Effective partnerships are critical to the development and implementation of preparedness, response, and recovery plans that protect the health, safety, and well-being of North Carolinians during times of crisis. In the early months of the COVID-19 pandemic, representatives from local and state-level organizations had frequent meetings—over the phone or virtually, and often on a daily basis—to share information and updates from their agencies or sectors, or from within their communities, to promote collaboration and coordination. These partnerships also helped to promote sharing of technical expertise and skills across organizations, along with personal protective equipment (PPE) and other supplies and resources. At a time when support and resources from the federal government were limited or inaccessible, cross-sector collaboration and coordination bridged gaps and generated creative solutions to new and complex challenges presented by SARS-CoV-2. Although the COVID-19 pandemic continues as of the writing of this report, many partnerships established during the response will endure, providing new and ongoing opportunities to align around shared goals before, during, and after other public health emergencies.[1]

"Certainly, the COVID-19 pandemic will go down in history as one of the most significant public health challenges of our time. Responding to the uncertainty of the pandemic put public health officials, health care and human services providers, and people working in all service industries front and center in the response. Across the board, COVID-19 also elevated systemic racial disparities not only in health care access, but also in access to food, housing, education, and other pillars of a healthy life. Fortunately, countless individuals and institutions in North Carolina approach these challenges with a combination of innovative thinking and norm-breaking collaborations. These innovations and collaborations were born of necessity in the pandemic, but hold great promise for continued applications years into the future."[1] –Dr. Susan R. Mims, *North Carolina Medical Journal*

COVID-19 Response

In the first few months of the COVID-19 pandemic, federal agencies were slow to develop a coordinated national response, causing confusion about strategies for mitigating the spread of the virus that continue to persist.[2–4] As a result, state and local governments exercised their public health powers unevenly, leading to variation in the issuing of mask mandates, stay-at-home orders, and other mitigation measures throughout the pandemic.[3,5] High case rates, hospitalizations, and deaths in the United States, particularly in comparison with other industrialized nations, have been attributed to this lack of interjurisdictional coordination, along with other factors.[6]

Figure 1. Overview of the Early Months of the COVID-19 Pandemic Response[7]

- **January 9, 2020:** The World Health Organization (WHO) announces that a cluster of coronavirus-related pneumonia cases has been identified in Wuhan, China.
- **January 20, 2020:** The U.S. Centers for Disease Control and Prevention (CDC) announces plans to screen travelers for coronavirus at three airports: JFK International, San Francisco International, and Los Angeles International.
- **January 21, 2020:** The CDC confirms the first coronavirus case in the United States.
- **January 31, 2020:** The WHO declares a global emergency; the United States declares a public health emergency.
- **February 11, 2020:** In North Carolina, Governor Cooper establishes the COVID-19 Task Force to develop the state's preparedness plan and begin coordinating response efforts.[8]
- **February 25, 2020:** The CDC states that COVID-19 is nearing pandemic status.
- **March 10, 2020:** Governor Cooper issues Executive Order 116, declaring a state of emergency to allow state government agencies, nonprofits, and private sector partners to coordinate on the state's COVID-19 response, and activating the state's Emergency Operations Center (EOC).[a]
- **March 11, 2020**: The WHO declares that COVID-19 is a pandemic.
- **March 13, 2020:** President Trump declares COVID-19 a national emergency, unlocking federal funding to mitigate the spread of the disease.
- **March 14, 2020:** Governor Cooper issues Executive Order 117 to close K–12 schools statewide.[b]
- **March 17, 2020:** Governor Cooper issues Executive Order 118, which closes restaurants and bars for dine-in service, and makes unemployment benefits more widely available.[c]
- **March 23, 2020:** Governor Cooper issues Executive Order 120, closing K–12 public schools statewide through May 15, prohibiting mass gatherings of more than 50 people, and closing certain types of businesses.[d]
- **March 26, 2020:** The U.S. Senate passes the Coronavirus Aid, Relief, and Economic Security (CARES) Act, authorizing $2 trillion in aid to state and local governments, hospitals and health systems, and small businesses.
- **March 27, 2020:** President Trump signs the CARES Act into law. In North Carolina, Governor Cooper issues Executive Order 121 to implement a statewide stay-at-home order beginning March 30, 2020, through April 29, 2020, directing North Carolinians to stay at home except to visit essential businesses, exercise outdoors, or help a family member. Executive Order 121 also prohibits gatherings of more than 10 people and directs everyone to physically stay at least six feet apart from others.[e]

a Governor Cooper, Executive Order 116, https://governor.nc.gov/media/1750/open
b Governor Cooper, Executive Order 117, https://governor.nc.gov/media/1759/open
c Governor Cooper, Executive Order 118, https://governor.nc.gov/media/1760/open
d Governor Cooper, Executive Order 120,https://governor.nc.gov/media/1768/open
e Governor Cooper, Executive Order 121, https://governor.nc.gov/media/1774/open

