds that are receiving by their will need written consent from a parent or legal guardian. We know that 16 and 17 year olds is FDA approved and and for the most part is best practice and we expected that parents and guardians are part of that conversation and part of that discussion, however, a adolescent 16 years of age and older may be able to consent for themselves, for the Pfizer vaccine, if they show the decisional capacity to do so. And then a reminder again about those additional doses for immunocompromised there for individuals 12 to 17 years of age, that is still under emergency use authorization, and again would require written consent from a parent or legal guardian. Moderna and J&J COVID-19 vaccines are currently not authorized for individuals under 18 at this time, and as I mentioned before, providers should not be vaccinating anyone 11 years or younger. That is not currently authorized or recommended and not consistent with that COVID-19 provider agreement. Studies are ongoing. Looking at the dose, looking at safety and effectiveness. Next slide.

And to that point. This is a summary that just gives you an idea of all this, as we are all looking forward especially with school in session. Being able to offer COVID vaccines to younger children. And so this just highlights some of the progress that has been made with the different age groups for the different vaccines that are available here in the United States, so far they're they're still doing the dose escalation

study and evaluating that safety, how long it's tolerated and immunogenicity, and three different age groups and that includes the five to 11 year olds, the two to five year olds, and the six months to two years in a Moderna continues to set it to study the different age groups as well. And we're still awaiting any expansion to include those all 17 years old. And we do anticipate a smaller dose, I think in the 5 to 11 year olds, due to the size and the stronger immune response. And I know the AAP has urged the FDA to authorize COVID-19 Vaccines for Children under 12 as soon as possible. and we are all looking forward to that possibility so that we can protect our younger kids in addition to our adolescents and adults. Just a quick note on vaccine incentive, we can move to the next slide. So, this is just a little information around our vaccine incentive program where we had our $100 Summer cards. So, with anyone 18 years and older who got their first dose of COVID-19 vaccine at a participating location was able to receive $100 on their card, and then that included the person who drove them to that location to get the vaccine and cover that transportation for the $25 summer cards through August 31. So today is August 31 Our CDC authorization for this program expires expires today, but we are looking towards creating a new program that may be accessible to more providers, we understand that the limitation and providing those cards only at particular areas was, I think, providing some, some difficult discussions, and in certain clinics and so we really are looking at hard at what the potential options might be, and looking to see if it'd be possible to have an expanded program with CDC authorization for a short time in the future. Next slide.

All right, and you can go on to the next slide. So, coming soon. What we wanted to make you aware of and know that we have heard, providers, we know that we've gotten a lot of feedback about why can we not use NCIR, to document our COVID-19 vaccines. Why can I not check for somebody COVID-19 vaccine status in NCIR, and so we really are trying to move towards a place where to meet, especially our primary care providers who may already have NCIR in their workflow during their day. And I think this is especially important in the fall, because we are moving into three cases very specially here. And we know that we can co administer vaccines everything covered administer COVID-19 vaccine and at the same time that indicated you can get flu vaccine. And so it is unreasonable to think that a provider would then go into CBMs and document because of vaccine go into NCIR and document vaccine and potentially do whatever documentation and electronic health records. And so we really are trying to move to a place where a provider, maybe it would document both in one system, and really provide that opportunity for a No Wrong Door approach to documenting COVID-19 vaccine. And we also have heard loud and clear that one consolidated vaccine record which includes COVID-19 vaccine is important for providers for being able to assess your patients on whether they may be due for their booster, whether they be vaccinated. To begin with, and then making that information more accessible, even if you're not a COVID-19 vaccine provider. So all of us wanting to use our technology to make sure we can improve vaccination rates, and also make sure that our primary care providers might be able to have this be a little easier in the workflow, and so that recipients can get back to me that by their trusted medical provider, which we know is you all have a relationship with those patients, and I can have that discussion with them. So more to come on this in the future but we wanted to make you aware of this effort as we move forward. And that we do hope in the future that providers to be able to choose whether they want to document in NCIR, or whether they want to document and CVMS. And with that. Next slide.

I believe I'm handing it over to Ryan Jury, our COVID-19 vaccine program director.

Ryan Jury

Everyone, well thanks for being here. Just wanted to let all of you know if you hadn't know the Pfizer vaccine was approved through studies that to be durable, beyond its original expiration date. So the FDA has authorized a three month extension for the shelf life of COVID-19 it is or has been stored in Ultra temperatures is really important to understand that Pfizer, more so than the other products have like a unique disc distinction between expiration and beyond new states, the expiration is related to the vaccine, if it is stored in an ultra cold setting, whereas if it's removed from an ultra quartz cold setting and placed in a refrigerator or freezer and then beyond you states now therefore then trump the expiration date, so I took vaccine that expired and or expires in December 2021 and move it into a refrigerator, and then therefore will spoil after 31 days. So just a reminder that this expiration extension only pertains to a vaccine that has been started. One of the things that we really want to ask all of you to do is one, to make sure that you have I think we were looking this morning and very few practices for that to change the expiration dates, so as you manage your inventory it's really helpful for us that you could go in and change the expiration date for that Pfizer vaccine, but a little cautious in doing so, likely do so here in the coming days we would love to just get verification, ultra cold storage and vaccines beans stored in ultra cold storage. So again, you could a ensure that wastage has been put in if it did, or is wasted, and or ensure that the expiration dates are accurate and CVMS. Next slide.

