NCIOM/IMPH Carolinas Pandemic Preparedness Task Force – North Carolina

Meeting 3 Summary

September 20, 2021

12:00 pm – 2:30 pm

Virtual Meeting

Meeting Attendees

Co-chair: Machelle Baker Sanders

Steering Committee Members: Kelly Fuller, Ellen Essick, Tatyana Kelly, Emily Roach, Lillian Koontz, Polly Welsh

Task Force Members/Interested Parties: Lori Byrd, Lenora Campbell, Jennifer Copeland, Kimberly Clement, Robin Cummings, Andy Ellen, Natalie English, Iris Green, Lynn Harvey, Kevin Lenard, Kathryn Lanier, Roy Lee Lindsey, Robin Tutor Marcom, Norma Marti, Shannon Pointer, Ben Rose, Janice Somers, Drew Stanley, A. Vernon Stringer, Hugh Tilson, Erin Tyson, Franklin Walker, Amy Widderich, Cornell P. Wright, Omari Richins, Tim Spittle

NCIOM Staff: James Coleman, Kathy Colville, Emily Hooks, Brieanne Lyda-McDonald, Alison Miller, Kaitlin Phillips, Michelle Ries

IMPH Staff: Brie Hunt, Brittney Sanderson

I. Fostering Connections: 12:00 – 12:10 PM

Alison Miller, MA, MPH
Project Director
North Carolina Institute of Medicine

Ms. Alison Miller started the meeting off by sharing welcome slides and housekeeping tips. She then informed attendees that they would be put into small breakout rooms with 3 – 4 other task force members to provide an opportunity to meet and connect. Meeting attendees were then moved into breakout rooms to meet, connect, and respond to several discussion questions.

II. Welcome: 12:10 – 12:15 PM

Machelle Baker Sanders, MHA
Secretary
North Carolina Department of Commerce

Ms. Alison Miller then invited Secretary Machelle Baker Sanders, North Carolina task force co-chair, to share opening remarks.

Secretary Sanders welcomed the task force members to the meeting and extended gratitude for their participation and the opportunity to move toward actionable recommendations together. She then reminded the task force that our partners in South Carolina have made the difficult decision to withdraw from participating in this meeting and the next meeting in October to allow their task force members to focus on responding to the surge in cases.

She shared that the NCIOM team is continuing to work closely with the South Carolina team, and that the teams are developing plans to ensure that cross-state learning about the COVID-19 pandemic continues over the next couple of months until both task forces reconvene. She expressed support for the South Carolina team in taking this approach, and said that she looks forward to future meetings where the South Carolina task force will be able to join.

Secretary Sanders also provided an overview of the content covered during the second task force meeting before introducing the content to be covered during this meeting. As she introduced the content for the third task force meeting, she explained that the meeting would focus on equity and the impacts of the pandemic on historically marginalized and vulnerable population during a six-month period of the response from May to November 2020. She concluded by thanking the task force for their continued work to address the pandemic and thoughtfully evaluating the state's response, while also emphasizing the importance of their work to building a safer, healthier, and more equitable future for North Carolina.

III. <u>Update: Task Force Process and Structure</u>: 12:15 – 12:30 PM

Kathy Colville, MSW, MSPH
President and CEO
North Carolina Institute of Medicine

Following Secretary Sanders' opening remarks, Ms. Alison Miller then invited Ms. Kathy Colville to share updates on the task force process and structure.

Ms. Kathy Colville discussed the task force responsibilities and framework, as well as the scope and the role of the steering committee. She then explained that the South Carolina steering committee requested a hold on meetings as task force and steering committee members address the surge in cases related to the Delta variant across the state. The North Carolina task force meetings will continue as scheduled, and the two states will continue to work together now and when the South Carolina task force reconvenes. Ms. Colville also explained that today's meeting agenda allows task force participants to look back at an earlier phase of the pandemic and document learning and insights from the current phase of response to the Delta variant.

IV. <u>Historically Marginalized and Vulnerable Populations – Key Perspectives</u>: 12:30 – 1:30 PM

Discussion Moderator:

Jennifer Copeland, PhD, MDiv
Executive Director
North Carolina Council of Churches

Key Perspectives:

Norma Martí
North Carolina Hispanic/Latinx Community Response Team Community Lead
North Carolina Community Engagement Alliance

Shannon Pointer, MSN, RN, CHPN
Vice President of Hospice & Palliative Care
Association for Home & Hospice Care of North Carolina

Drew Stanley
Warden, Nash Correctional Institution
North Carolina Department of Public Safety

Cornell Wright, MPA
Executive Director, Office of Minority Health and Health Disparities
Division of Public Health
North Carolina Department of Health and Human Services

Discussion Questions:

1. When you reflect on the COVID-19 response last year, what were some of the most difficult challenges for historically marginalized and vulnerable populations that were caused or exacerbated by the pandemic?
2. How were those challenges addressed, and what were some of the outcomes associated with the changes that were implemented?
3. How have those lessons learned influenced or changed the response to the current surge in cases?
4. What are some ongoing challenges or barriers facing historically marginalized and vulnerable populations that still need to be addressed in anticipation of future surges?