The variation in official response across state and local jurisdictions also contributed to public perceptions that scientific experts and leaders had not reached a consensus about effective countermeasures to address the spread of SARS-CoV-2, raising highly nuanced questions that were difficult or impossible to definitively answer in the face of numerous uncertainties and information gaps. In response, some leaders acknowledged these uncertainties and attempted to provide answers that broadly applied to all groups, while others attempted to downplay the severity of the virus to reduce anxiety and offered reassurance that the situation was under control despite PPE and other supply shortages, rising case rates, and other widely publicized challenges.[9,10] The lack of clear, consistent, and coordinated communications (across all levels of government) facilitated the spread of misinformation around COVID-19 as the public searched for definitive answers and transparency from trusted messengers.[11] Low public confidence in the government, which can reduce adherence or willingness to accept public health mitigation measures, is another key factor in the disproportionate impact of the COVID-19 pandemic in North Carolina and throughout the United States.[12] **Chapter 6** (Data-Driven Decision-Making and Effective Communications with the Public) addresses the importance of effective communications in shaping public trust, transparent decision-making informed by reliable data, and the need for a robust public health infrastructure to support these goals. **Chapter 7** (Improving Access to Information and Services) includes recommendations from the task force to ensure the ability of all North Carolinians to receive essential communications and access services before, during, and after public health emergencies.

"This is the dark side of federalism: it encourages a patchwork response to epidemics. ...The defining feature of the U.S. response to COVID-19 therefore continues to be localized action against a threat that lost its local character weeks ago. The U.S. approach contrasts strikingly with those of South Korea and Taiwan, which have prevented widespread community transmission by rapidly implementing a centralized national strategy. Lacking strong federal leadership to guide a uniform response, the United States quickly fulfilled the World Health Organization's prediction that it would become the new epicenter of COVID-19."[3] – Haffajee & Mello, *New England Journal of Medicine* (2020)

An interim review of the state's response to the COVID-19 pandemic from January 2020 through December 2021 published by the North Carolina Department of Health and Human Services (NCDHHS) also cited the uncoordinated federal response and the collapse of the global supply chain as external challenges.[8] NCDHHS also recognized the state's chronically underfunded public health system, fragile health care safety net, high uninsurance rates, inadequate behavioral health services, and health and economic disparities in rural and historically marginalized communities as significant vulnerabilities.

"The lack of comprehensive federal guidance, particularly in the early days and months of the pandemic, made local efforts harder. When federal guidance did emerge, it was, at times, confusing. A slow and flawed COVID-19 national testing roll-out meant demand for tests quickly outpaced supply and manufacturers' ability to scale up production. ... At the same time, the federal government and the U.S. Congress acted quickly to ensure regulatory flexibilities, provide financial support, remove barriers to vaccine development, and ensure access to and payment for testing, treatment or vaccination. Civil servants at [the U.S. Department of Health and Human Services] HHS and other federal agencies provided essential research and information to their state counterparts. The Federal Emergency Management Agency (FEMA) worked to build supply stockpiles and provide both on-the-ground support and funding to states, including North Carolina."[8] – NCDHHS' Interim Review of the COVID-19 Response, January 2020 – December 2021 (p. 13)

Collaboration and Coordination to Address COVID-19 in North Carolina

In the absence of a coordinated federal COVID-19 response strategy, state and local leaders moved to address the pandemic by scaling up long-standing partnerships and forming new, cross-sector partnerships to meet the emergent and often unprecedented needs of communities across the state.

"Side-by-side coordination during disasters and training created access to capabilities that were not possible alone."[13] – Persia Payne-Hurley, North Carolina Emergency Management

Between March 10, 2020, and April 9, 2020, Governor Cooper issued 11 Executive Orders to enable the state's initial response to the COVID-19 pandemic (**Figure 1**).[8] Executive Order 116 declared a state of emergency, allowing state government agencies, in partnership with nonprofit and private sector organizations, to coordinate on the development and implementation of strategies to mitigate the spread of SARS-CoV-2. Executive Order 116 represented a critical recognition by the state of the high transmissibility of the virus and its potential to overwhelm health care and hospital systems, a situation that was occurring in several states experiencing surges in COVID-19 cases.[8] NCDHHS quickly partnered with the North Carolina Department of Public Safety's Division of Emergency Management (NCEM) to launch the state's response and worked closely together in the state's Emergency Operations Center (EOC) to secure necessary resources jointly. NCDHHS emphasized its partnership with NCEM, which was built on past collaboration between the agencies in response to hurricanes, as a key strength during the early months of the COVID-19 response. Existing relationships with health care and hospital systems across the state also supported effective collaboration and coordination with NCDHHS, NCEM, and other key partners.[8]

"Senior leaders from NCDHHS relocated to [NCEM] Emergency Management and worked out of conference rooms and makeshift office spaces and desks, separated to adhere to distancing requirements, for over a year to ensure effective and efficient collaboration. Heading into the pandemic North Carolina had both notable strengths to build on and daunting challenges as it faced the threat from SARS-CoV-2."[8]
– NCDHHS' Interim Review of the COVID-19 Response, January 2020 – December 2021