So, we wanted to also announce for you all kind of the current status for weekly allocation process for those who do or don't know there were about 1.6 million doses that were in the state, in May of 2021, and over the period of this month we've been able to administer shy of a million doses of that vaccine is in the state inventory. So without and also the analysis of additional booster doses and vaccine mandates, demand for vaccine is increased week over week about 20% over the last month. And so what we're seeing here is an increase in vaccine demand, and therefore we are beginning to bring directions to the process as you can submit a vaccine request seven days a week. And on Thursday we'll review all the requests, taking into account your four week administration rates as well as transfer rates, and then making an improvement for them based on those orders, and therefore the person finally expected shipment to arrive on Tuesday or Wednesday. It is important to remember that many order quantities required. So, for Pfizer it's 1170 for Moderna it's now 140 because they've moved to a 14 dose vial while and Johnson and Johnson's 100 doses. So if you can, if you can administer or likely administer the minimum or quantity within three months will send you a direction cannot and we will likely ask that you receive a transfer, one of the 12 vaccine -- and therefore your request may be denied, and encourage you to get a vaccine from vaccines --. So, in terms of where we are, these are the, again these were the minimum quantities per vaccine brand, so we have Pfizer Moderna and Johnson Johnson with various minimum orders that we can place for production. Our ask is that we usually don't give providers more than a vaccine that they can administer within the next four weeks taking into account their previous four weeks worth of administration's. We're not really in the process right now of stocking the shelves quote unquote for booster doses, mostly because the timeline is not really set in stone as well as there are some federal ordering limits as well and so we are instructed to order enough for about two to four weeks worth of vaccine administration, so if you find yourself doing a large event,

having a large increase in demand the state may be its mandate for employees, whatever it is you put into the comments while you're asking for more vaccine, then why you're asking for more vaccine injured under administration data may not support that. We currently are able to direct ship Pfizer will be shifting within the next probably couple of weeks into doing more direct shipping whereas Moderna is rather readily available across most of the state across most providers, and then Johnson and Johnson is currently not over go through federal program, and it sounds like. Probably the second week of September we will be able to order Johnson and Johnson again with Johnson and Johnson because of suitable supply disturbances, over the summer in the spring which not a lot of vaccine available. So these allocations will be very small, and likely not abundant.

Right so additional dose Booster planning. Just want to communicate the differences and nuances between the precision of language here, and why it is that we're calling different doses, it's not appropriate to call it third dose because there is a likelihood that it could still be there for Johnson and Johnson, and that therefore will be a second dose for those individuals who receive their primary series of Johnson and Johnson says we think about using the language, additional doses were given to individuals, didn't necessarily elicit an immune response from the primary series and therefore need an additional dose. As part of our primary series to get --. There's currently only approved for individuals who are moderately and severely compromised, is a self attestation program, and you can administer them now through --. Those doses, additional doses are authorized give 28 days after the second dose of the initial. For booster doses, those have not yet been authorized, and there's currently a discussion right now around an additional booster dose after a series completion, the data is on all over the place but it's likely to be around termination the last formal of communication which received ads to be around eight months. There are is not and has not been much guidance, there was an ACIP meeting last night. They indicated in the timeline, ACIP will meet again likely at mid September to review the data, again, and then therefore the FDA would have to be able to take action after that additional ACIP. And then following that FDA action would be another ACIP meeting to recommend booster doses. That's a sad way of saying that I think we're not going to know a whole lot until it's really really close to September 20. We also have been told several times over that September 20 is an ending date, and that those dates are not have not have not and will not be based upon the FDA and ACIP and CDC moving forward.

Next slide, the conditions that meet criteria for moderate to severe immune compromised are listed here on the five as follows and there within the slides again patients consultant tests and that's encouraged to reduce barriers for those who don't have -- or don't have access to healthcare. And then lastly it's important to assess the general level of competence, and there might be some other indications that are clinically appropriate for a provider to incur your suggestion individual get in addition with dose. Serological testing it's not recommended, for determining this also based on requirements. So, again, what are some differences between planning as we think about additional doses and booster doses. You know, most importantly, patients should not receive more than three mRNA vaccines currently, if they're receiving additional dose. These are similar administration rates in relation to the timeframe in which one is eligible for an additional dose. The nuances around the booster doses is that we are really only adding posture at this time. The health and human services

document indicated that it could and likely will start around September 20. And they could be eligibility would be eight months after the initial series.