Ms. Alison Miller introduced the discussion moderator and key perspectives. Rev. Jennifer Copeland began the discussion by asking Ms. Norma Marti to describe her experiences with COVID-19.

Ms. Marti discussed the disparities in cases among Hispanic and Latinx populations. Ms. Shannon Pointer then discussed her professional experience with COVID working in the long-term and home and hospice care sphere. She explained that difficulties surrounding accessing patients in the home quickly became a challenge during the early phase of the pandemic.

Rev. Copeland then asked Mr. Drew Stanley about COVID in the prison setting and impacts on justice-involved and incarcerated populations. He explained that witnessing outbreaks in other prisons reiterated the fact that early on we didn't understand fully how to mitigate the risk of an outbreak in congregate settings. He also explained that there are lasting challenges surrounding social distancing and vaccination in the prison setting.

Mr. Cornell Wright then discussed the early impacts of COVID on historically marginalized populations including racial minorities, people experiencing homelessness, and veterans. He mentioned that the North Carolina Department of Health and Human Services are working to ensure that equity is a component of current and future response efforts. Rev. Copeland asked what lessons we have been able to implement during the recent surge of the Delta variant. Mr. Wright explained that he has witnessed intentional activities to embed equity in services to ensure that historically marginalized groups are able to access preventive care such as testing, contact tracing and quarantine supports, and vaccination, while also establishing workstreams across NCDHHS and creating strategic partnerships to support efforts by the historically marginalized populations workgroup.

Mr. Stanley explained that in congregate settings such as prisons, the greatest challenges have involved social distancing. Ms. Pointer said she believed that partnerships have been a great strength in responding to the pandemic, and that these partnerships are supporting efforts related to the current surge in cases. She added that these partnerships were not so well established at the beginning of the pandemic, so this has been an important step forward. Ms. Marti then described some of the challenges we've addressed, and stated that the cumulative knowledge that has been gained as the pandemic has continued represents a strength. She also mentioned that the leadership in North Carolina was receptive to innovative solutions, which was a profound strength in their response. She added that the grant money needed to be distributed externally to grassroot organizations and that the state's leadership was especially receptive to this, leading to outreach in multiple languages and support for grassroots organizations across the state.

Rev. Copeland moved on to ask about the most pressing current challenges. Mr. Stanley explained that the primary challenges in the congregate setting include logistics surrounding quarantine, as well as enforcing mask mandates and social distancing. He explained that he hopes that they have an advantage if an outbreak were to occur as understanding of the virus and transmission has increased over time, but stated that he remains concerned about future outbreaks because vaccination levels among staff are low (55%) and vaccination hesitancy is a significant barrier. He also explained that staff exposures outside the prison setting threaten the safety of inmates and staff, although 90% of inmates are vaccinated.

In describing lessons learned, Ms. Marti said she believes that the challenges in maintaining safety with children going back to school are the most pressing today, and that understanding of the best ways to respond is limited because children were out of school for the past year. Mr. Wright explained that he believes that building partnerships and extending funds to grassroots organizations were perhaps the greatest lessons learned. Ms. Pointer agreed with Mr. Wright in terms of our new understanding of the necessity of partnerships, while also emphasizing the importance of elevating equity and access to services, particularly in terms of the availability and ability to utilize technology to access essential services.

Rev. Copeland asked the panel about the ongoing challenges affecting historically marginalized and vulnerable groups. Ms. Pointer explained that vaccinating employees and distributing the vaccine to homebound individuals and their families with the existing regulatory barriers were ongoing challenges. Mr. Wright agreed with Ms. Pointer and explained that equitable access to information and vaccines are ongoing challenges impacting the populations he works with as well. Mr. Wright added that information surrounding monoclonal antibody treatment and difficulties associated with evolving information are

ongoing challenges influencing trust and COVID fatigue. Ms. Marti explained that rural populations and technology represents a particular challenge. She elaborated by stating that communications via technology have been challenging for many populations and that we need to make sure we are reaching populations where they are even if that involves creating simple, low-tech communication strategies in the future. She also explained that we need more upstream thinking in terms of how to access hard-to-reach populations such as migrant farmworkers. Mr. Stanley added that their primary current challenges involve preventing outbreaks in congregate prison settings while working within existing regulations.

Ms. Alison Miller then concluded the discussion by thanking the panel for sharing their thoughts and the illuminating discussion.

V. <u>Synthesis Groups</u>: 1:30 – 1:50 PM

1. What problems were raised during the key perspective discussion?
2. Which problems may have been preventable in hindsight?
3. What are some potential solutions to address the identified problems?

Following the key perspectives discussion, Ms. Alison Miller explained that attendees would be moving into small discussion groups to discuss what they heard and learned from the key perspectives and answer targeted questions for approximately 20 minutes.

Synthesis Group Discussion Notes (organized by theme)

<u>Anticipating Challenges</u>

- The ability to be predictive and anticipate challenges is key moving forward. Several groups of concern (including homebound, HMP, migrant farmworkers, etc.) have different communication needs and we could probably have predicted that they would have had difficulties in receiving and understanding information.