As part of their shared work, NCDHHS and NCEM coordinated with the National Guard to promote a unified statewide response and engagement with other state-level agencies, such as the State Board of Education, Department of Public Instruction (NCDPI), Department of Agriculture and Consumer Services (NCDA&CS), Department of Labor (NCDOL), and the Department of Transportation (NCDOT). NCDHHS and NCEM also collaborated and coordinated with local health departments, county officials, community and industry leaders, and other key perspectives and stakeholders to provide technical assistance, guidance, and other resources and support.[8]

Spotlight: Examples of Partnerships in North Carolina During the COVID-19 Pandemic

A number of partnerships emerged to address the unique challenges presented by the COVID-19 pandemic in North Carolina, several of which are described below:

- ***Regional Collaboration and Coordination in Western North Carolina:*** In March 2020, the Chief Medical Officers of hospitals in Buncombe and Henderson counties organized a weekly informal regional collaboration call to address the need for local support, information sharing, and pandemic planning. This collaboration included representatives from local health departments in the region, the medical director from the Cherokee Indian Hospital Authority, clinical/administrative leadership from other health system hospitals, Mountain Area Health Education Center, WNC Health Network, and Dogwood Health Trust. Partners focused on maximizing the availability of COVID-19 testing and PPE across the region, delivering resources to long-term care facilities, and implementing new patient care guidelines, facility visitation policies, and scarce resource allocation plans. As a result, partners were able to transfer patients between hospitals to ensure appropriate levels of care and prevent individual hospitals from becoming overwhelmed during the late 2020 surge in COVID-19 cases. This partnership also built trust between hospital leaders in the region and provided a forum in which partners were able to offer support to one another through challenging times.[1] WNC Health Network also brought regional partners together to form the WNC Health Communicators Collaborative, which focused on developing and implementing effective communication strategies to increase adherence with COVID-19 mitigation measures, such as masking and vaccination.[14,15]
- ***Hispanic/Latinx Populations:*** LATIN-19, which formed in March 2020 with the goal of advising and promoting Hispanic/Latinx community interests, represents a partnership between the Duke Pandemic Response Network, North Carolina Department of Health and Human Services' Historically Marginalized Populations Workgroup, Andrea Harris Social, Economic, Environmental, and Health Equity Task Force, Durham Recovery and Renewal Task Force, and the Duke Quality of Care Committee. Areas of focus for LATIN-19 included partnerships and outreach to improve access to COVID-19 testing and vaccinations, as well as addressing other drivers of health including housing, food, and transportation. As of August 2022, LATIN-19 continues to host weekly virtual meetings that are open to the public at which attendees can discuss challenges, needs, opportunities, and potential solutions to improve health and advance health equity.[16] LATIN-19 also engages in advocacy with key stakeholder groups, offers multilingual COVID-19 resources, and collaborates with LATIN-19 member organizations to build their capacity to achieve policy change through advocacy. Among many other successes, LATIN-19 has helped local health departments and state agencies publish COVID-19 data disaggregated by race and ethnicity to better understand impacts of the pandemic on historically marginalized communities.[16]
- ***Rural Populations:*** To address the challenges faced by rural communities across the state during the COVID-19 pandemic, the NC Rural Center, Foundation for Health Leadership and Innovation, Hometown Strong, North Carolina Area Health Education Centers, Governor's Office of Public Engagement, and North Carolina Department of Health and Human Services' Office of Rural Health partnered to form the North Carolina Rural Coalition Fighting COVID-19. Together, the Coalition offers rural-oriented tools, training, guidance, and messaging to trusted community leaders, such as county commissioners, health departments, faith-based leaders, business owners, and civic organization leaders. Since February 2021, the Coalition has hosted virtual meetings weekly, biweekly, or monthly that have helped to disseminate vital resources and messaging to rural communities.[16]
- ***Vaccine Distribution:*** Several partnerships have been formed in support of the state's COVID-19 vaccine distribution plan. The Healthier Together – Health Equity Action Network initiative represents a public-private partnership between the North Carolina Department of Health and Human Services and NC Counts to increase vaccine uptake among historically marginalized populations; Honeywell, Atrium Health, Tepper Sports and Entertainment, and the Charlotte Motor Speedway partnered with the North Carolina Department of Health and Human Services in the summer of 2021 to administer 1 million vaccinations at the Charlotte Motor Speedway, Bank of America Stadium, and other locations.[17,18]
- ***Research to Inform North Carolina's COVID-19 Response:*** In May 2020, the North Carolina General Assembly appropriated $29 million to the North Carolina Policy Collaboratory to research vaccines and treatment, community testing, prevention of COVID-19 transmission, economic impacts, mental and behavioral health impacts, and racial disparities facing communities across the state.[19] Partners involved in the Collaboratory worked closely with leadership at colleges and universities across the UNC system to develop research plans, solicit proposals, and award funding for projects aligned with the Collaboratory's funding priorities. Projects funded by the Collaboratory have focused on water and wastewater utilities as essential services, COVID-19 impacts on nursing homes and long-term care facilities, and impacts of the pandemic on Black families, among other research areas.[19–21]

The COVID-19 pandemic underscored the value of building and maintaining effective cross-sector partnerships to promote collaboration and coordination, as well as sharing technical expertise, skills, and resources to address gaps within individual agencies. To strengthen collaboration and coordination in anticipation of future public health emergencies, the task force recommends:

Recommendation 10.1
Strengthen emergency management infrastructure to support collaboration and coordination around emergency preparedness, response, and recovery.