Ryan Jury

We're still waiting for FDA authorization, CDC and ACIP recommendations and guidance in about the timing--. One of the big differences right now that there are more providers than there were initially and supply is good, although we did talk to you about a little bit about supply and trends --, there's adequate supply from the Feds to the demand for booster doses. In some settings there may likely be mass vaccination sites but not necessarily for the same duration or the same setting that it was before. And we also have to remember that eligibility based on when they determine when individuals are eligible, will likely still be staggered because it is first and second doses are given, in a staggered priority framework initially.

I think there's a lot of discussion to get around those who really know the literature I just wanted to project two different scenarios. In Israel, they have leaned into a six month eligibility program and the US, it looks like we're leaning into an eight month eligibility. In terms of those who are eligible statewide for vaccinations it dramatically changes the response and the intensity in which individuals will receive a booster dose. In the scenario where eligibility is within six months 1.8 million North Carolina, North Carolinians will be eligible for vaccination, as the program starts in September. Whereas in an eight month view. There are only 150,000 individuals. So as we think about planning, when we think about how to do this any shifts in eligibility timeline have huge implications for operational capacity as well as operational response. And so although, you know, although we've made these balances, do take into account the realization that a earlier time window may also make you may make access limited. So at 1.8 million may be eligible in September, it was unlikely that the system will be able to administer those doses, on day one or day two or later. These were based on recipient. And the second dose receives -- nuances to the --.

Next Slide the last part of this is long term care for some period of time it's been called long term care 2.0. Also looking into long term care, what does that look like and how could booster doses be administered in a long term care setting. They're kind of different layered approaches. But as we've been planning and buying for the last several months. One of the things that we encourage long term care facilities to do is to make plans now around booster doses, in addition to that we want campaigns campaigns and communicating differences between booster doses and additional doses, and we're now offering matchmaking, or we're trying to matchmake vaccine matchmake vaccine providers who are willing, or have established relationships with long term care facilities to provide vaccination for them during the booster setting. We will continue to monitor access our hopes are sounds like, about 95% of providers feel like they will be able to meet the demands of their established and current relationships, about 80% of long term care facilities, already have a relationship with North Carolina, North Carolina vaccine provider. So we're currently also co planning back end for gap programs, our understanding is that there will be a federal GAP program to deal with some of the gaps in those facilities, through matchmaking, and likely the state will also have a GAP program to support those who are unmet through matchmaking, for --.

Amanda Fuller Moore

Thanks Ryan. I'm gonna take over from here. So we're going to talk about. Sorry, we're gonna talk about ivermectin a specifically health advisory and then also monoclonal antibody so on the next slide. That. Next one, sorry, the CDC issued an official Health Advisory this week specifically related to a rapid increase in ivermectin prescriptions so ivermectin is a prescription drug that is used in general to treat infections caused by internal and external parasites. What we are seeing is a rapid rise in people trying to use it to treat COVID-19 there are some ongoing studies, the current literature does not support the use of the product, or is not yet been made, officially a product that should be used. And we are seeing rapid rise in the number of reports to our poison control centers have adverse effects. There are also animal products that are over the counter that are in large doses. People have also been purchasing those in the community, which is also leading to these increases and reports to our poison control center so the current guidance is that this is not a product to be used for COVID-19 treatment. Next one.

So now I'm gonna switch gears totally and go to products that are supposed to be used for COVID-19 treatment because you have the slides I'm gonna hit these quickly. So on the next slide, there are on the next slide. There are three monoclonal antibody products available REGEN-COV, Sotrovimab and a combination Bamlanivimab product so these three products are all available. This a trove of map is commercially available, the REGEN-COV and the Bamlanivimab are controlled through us ordering we'll, we'll get to in a minute. The Bamlanivimab combination product. They are all three under EUA but the combination Bamlanivimab product EUA was actually revoked in April 2021 because the product does not have great success in the setting of variants, as we see some states, start to have declines in their variant proportions, the EUA in those areas that have a combined frequency of variants of 5% or less have been allowed back into circulation. And so, North Carolina is not on that list, so the product right now that's in primary circulation in North Carolina is the REGEN-COV. The monoclonals in general are given to patients directly with an infusion, or subcutaneous injection, and if they are taken early reduce the risk of severe disease hospitalization or death. Um, providers can get more information from our website which is on the bottom left hand side of the slide, and patients can find the site nearest them by either using the map locator or calling the one 800 number on the bottom right hand side of the screen that 1 800 Number does connect you to a live person to provide assistance and matchmaking, on the next one.