- We know when migrant farmworkers arrive in the state and we should have been more prepared for that. We know when hurricane season is and we prepare in advance. A system that relies heavily on using technology to sign up for vaccines shouldn't be rolled out to people over 65 years of age.

- COVID ripped the Band-Aid off the underlying issues that existed, but we hadn't spent enough time thinking about.

- In terms of the work in prisons and other congregate living situations, there were experts who knew more about what those groups needed and how they worked. Those experts could have been involved earlier on.

- Series of systemic problems and challenges that if we don't learn from and try to address, it will be a huge lost opportunity.

- One thing that concerned me at the beginning was that people were caught off-guard by infection control in nursing facilities and long-term care. After years of working in LTC, I was constantly saying they won't just have isolation rooms available, what do you do if you have a patient who is sick and isn't in a private room? Maybe if we had known something like this we could work on that, but the sheer cost of renovation and having that in LTC is too high.

- Leadership played an important role. In terms of the things that could have been prevented, it was not because of a lack of effort. What we should have known from past disasters was the technology piece. We should have known that technology creates barriers for HMPs. It's not throwing out the things that we know work – a lot of people still use the telephone, and getting community health workers out into the community to provide support is important.

- When we had to transition to virtual learning, that was a vulnerability. Interorganizationally, there were issues. A database wasn't set up to differentiate where members were located based on need/county.

- One of the things that has really concerned me is how we put our blinders on and are so unaware of what's around us every day. The hardest part of my job has been getting people to understand the importance of agriculture to our state and having a $100 billion industry that has workers who are invisible to the entire state. We don't think about where people's natural lifeways take them – for instance, schools having events and the whole communities at those events, and use those locations for outreach.

<u>Communications</u>

- The simplicity of communication is important. Not sure if that could have been fixed at the time.

- We are a country of individual rights, but during a pandemic you have to put the group first. Not sure about specific things that are preventable, but communicating that coming together for common good is critical.

- Reaching groups with the information they need—it can't be the first time they're hearing from you. Find the people who is already doing this type of work, and find ways to communicate with people where they are. Connecting institutional messaging with grassroots messengers is key.

<u>Politics</u>

- The politics have been catastrophic. The public health message often conflicts with the economic message. If you are a small business who is put out of business, that is a significant problem and we have to figure out what to deal with. We can't stay in our echo chamber, and we need to hear from folks who don't care about COVID.

- In the community college system, we have a lot of students who were impacted socially and economically. We have lots of rural schools and we have people in those schools who are receiving mixed messages about vaccines and masks. Lots of political debate. We recently had students

dropping out of nursing school because they are afraid and won't get vaccinated. We had nursing faculty quit because of vaccine misinformation. It's very concerning.

- What I resent the most is that COVID has been politicized. I blame that for many of the deaths. Nurses had a blue tarp from Lowes to use as PPE. We didn't get things we needed from the government, it was from private enterprise. It should have never been a political decision at the beginning. Blame the government for a lot of our deaths.

- So happy we're having this conversation to better prepare. The rationing of care discussions that were had at that time about who gets treatment and who doesn't was heartbreaking. Have to get away from politics and put health care above everything. Human lives matter and there is a responsibility to take care of people. What do you do when you are an owner of a thriving business and what do you do when it disappears?

<u>Partnerships and Collaboration</u>

- Being able to communicate and work with different organizations has been an asset. Different voices coming together helps solve some of these problems. Our marginalized communities, a lot of students were going hungry. We did food drives. The speaker from the last task force meeting with his business, I thought of a lot of what he said. He gave me a new perspective to consider.

- There is still so much that people need. All the collaborations, we need to keep those going. How do you balance everything that everyone is doing AND keep these going? Brings up issues of fatigue and burnout.

<u>Equity</u>

- We sacrificed equity for speed. It's hard to catch up on the equity side of things if you don't lead with equity. Doing equity bumps to local health departments for HMPs – it added another layer to the narrative that HMPs have. Booster shots will need to have equity baked in.

- One of the lessons learned from the vaccine advisory committee related to how we handled stigmatized populations including incarcerated and unhoused populations.

- Kudos to our leadership – I think we made the right decision to follow the state in terms of vaccinating our staff and our incarcerated population based on age.

<u>Other Points</u>

- Advanced care planning – the importance of advanced care planning for the state as a whole, which was also reflected in the Serious Illness Care Task Force report that the NCIOM produced. This issue seems to be coming back up for this task force as well.

VI. Break: 1:55 – 2:00 PM

VII. Discussion – The Fourth Wave: 2:00 – 2:28 PM

Alison Miller, MA, MPH
Project Director
North Carolina Institute of Medicine

Michelle Ries, MPH
Associate Director
North Carolina Institute of Medicine

Ms. Alison Miller welcomed attendees back from a short break and introduced the format of the large group discussion, which used Jamboard to organize the responses.

A link to the Jamboard discussion is provided here.

VIII. Next Steps and Closing: 2:28 – 2:30 PM

Ms. Alison Miller brought the meeting to a close by thanking attendees for the wonderful discussion and sharing next steps.