Recommendation 10.2
Improve communications between local and state-level agencies to promote collaboration and coordination in the absence of a coordinated federal response strategy to guide response efforts.

Recommendation 10.3
Sustain and strengthen partnerships between school districts, local public health departments, and community partners.

The following organizations are responsible for implementing Recommendations 10.1–10.3:

- North Carolina General Assembly
- North Carolina Emergency Management
- North Carolina Department of Health and Human Services
  - Division of Health Service Regulation, Office of Emergency Medical Services
  - Division of Public Health
- Local health departments
- North Carolina Association of Local Health Directors
- North Carolina Healthcare Association
- North Carolina Medical Society
- Old North State Medical Society
- North Carolina Medical Group Management Association
- Western Medical Group Managers Association
- North Carolina Department of Commerce (NC Commerce)
- North Carolina Healthcare Facilities Association
- NC Chamber
- Philanthropic organizations
- State Board of Education
- School Health Advisory Councils
- PSU Offices of the Superintendent

RECOMMENDATION 10.1

To support collaboration and coordination between key partners at the state and local levels, a robust and resilient emergency management infrastructure must be in place. This infrastructure is critical, particularly in the absence of a coordinated federal response strategy, which was a key challenge during the height of the COVID-19 pandemic.

How is an emergency declared?

A declaration of emergency by the President in an affected state is required for access to federal emergency management funds. According to the Federal Emergency Management Agency (FEMA), requests for a declaration of emergency by the President must be made by the Governor of the affected state under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207 (the Stafford Act) §401.[22,23] This requirement also applies to the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. The Republic of Marshall Islands and the Federated States of Micronesia are eligible to request a declaration and receive assistance through the Compacts of Free Association.

In North Carolina, the Governor can also declare an emergency under the Emergency Management Act (Chapter 166A),[f] which is intended to:

- Reduce vulnerability of people and property of this State to damage, injury, and loss of life and property.
- Prepare for prompt and efficient rescue, care, and treatment of threatened or affected persons.
- Provide for the rapid and orderly rehabilitation of persons and restoration of property.
- Provide for cooperation and coordination of activities relating to emergency mitigation, preparedness, response, and recovery among agencies and officials of this State and with similar agencies and officials of other states, with local and federal governments, with interstate organizations, and with other private and quasi-official organizations.

The Emergency Management Act also outlines the powers of the Governor, Secretary of Public Safety, and the Division of Emergency Management. Along with other duties, the Division of Emergency Management (NCEM) is responsible for coordinating the activities of all state agencies for emergency management, including "planning, organizing, staffing, equipping, training, testing, and activating and managing the State Emergency Response Team and emergency management programs."[f]

Overview of Emergency Management in North Carolina

Under the Emergency Management Act (Chapter 166A)[f] of the North Carolina General Statutes, the Governor delegates authority to the Secretary of the North Carolina Department of Public Safety (NCDPS) to direct and control operations upon a declaration of emergency as the State Coordinating Officer (SCO). As the SCO, the Secretary delegates responsibility to the Director of NCEM, who has authority and responsibility to respond to emergencies and disasters. NCEM also updates and maintains the North Carolina Emergency Operations Plan (NCEOP).

[f] *Chapter 166A, North Carolina Emergency Management Act, https://www.ncleg.net/enactedlegislation/statutes/html/bychapter/chapter_166a.html*

The NCEOP represents a "comprehensive framework of policy and guidance for state and local disaster preparedness, response, recovery and mitigation operations," and details the capabilities, authorities, and responsibilities of federal, state, local, and other public and private nonprofit organizations that comprise the State Emergency Response Team (SERT). Forms of assistance to be provided during times of crisis are outlined in the NCEOP according to the federal emergency support function (ESF) structure, which promotes interagency coordination in response to an incident.[24] The NCEOP also describes the responsibilities assigned to the eight SERT sections, which are collectively charged with ensuring that specific state and county-level needs are addressed:

1. SERT Public Information Section[25]
2. SERT Recovery Section[26]
3. SERT Operations Section[27]
4. SERT Planning Section[28]
5. SERT Logistics Section[29]
6. SERT Fiscal Section[30]
7. SERT Risk Management Section[31]
8. SERT Hazard Mitigation Section[32]

Each ESF is assigned a lead state agency, selected based on that agency's authorities, responsibilities, and capabilities within a particular area, along with an NCEM Office of Primary Responsibility (OPR). The assigned OPR coordinates activities between primary and support agencies, and the federal, state, and local emergency management structure.[27]