So, the EUA for the monoclonal products is for adult and pediatric patients who are 12 years in a way at least 40 kilos have tested positive for COVID-19 have mild and moderate mild to moderate symptoms for 10 days or less and are at high risk of more serious symptoms, we'll come back to that in just a minute. However, they are not for people who are in the hospital due to COVID-19 require oxygen therapy, or have an increase in their baseline oxygen needs. So there are some limitations on the use once you're in the hospital, you are no longer a candidate, next one. So, this is the long list of things that can qualify a person as being at increased risk for severe disease. However, the one of the key things for providers is to know there is provider discretion, you may have our provider that you deem as a candidate, not because they have, they meet one of the criteria in this list, but some other condition

that you are really aware of based on your patient provider relationship tells you that they are at increased risk for severe disease and that makes them a candidate. Next one. So, there is also the option with Regeneron Cov to use it for post exposure prophylaxis, same population of adult and pediatric patients who are at risk for progression, but they need to be not fully vaccinated or not expected to mount a full immune response. They are known to be exposed to someone, or they live in a setting of high exposure so a institutional setting a prison or a long term care facility where there's an ongoing outbreak. The product, though, is not approved for pre exposure prophylaxis, of patients, next one. So, the Regeneron Cov product is the one that comes in two forms both intravenous and subcutaneous, it's the same dosage both what both ways, the IV formulation is recommended for treatment, however the subcutaneous injection is the alternative route if IV infusion is not feasible or would would lead to a delay in treatment, in terms of post, post exposure prophylaxis either one is considered appropriate, there is a one hour post infusion, or injection monitoring period, there's some very specific mixing instructions in a healthcare provider sheet, much like with the vaccines, there are patient back sheets and provider back sheets because all of these products are still under an EUA. So, the links to both of those are on the slide next month. These products do not go through us at the state as the vaccines do so a health care facility can place an order for the Regeneron or the Bamlanivimab combination product in states where that product is currently in use, but in North Carolina, it is placing an order for the Regeneron Cov directly through Amerisource Bergen and then Amerisource Bergen does the distribution across the United States directly from ordering to the provider's office, the drug itself is free of charge it is paid for under contract by the US government for the Regeneron and the Bamlanivimab combination product, this a trove map product is not controlled by the federal government is about $2100 per dose. So, there is a link there so that you can get more specific information on ordering but again it is all done directly through the Amerisource Bergen link, and any provider that has the capability and capacity to administer the product can place an order with Amerisource Bergen to do that, next one. So, just a few more things the top side is our infographic that gives information to patients about monoclonal antibodies, and then also links for the appropriate billing codes and reimbursement information, the in office reimbursement for monoclonal antibodies is about $450 per administration, and then also some information for how to get reimbursement for uninsured clients. Next slide.

Just to give you a quick picture of what administration in North Carolina looks like there were over 3000 administration's last week that was up 62% from the week before, we have 163 locations providing monoclonal antibodies in our state. And based on their Regeneron COV clinical trial number needed to treat to prevent a hospitalization we estimate that last week's administration's prevented almost over 180 hospitalizations. So, we are continuing to try to make our monoclonal antibody information more prominent on our website for both providers and patients, and work with all of our vendors to get information in their testing reports so that if a patient tests positive, there is a note in there that lets them know that monoclonal antibody treatment is an option and gives the phone number to that national hotline that leads to a live person to help them find the closest monoclonal antibody provider to them. At this point I am going to turn it over to our Medicaid Medical Director Dr. Shannon Dowler who's going to give you a little bit of information on our Medicaid claims data related to monoclonal antibodies.

Dr. Shannon Dowler

Awesome, thank you and I almost didn't make it on time because I'm actually making a meme about ivermectin and writing in limerick for Amanda Fuller Moore so that was, um, so thank you for that update. I can't wait for the limerick to be finished. We have been studying monoclonal antibody and Medicaid looking at it from an equity perspective and I wanted to share our findings because I think it's really interesting. We did see that there were some health disparities as far as race and who gets access to monoclonal antibody, at least for our Medicaid population, and this is January through June. But the real striking and equity resolve was an ethnicity based inequity, where our patients who are not Latin X are like exponentially more likely to have access to monoclonal antibody, so just be thinking about that in your practice and who you're referring and how and why because we are seeing a really striking disparity there, that is got us really scratching our heads. If you go to the next slide, we also looked at from a geographic disparity standpoint and this is like a claims volume slide around what was paid in that paid but what you see is in higher counties where no monoclonal antibody is given to people who live in those counties, and then some, where they're just the pinpoint those pinpoint counties have one bill. So, you know, very small numbers, and not at all in a lot of our communities around the state. And so really we need you to use this and bring it into your practices if you're able to, I know some of the folks that are doing it now are doing an amazing job and they're willing to share what they've learned and make this easier so you don't have to recreate the wheel. I spent some time on the phone with the main hack team last week, hearing all about they have a really cool model, And they shared everything they have with us so I know that teams are interested and willing to help share what they've done to make it easier to pick this up. Alright, if you're running to the next slide we did want to make you aware that Medicaid did declare an early RSV season. We've seen this really strange, super big peak in the summer, which led us to make the decision to go on and start covering -- just for those people who qualify for it based on the Red Book guidelines. We have encouraged other painters to follow suit and to do this as well. They are considering it, but just to you know because Medicaid does take care of a lot of children in the state. We are recommending that you go on and use images in your practices based on this very large early season, because a lot of these kids are getting in hospital beds, and historically if you get a big surge of RSV, you take over some adult hospital beds for your peds patients when the peds fills or your peds --fills, but there are not on those beds available. So we really want to do everything we can to prevent this, so you know, Medicaid is not covering it.

Last thing I'm going to cover is just wanting you to see to go to the next slide. How much is going on right now these are things in the last week the Medicaid team has put our heads together with surge to say what can we do, what are the levers that we can use Medicaid public care to help hospitals unload, to help get beds empty faster to get folks not going into the beds in the first place and so these are some of the things that we are doing using Medicaid, we're going to be reimbursing for hospital at home for those that have that CMS waiver. We are, as of tomorrow, going to be waiving PA for post acute care so that you can get your beds empty faster when they need home health LPAC rehabs, SNIF we have this early season for ISG RSP, we're really pushing monoclonal antibody provision and making sure that we're, we're covering that there are no problems with that we're working with our FQHCs and rural health centers and we're actually working with CMS to see if we can help them get paid on the earlier side not at the end of the year with their cost report, and then all the other things we've done in relation to managed care launch, we know everyone is overwhelmed right now, and we're trying to do

everything we can to help take away the stress, where we can take it away from you, so just know that Medicaid is doing all sorts of things, and very soon we're going to be asking our plans to provide vaccine incentives so for beneficiaries that have Medicaid managed care plan, they're going to actually get paid, get some sort of incentive to get their vaccine. So I if you have ideas of things we haven't done that you'd like us to do, you know, I am always glad to hear from you and really look forward to hearing from you. So those are the quick Medicaid update, I will hand it over to my colleague, Dr Betsey Tilson.

Dr. Betsey Tilson

Thank you, and I really want to thank also our team that has been busily answering all those questions up what an efficient use of technology so thank you all and we've gotten a lot of those questions answered. All right, so, mix it up a little bit. We also got some questions so just so you know we did get questions ahead of time so we were trying to be proactive in answering those questions that were posed, but we had some questions about testing kind of one off questions about testing so the next two slides will just be a quick round robin of testing q&a that we got. So the first question was, oh no I hear that we're running low on testing reagents. And so the answer to that is there is one manufacturing second which does a rapid PCR, a little bit of minor shortage in that one manufacturing because they're kind of shifting platforms, but overall we haven't heard of any major shortages, widespread shortages like we had last golly, what was it last March last April so we haven't heard any major stock shortages that is concerning. Second, hey with Delta going on our test reliable they split this new delta variant, the answer is yes, and the FDA continues to make sure that the diagnostic performance for the tests are good. And so we have not heard any concerns that tests may not be accurate with Delta. Third question is what about antigen testing. I, on this antigen flow chart on that link that brings you right to the CDC antigen testing algorithm and actually gives you a lot of good information on antigen, testing and you see a little bit of that blue sheet there. So specifically, the question is if I have somebody with no symptoms and my antigen tests that my origin testing is negative, is that okay. And so that would fall into a symptomatic no symptoms and you're negative. And then as long as the person didn't have a known exposure, then you can trust that negative, And you can walk through all those different scenarios of when you should use an antigen when you should back it up with a PCR when you get to antigen flowchart. The next slide. The last two came providers rely on home tests for back to school notices, no currently that is not the policy and we're working with our local health departments to work to address that. And then finally, and I know there is a lot of PTSD and I don't mean that kiddingly I really know there is a lot of trauma about PPE. So the question is, Are we worried about PPE especially with more testing and treatment going on and currently we have no concerns about PPE we're very well stocked. You either can get it to your regular store so we still do have that link that healthcare providers can repair request PPE. And that is it. Look at that we made it exactly seven, and have been keeping up with our questions so we can have a little bit more time for q&a, and go from there.

Hugh Tilson

Thanks, you guys have done an amazing job with questions and answers. We don't really have that many, but a couple more have come in. So, want me to go ahead and pose them or do you want to, you can see them, are there any that you particularly want to respond to.

Dr. Betsey Tilson

So this is, let me I will scroll through see what I can pick off and then I can see the other team members so there was a question specifically in the strong schools toolkit about three to six feet. So let me just talk, there was some questions I answered about quarantine as well so let me tackle that one in the strong schools toolkit, I should be able to say that better than I do. If you have a child to child exposure. Both children are wearing a face covering the infected person in a close contact person, Regardless of how close they are together, the exposed part child does not need to quarantine as long as they don't have symptoms, so I know and actually if you look, we updated that strong school toolkit to get rid of that three to six feet because people were getting confused by that. So regardless of distance in a child to child exposure in a school setting if both children are consistently masked exposed child doesn't need to quarantine. Now that doesn't apply to adults, because adults are much efficient spreader, but it does apply to child to child contact.