In alignment with the National Incident Management System (NIMS) model, emergency operations in North Carolina are "handled at the lowest level of government that can effectively respond and manage an incident," with each county having emergency management personnel trained and capable of responding.[27] Acknowledging that local resources and capabilities vary between rural and urban areas of the state, the NCEOP underscores that local jurisdictions can ask for assistance when needed by calling upon mutual aid agreements with neighboring counties. These agreements are designed to facilitate the flow of additional resources into the affected county, and state and federal resources are also available should local government resources become overwhelmed or exhausted.[27] It is important to note that each county maintains an emergency operations plan of its own, along with an emergency operations center staffed by these personnel when activated.

At the state level, NCEM operates three branch offices, two warehouses, and the state EOC, which is co-located at the North Carolina Joint Force Headquarters alongside the National Guard. Each branch office becomes a regional coordination center during an emergency, ensuring operational information sharing and resource coordination between counties within each region and the state. Commodities such as bottled water, tarps, non-perishable foods, and other supplies are stored in the two warehouses, which serve as staging areas where warehouse personnel can pick up and transport needed supplies via NCEM trucks or contracted carriers.[27] The National Guard strengthens the state's response to an emergency, providing "Mission Ready Packages, which are assembled response and recovery capabilities that are organized, developed, trained, and exercised prior to an emergency or disaster."[27]

Collaboration and Coordination with Businesses and Other Private Sector Partners

The NCEOP emphasizes the importance of collaboration and coordination with businesses and other private sector partners during an emergency response. With this goal in mind, the North Carolina Business Emergency Operations Center (BEOC)[27,33] is established as a "physical and virtual communications and operational hub for business and industry" during events that pose hazards to the state. The NCEOP also states that "private sector partners are incorporated into the SERT, capitalize on shared information in the response, recovery, preparation and mitigation phases of state emergency management," which helps to ensure their ability to "make strong operational decisions, prepare, continue or resume normal business operations as quickly as possible before, during and after an event." The collaboration and coordination activities with private sector partners as part of the BEOC are summarized below and described in additional detail in the NCEOP:

- **Private sector partners provide input, recommendations, and sector analysis to build capacity and resiliency across the state.**
- **Private sector partners collaborate, train, and exercise with the SERT on preparedness activities.**
- **Fulfillment of resource requests, which are delegated to private sector partners and coordinated through the BEOC to expedite the provision of support whenever NCEM is activated.**
- **Support coordination of private sector offers to rent, lease, or donate resources.**
- **Encourage mutual aid between private sector partners to maximize resources.**

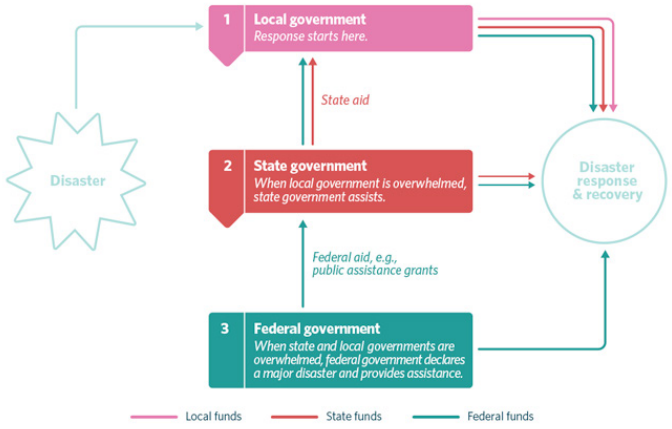
The NCEOP states that the mission of the BEOC is to promote situational awareness and information sharing to private sector organizations across the state during times of crisis, while also increasing support for the SERT. For more information, please refer to the NCEOP.[27]

The North Carolina Healthcare Preparedness Program (HPP), which was established in 2002 as a federally funded program, has been another critical component of the state's COVID-19 response.[34] Located within NCDHHS, HPP partners with health care and emergency response organizations to "prepare for, mitigate, and respond to and recover from emergencies and disasters affecting the residents and guests of North Carolina." HPP provides oversight to eight regional health care preparedness coalitions focused on strengthening health care preparedness, supporting continuity of operations, enhancing situational awareness, improving incident management, and augmenting medical surge capacity, a structure known as ESF-8.[34] HPP also serves on the SERT as the lead entity for disaster medical services under ESF-8. The responsibilities and capabilities of HPP include managing federal coordination

centers, supporting morgue capacity, leading state medical assistance teams, and providing infrastructure and logistical support, among other activities.

NCEM and HPP heavily rely on federal funding to support their activities, primarily through the Homeland Security Grant Program (HSGP) and the Emergency Management Performance Grant (EMPG) administered by the Federal Emergency Management Agency (FEMA).[35] Upon declaration of a national or state emergency by the President of the United States, NCEM can request reimbursement from FEMA for certain activities outlined by these programs. Funding streams to support emergency management activities, as well as the complex relationships between local, state, and federal government on response and recovery spending, are illustrated in **Figure 2**.