Hugh Tilson

Getting questions about the accuracy of the home kit so I guess is the home kit, a test of trust test.

Dr. Betsey Tilson

Depends. We do actually have a home testing, we have a guidance on home testing. It depends on them so I can do a link. I will try to find that link to our home testing guidance,

Hugh Tilson

Some testing accurate and available.

Dr. Betsey Tilson

So it depends, it depends. That's what I was doing it depends on kind of the type and the brand and I'll send a link to our home testing.

Hugh Tilson

Vaccinated nursing home staff are exposed to a household person with COVID when can he or she returned to work.

Dr. Betsey Tilson

So if that if it is a fully vaccinated person, meaning 14 days after the second dose of a two dose series or 14 days after that one knows. They do not need to quarantine and they can go back to work as long as they're fully vaccinated, however, they should wear a mask, and they should get tested. Five days after that exposure they should wear a mask until they get back a negative test.

Hugh Tilson

Are there any considerations for funds for staff retention.

Dr. Betsey Tilson

So we've thought about different funding sources to help with our, our practices. So we can we can continue to look into that I don't have any real concrete options to share right now.

Dr. Shannon Dowler

And I can throw a jump right in with CMS just released yesterday some new guidance on ways Medicaid can potentially create some provider incentives that are brand new, just off the press, I was on a CMS call this afternoon trying to understand that. So, so if you have suggestions for things that we can use Medicaid for for provider incentives, I would love to hear your ideas. Because if we should we start to have approval and authority from the Fed, but it gives us a starting place of what would be meaningful and impactful for you if you're not carrying vaccine to be able to do it or to be able to keep providing vaccine.

Dr. Shannon Dowler

Already authority from the Fed, but it gives us a starting place of what would be meaningful and impactful for you if you're not carrying vaccine to be able to do it or to be able to keep providing vaccine.

Hugh Tilson

I think you've answered some of these isolation quarantine time for vaccinate patients who tests positive 10 days does Delta shed longer. You got that one.

Dr. Betsey Tilson

Yeah, no once you've turned positive, there's no difference in the isolation guidance for people, regardless of their vaccine or not so if you're positive you still need to isolate for at least 10 days, and then assuming you are fever free for 24 hours and your symptoms are improving

Hugh Tilson

Any advice for screening testing in schools especially boarding schools.

Dr. Betsey Tilson

Yes, and we have in our we have our strong schools toolkit as well as a testing guidance as well in there. and so you'll see that what we're recommending is, you can do weekly screening testing, and then also have the availability of diagnostic testing as well. So, we are recommending, especially in areas of high rates of viral transmission. Certainly screening the adults, and then the high, high areas about transmission screening children, and if you can't do at all of them then also thinking about one of those real high risk activities that you want to do and that includes athletics. It includes things like singing, where you have that increased respiratory effort, and we have all of that in our strong schools toolkit. The specifics of that of that or that lab testing.

Hugh Tilson

Shannon that there was a question in there about who do we send suggestions to about provider incentive funding is that you.

Dr. Shannon Dowler

Yeah, yeah, go ahead and shoot me an email Shannon.dowler@DHHS.nc.gov. In the questions and answers I have, I put it in there on a few of the questions and answers that you might see as well.

Hugh Tilson

Thank you. Is there a need to have COVID Positive vaccine healthcare providers retest to confirm resolution beyond the 10 days quarantine.

Dr. Betsey Tilson

So you don't want to retest people because people may test positive up to 90 days after their initial infection so a long while ago both us and the CDC moved away from a testing requirement once you meet those clinical parameters that is 10 days from your first day of symptoms or 10 days from your test if you never have symptoms, no fever and resolution of symptoms, that's a requirement to return to work, but not a testing, not a not a test to return to work again because you might continue to test positive for 90 days.

Hugh Tilson

There's another question about schools and having air purifiers and upgrading ventilation, and whether there's any specific guidance for the long term cost for the schools or how to handle that.

Dr. Betsey Tilson

So, so ventilation is a really good thing. Our learning that's a real good thing again, in our strong schools toolkit we have lots of granular detail on ventilation for for schools, so it is a it is a it is definitely recommended as one of our prevention's and we are very detailed guidance in the strong schools toolkit. I'm trying to find I'm trying to do. I have the link of our strong school toolkit, and also the testing guidance that I've been trying to copy and paste and talk so I'm going to put that in in the chat as well so you have those links.

Hugh Tilson

I guess I don't know what this question means but is are there any child specific symptoms for delta for the Delta variant. Is there any difference between children and adults.

Dr. Betsey Tilson

Um, no, not really specific to Delta. Overall, you know, I think what we've learned is there's a whole range of symptoms, some specific like, you know, loss of sense of taste and smell some very nonspecific. So a whole host of it. What we've seen is children have often a little bit more GI symptoms than respiratory symptoms. But there's a wide range of symptoms in adults and children. But again, maybe a little bit more of the GI symptoms and kids.

Hugh Tilson

So, there are other questions but somebody said, When will we get a copy of this presentation, especially the q&a. As a reminder, there's a link to the presentation. It's on the NC AHEC website and we will post recording of this. Tomorrow on The NC AHEC website. So that's how you'll get those. Um, another question Are there handouts for this webinar if you don't have the link to the website I can post that in there just a second. What's the best ventilation system to have was interested in me for my independent pharmacy. Not that it would break the bank, any thoughts about that or any way to go to get that information.

Dr. Betsey Tilson

I'm not a content expert in ventilation, but I do, we have again really good guidance in our strong tool, schools, toolkit about ventilation that I would start there as well and they also reference the professional organization that has those those ventilation guidance so I would start there as a good base.

Hugh Tilson

Primary Care Physician I have patients who are school principals and teachers they're interested if when there'll be a decision to go virtual to stop the spread.

Dr. Betsey Tilson

It will likely be at the local level, making that decision.

Hugh Tilson

Our hospital hospitals are strained and high positive rates can we anticipate an executive order to help many fairs and other large events are coming.

Dr. Betsey Tilson

I'm sorry, what was the question,

Hugh Tilson

I guess, will there be an executive order to help with fairs or large events, upcoming and do you anticipate state doing anything to prevent or address large mass gatherings.

Dr. Betsey Tilson

So it's a couple things we do have updated for an event guidance, updated on our guidance website, and you know we're in a very different place than we were in the beginning in the beginning we didn't have any tools all we had was our executive orders and our non pharmaceutical interventions we're in a very different place now. We have our vaccines we have treatments we have testing. And so we're really leaning hard on those strategies, not so much on the strategies that we employed earlier in the year specifically through executive orders. Now, having said that everything is on the table and this governor will always do what he feels he needs to protect North Carolinians but we're very we're in a very, very different phase now than we were in the beginning and then we have so many other tools which is why we're trying so hard to promote vaccine testing treatment to avoid having to do those lock downs that we didn't have to do in the beginning.

Hugh Tilson

Does the State send PCR results to PCPs if the results of the Delta variant, and what does that report look like.

Dr. Betsey Tilson

No, most labs don't, so we do some of that not all levels have the ability to do the sequencing state lab does some of our commercial labs do in a network but it's really more of a population surveillance, not at the individual level, but to know if you are patient it tests positive now, 98.9% is likely they have delta but we do the sequencing really more as prevalence to understand what's going on and again not at the at the individual level but again close to 99% now if your patients 1000 If they have delta.

Hugh Tilson

I'm gonna ask your question, it looks like Kelly's responding to. Our problem is finding and keeping staff to give vaccines especially nurses if incentives could be used for staffing bonus for nurses or and CMAs that would help, or if there's a way to get PRN nurses from others somehow having no luck recruiting and quarantine and virtual school is challenging, more of a comment. A couple questions about incentives, which you've already talked about.. child care toolkit indicates we can use reduce quarantine periods seven to 10 days but that non pharmaceutical intervention should be implemented for the full 14 days, eg masking social distancing since children under two should wear a mask this mean we should not allow zero to two year old classes to use reduce quarantine periods in childcare settings.

Dr. Betsey Tilson

Yeah. And, yeah, and the option for those, the optional quarantine rests within that the authority of a local health director and what's going on in that county for that, yes, that would be correct because, let's just say so there's, there's the full, the CDC, still, still recommends that for 14 full 14 day quarantine. Now there are options for a reduced quarantine one would be 10 days with no symptoms, or seven days with a negative test on day five. However, just as you said that, if, if you have that shortened quarantine you still need to do, again those non pharmaceutical interventions, meaning you still need to wear a mask, and then have that six weeks social distancing until you hit that 14 day mark so right, that would be very difficult to implement in childcare because those children under two can't be consistently mask. It also a real learning with our schools it's pretty hard to operationalize those shorter quarantines especially in a school that does not have a mass mandate, because they're not going to know which child, maybe has only a 10 or a seven day quarantine and needs to continue to the mass for the full 14 days so there's some operational complexity in applying those, those quarantine options.

Hugh Tilson

So somebody asked I cannot, I cannot see chat where Dr. Tilson's posting information with the chat we post as well as the slides and we'll work on doing that. So Nevin remind us to post the chat as well. Are

there places where providers can get more peepees that are not too expensive private physicians might be stretched thin.

Dr. Betsey Tilson

Yeah we did that, like in the testing q&a We gave you that link where you could request PP so that link is in almost the last slide. There's also a question about plan for statement it from asking, I wanted to share some extra, what I think is really, really positive news. So we've had. We have more than 96% no excuse me more than 96 of our school districts who now are requiring masking and that covers about 92% of our students so we're seeing really really really good movement at the local level. For required masking.