Figure 2. Sources of Emergency Response Funding



Notes: Funding flows are representative and reflect mainly post-disaster activity for a declared major disaster. They do not reflect funding amounts or the process for all federal and state programs. State and local funds include cost share payments related to federal programs.

Sources: Pew's analysis of information from J.T. Brown and D.J. Richardson, "FEMA's Public Assistance Grant Program: Background and Considerations for Congress" (2015), https://crsreports.congress.gov/product/pdf/R/R43990; U.S. Government Accountability Office, "Budgeting for Disasters: Approaches to Budgeting for Disasters in Selected States" (2015), https://www.gao.gov/products/GAO-15-424; Federal Emergency Management Agency, "FEMA Public Assistance Guide" (2007), http://www.fema.gov/pdf/government/grant/pa/paguide07.pdf

Source: Reprinted with permission from The Pew Charitable Trusts. Pew's analysis of information from J.T. Brown and D.J. Richardson, "FEMA's Public Assistance Grant Program: Background and Considerations from Congress." (2015).

The task force emphasized the need to ensure the capacity of NCEM and other critical partners to effectively collaborate and coordinate on emergency preparedness, response, and recovery activities. To strengthen emergency management infrastructure in support of this goal, the task force identified five strategies:

RECOMMENDATION 10.1

Strengthen emergency management infrastructure to support collaboration and coordination around emergency preparedness, response, and recovery.

Strategy 10.1a: The North Carolina General Assembly should explore opportunities to provide sustained, multi-year state appropriations to the North Carolina Department of Public Safety's Division of Emergency Management and the North Carolina Department of Health and Human Services' Healthcare Preparedness Program to ensure stable funding and reduce reliance on federal grant funds.

Strategy 10.1b: The North Carolina General Assembly should provide direct access to emergency funding to allow the North Carolina Department of Health and Human Services and local health departments to support ongoing COVID-19 response and recovery needs, such as vaccine administration, testing, communications and outreach, and protective equipment, once federal funds are no longer available for this purpose.

Strategy 10.1c: The North Carolina Department of Health and Human Services should expedite the establishment of the Office of Emergency Preparedness, Response, and Recovery to promote effective collaboration and coordination with North Carolina Emergency Management and leverage their successful partnership in the work of the State Emergency Response Team.

Strategy 10.1d: The North Carolina General Assembly should explore opportunities to provide sustained, multi-year state appropriations to the Office of Emergency Preparedness, Response, and Recovery in SFY 2024–2026.

Strategy 10.1e: North Carolina Emergency Management, the Office of Emergency Medical Services, and the Division of Public Health should define and update the roles and responsibilities of partnering entities outlined in the North Carolina Emergency Operations Plan and other preparedness plans based on input from partnering entities, which should be reviewed and signed by partnering entities annually.

STRATEGY 10.1a

Ensure stable funding to support emergency preparedness, response, and recovery.

The North Carolina General Assembly should explore opportunities to provide sustained, multi-year state appropriations to North Carolina Department of Public Safety's Division of Emergency Management and the North Carolina Department of Health and Human Services' Healthcare Preparedness Program to ensure stable funding and reduce reliance on federal grant funds.

DESIRED RESULT

Stable funding for key partners engaged in developing and implementing emergency preparedness, response, and recovery plans.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force emphasized that continuous funding for the North Carolina Department of Public Safety's Division of Emergency Management (NCEM) and the North Carolina Department of Health and Human Services' Healthcare Preparedness Program (HPP) is essential to improving the state's ability to prepare, respond, and recover from public health emergencies.[36,37] **Strategy 10.1a** is designed to provide stability to these agencies by reducing their reliance on federal grant funding to develop and implement emergency response plans.

Strategy 10.1a also recognizes that NCEM and HPP are central to emergency preparedness and response efforts in North Carolina, helping to coordinate activities between partners and provide technical assistance. Stable funding in the form of state appropriations will reduce reliance on federal grant funds, which may decrease or otherwise vary across fiscal years, and support NCEM and HPP in developing and implementing emergency response plans based on more predictable funding levels.

ADDITIONAL CONTEXT

The North Carolina General Assembly is the entity involved in **Strategy 10.1a.**

NCEM and HPP heavily rely on federal funding to support their activities, primarily through the Homeland Security Grant Program (HSGP) and the Emergency Management Performance Grant (EMPG) administered by the Federal Emergency Management Agency (FEMA).[35] Upon declaration of a national or state emergency, NCEM can request reimbursement from FEMA for certain activities outlined by these programs. FEMA may ultimately deny the reimbursement request, leaving the state to absorb unanticipated costs. Reimbursement processes may also be administratively burdensome and difficult to navigate.

STRATEGY 10.1b

Ensure direct access to state emergency response funds for the North Carolina Department of Health and Human Services.