Hugh Tilson

Then the only question that's not being addressed has to do with. Where's the line of criteria that where we do virtual school and stop large group events from that provider the impression is that politics is driving this versus public health, you've already touched on that so. Yet another similar comment about concerns about mass gatherings. Again, I know there's much to respond to you've already talked about that.

Dr. Betsey Tilson

Not really, again, we're working with a lot of our event organizers, we have a guidance for working with them on how to reduce the risk of these large events and again we're in a very different place. Really getting more people vaccinated we were working with some of our large event providers in fact Merlefest. They were having people either show proof of vaccination or a negative test within 72 hours. Many of our large event organizers are actually doing that as well, which is really nice. So we have a lot of different tools in our toolbox now in lowering the risk of these large gatherings and so that is a really good thing. And again, we're in a very different place, very different place now.

Hugh Tilson

Got a response identity working ie Lollapalooza, so it's not gonna be perfect. I have heard some concerns for supply chain issues regarding testing supplies again, I know you already talked about that but any projection for reduce reagent swabs going into the fall.

Dr. Betsey Tilson

Now again, As I mentioned on the slide we have not heard of any systematic, widespread supply chain issues. Go ahead. Yeah, so let's see Dr --'s question so again in the strong schools toolkit. We have a very detailed table on exactly what tests to accept what, what, in what scenario and I know that because I

pored very closely over that wording. So, in the strong schools toolkit, it is interpretation of different tests and it does say that a negative antigen test, if there's a low risk of that child is positive is has a contact or low risk of that child can be accepted as a negative test so look in that strong schools toolkit and interpretation of those test results. Yes, we had the medical board is posting something on that I reckon yes we are aware we sent that to the medical board on Thursday evening, asking him to push out to all the members so they are glad they're doing that.

Hugh Tilson

What age for high school are we considering teens to be more in the adult category for COVID exposure and CDC guidance.

Dr. Betsey Tilson

I think this question may be related to an earlier question of the mask on mask, and you'd have to quarantine or not the way that we are defining em CDC is students. So that would mean, five to 18 students mask on mask, don't need to quarantine. There was no age cut off the CDC guidance there was not an age cutoff.

Hugh Tilson

There is a follow up but no it's a follow up to so, I was asking if it was working public health data but I don't know if that's a follow up to. So, I think we're just about winding down but a couple more questions. But there's some talking points available for people to provide to local school districts as they discuss mask mandates for their students. And these are asking for statements to support mask waivers, which I do not support the guidelines for what conditions, wouldn't meet criteria for exemption. Do you have talking points for local folks who want to work with their schools, to encourage mask mandate.

Dr. Betsey Tilson

And we've been working really closely with our local health director so I think this is from Leslie. Leslie I'm not sure what county you're in, but you could give me a no, no, and then also make sure you connecting with your local health director we've been working again really closely with them as well, making sure they have talking points as well. And so, first place that we go to your local health director and then if you want to send me a note I can send you some of the talking points, I've been spending a lot of quality time with a lot of our local school boards, so I can send you some of the tracking points I've been using.

Hugh Tilson

So the follow up question was, is the vaccine Carter test before Mass gatherings, does that seem to be helping.

Dr. Betsey Tilson

Oh well, a lot of those events are just, they're being planned right now. So it's a little bit hard to, to know the effectiveness of that as they are, they are planning now.

Hugh Tilson

A person is with vaccines still having to double mask for being in an event, I guess.

Dr. Betsey Tilson

I think the question is, are fully vaccinated people still need to mask. So our recommendation is, when we are in an area of high transmission and again that is all 100 of our counties. It is recommended that even fully vaccinated people wear masks in a public indoor setting. And so that means a mask that has at least two layers to either codable mask or you have one mask that has double layers that is well fitting. So that is the recommendation for areas of high transmission and that is unfortunately all 100 of our North Carolina counties.

Hugh Tilson

What type of masks should be used in medical offices N95 or level two?

Dr. Betsey Tilson

I don't know exactly what the level two is I apologize but we do have a lot of us and the CDC, we did have a lot of PPE guidance specifically for health care settings on our website.

Hugh Tilson

Dr Tilson and team, you have successfully responded to all the questions that have been submitted. I hope you also saw there were a large number of thank yous great information, timely information and gratitude for the work y'all are doing. So, let me just make me vocalize what others have written, and thank you so much for your time tonight and all that the work that you do all day every day. Thanks. I'll turn it over to you.

Dr. Betsey Tilson

Well, thank you and thank you to our team and thank you to all of our DHHS as well as all of you for day in day out really really really appreciate all of our partnership. And as much as I wish we were out of this pandemic, I am glad that we are navigating this pandemic with people like you and be in North Carolina to do it. So thank you all very much.