The North Carolina General Assembly should provide direct access to funding to allow the North Carolina Department of Health and Human Services and local health departments to support ongoing COVID-19 response and recovery needs, such as vaccine administration, testing, communications and outreach, and protective equipment, once federal funds are no longer available for this purpose.

DESIRED RESULT

Direct access to emergency response funds to support the North Carolina Department of Health and Human Services in its ongoing efforts to address the COVID-19 pandemic.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

As the COVID-19 pandemic has continued, there has been a tremendous influx of federal funding to states for various aspects of response and recovery, as is detailed throughout this report. However, even as extensive planning and infrastructure have been implemented to allocate, monitor, and evaluate the use of federal relief funds, states including North Carolina acknowledge the expiration of these funding sources, and the need to have ongoing support from state legislatures for additional response and recovery needs. The task force recognized the need for dedicated response and recovery funding in the face of additional case surges, additional and potentially more severe virus variations, and even as COVID-19 is no longer considered a pandemic but continues to pose risk to individuals and communities in North Carolina.

ADDITIONAL CONTEXT

On July 11, 2022, Governor Cooper signed into law the 2022 Appropriations Act (Session Law 2022–74), which includes a section addressing disaster relief and COVID-19 recovery, mitigation, and resiliency.[9]

In addition, the North Carolina Institute of Medicine Task Force on the Future of Local Public Health is having ongoing discussions about the current structure, needs, and funding sources of local public health in North Carolina, including what is necessary for ongoing, robust, and dedicated outbreak response. The full recommendations for funding and infrastructure needs can be found in the task force report, available here: https://nciom.org/future-of-local-public-health-in-north-carolina/

State and local policymakers are also planning spending of federal funding according to deadlines for the appropriation and spending of these funds. For instance, funding from the American Rescue Plan Act must be appropriated no later than December 31, 2024, and the funds must be spent by the end of 2026.[38]

[9] *Session Law 2022-74, https://www.ncleg.gov/Sessions/2021/Bills/House/PDF/H103v5.pdf*

STRATEGY 10.1c-10.1d

Launch and sustain the Office of Emergency Preparedness, Response, and Recovery.

Strategy 10.1c: The North Carolina Department of Health and Human Services should expedite the launch of the Office of Emergency Preparedness, Response, and Recovery to promote effective collaboration and coordination with the North Carolina Division of Emergency Management and leverage their successful partnership in the work of the State Emergency Response Team.

Strategy 10.1d: The North Carolina General Assembly should explore opportunities to provide sustained, multi-year state appropriations to the Office of Emergency Preparedness, Response, and Recovery in SFY 2024–2026.

DESIRED RESULT

Timely launch of the Office of Emergency Preparedness, Response, and Recovery to formalize and strengthen the collaboration and coordination between the North Carolina Department of Health and Human Services, North Carolina Emergency Management, and their partners before, during, and after public health emergencies, along with funding to sustain this work beyond December 31, 2024.

WHY DOES THE TASK FORCE RECOMMEND THESE STRATEGIES?

The North Carolina Department of Health and Human Services and North Carolina Emergency Management have an extensive history of collaboration and coordination in their response to public health emergencies. The North Carolina Emergency Operations Plan outlines their roles, responsibilities, and other aspects of their partnership, but NCDHHS and NCEM remain separate entities.[39] The task force emphasized the forthcoming Office of Emergency Preparedness, Response, and Recovery as an important opportunity to create a well-supported bridge between these partners to encourage alignment. The Office of Emergency Preparedness, Response, and Recovery will rely initially on American Rescue Plan Act funds, which must be spent by December 31, 2024. **Strategy 10.1d** aims to ensure funding in the form of state appropriations to continue this work once American Rescue Plan Act funds have been spent.

ADDITIONAL CONTEXT

In April 2021, then North Carolina Secretary of Health and Human Services Mandy K. Cohen announced the department's plan to establish an Office of Emergency Preparedness, Response, and Recovery that will "bring together teams from across NCDHHS to prepare for, respond to, and recover from disasters and health emergencies affecting North Carolina, strengthening the department's partnership with the Division of Emergency Management at the Department of Public Safety."[40] This work was led by Deputy Secretary Kody H. Kinsley, who has since been appointed by Governor Cooper as Secretary of Health and Human Services following Dr. Cohen's departure in November 2021.

STRATEGY 10.1e

Ensure clear roles and responsibilities for all entities involved in the North Carolina Emergency Operations Plan.

North Carolina Emergency Management, the Office of Emergency Medical Services, and the Division of Public Health should define and update the roles and responsibilities of partnering entities outlined in the North Carolina Emergency Operations Plan and other preparedness plans based on input from partnering entities, which should be reviewed and signed by partnering entities annually.

DESIRED RESULT

Increased understanding of the roles and responsibilities of all entities involved in implementing the North Carolina Emergency Operations Plan to support interagency collaboration and coordination, along with improved internal planning among these entities.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force underscored the importance of providing entities involved in the state's emergency preparedness, response, and recovery efforts with clear roles and responsibilities that reflect their input and capabilities. The task force also underscored that these materials should be reviewed and updated frequently to ensure accuracy and promote ongoing discussion about opportunities for improvement.

ADDITIONAL CONTEXT

The North Carolina Department of Public Safety's Division of Emergency Management (NCEM) and two divisions within the North Carolina Department of Health and Human Services, the Division of Health Service Regulation's Office of Emergency Medical Services, and the Division of Public Health, are the entities involved in implementing **Strategy 10.1e**. The roles and responsibilities of entities involved in the State Emergency Response Team (SERT) are outlined in Annex A and subsequent appendices of the North Carolina Emergency Operations Plan.[41,27]

RECOMMENDATION 10.2

To promote collaboration and coordination between local and state-level agencies engaged in emergency preparedness, response, and recovery activities, the task force and its Communications, Misinformation, and Public Trust Work Group underscored the importance of effective communication. Effective communication ensures that plans are developed and implemented based on an informed understanding of the capabilities and resources of partnering agencies, along with the realities experienced by partners within their respective sectors and communities. To gain an informed understanding, key perspectives and experts in communities across the state must be identified, engaged, and meaningfully included—with compensation provided for their time and contributions—in emergency preparedness, response, and recovery activities.

"Pandemics and epidemics are most dangerous to those already at risk: people with underlying health conditions (caused, in part, by deeper racial, structural, and systemic inequities), and those who are members of marginalized communities without access to preventive care or health care services at their time of greatest need. As was seen in AIDS, SARS, and now COVID-19, responding to an evolving pandemic requires identification of and collaboration with those groups at greatest risk, who often lie outside the mainstream. Engagement with communities early on and throughout is critical, especially communities of color and other marginalized groups that require a public health response that is not channeled through discriminatory systems and structures and does not perpetuate inequities in the midst of crisis.... Community engagement and partnerships are at the heart and core of public health, are essential for achieving health equity, and are most dramatically needed during pandemics such as we now face."[42] – Michener, et al., *Engaging With Communities — Lessons (Re)Learned From COVID-19* (2020)

The meaningful inclusion of key perspectives and experts across a wide range of sectors can create invaluable opportunities to learn about the barriers and facilitators that can shape the uptake of strategies to protect health, safety, and well-being during times of crisis in North Carolina's communities. Engaging and partnering with communities in the development, implementation, and communication of public health strategies also serves to build trust within those communities.[42] In response, the task force and its Communications, Misinformation, and Public Trust Work Group recommend the following strategies to promote collaboration and coordination between local and state-level agencies:

RECOMMENDATION 10.2

Improve communications between local and state-level agencies to promote collaboration and coordination in the absence of a coordinated federal response strategy to guide response efforts.

Strategy 10.2a: North Carolina Emergency Management (NCEM), in partnership with the North Carolina Department of Health and Human Services, should convene local health departments and other partners on a quarterly basis to increase awareness and understanding of the role of NCEM in providing technical assistance and support during emergencies, the value of the incident command system, and the role of the forthcoming Office of Preparedness, Response, and Recovery.

Strategy 10.2b: Local health departments and/or regional coalitions should convene quarterly meetings with local businesses, community-based organizations, faith-based leaders, and other partners to strategize, develop, and update communication plans that can be leveraged before, during, and after public health emergencies.

Strategy 10.2c: The North Carolina Department of Health and Human Services, North Carolina Healthcare Association, North Carolina Medical Society, Old North State Medical Society, North Carolina Medical Group Management Association, Western Medical Group Managers Association, and philanthropic organizations should work together to identify sustainable funding sources to provide compensation to partners working in community-based organizations for their time, expertise, and contributions.

Strategy 10.2d: The North Carolina General Assembly should (1) provide additional state appropriations to support state and local public health infrastructure, including positions focused on community engagement, small business support, and partnerships, and (2) provide state appropriations to increase capacity among community-based organizations to engage and partner with local and state public health; the Departments of Commerce, Labor, and Agriculture and Consumer Services; Economic Development Partnership of North Carolina; and other organizations.

Strategy 10.2e: The North Carolina Department of Health and Human Services, North Carolina Association of Local Health Directors, North Carolina Emergency Management, North Carolina Department of Commerce, and NC Chamber should establish an advisory group charged with developing strategies to ensure the ongoing, sustainable inclusion of business and private-sector emergency management representatives in public health emergency preparedness, response, and recovery planning.

Strategy 10.2f: The North Carolina Department of Health and Human Services should (1) consider opportunities to strengthen the partnership between state and local public health and the Centers for Disease Control and Prevention (CDC) to increase awareness of resources and tools needed locally, regionally, and statewide, and (2) engage with entities receiving CDC funding to promote coordination.

STRATEGY 10.2a

Increase understanding of emergency management systems and processes among local health departments and other partners.

North Carolina Emergency Management, in partnership with the North Carolina Department of Health and Human Services, should convene local health departments and other partners on a quarterly basis to increase awareness and understanding of the role of NCEM in providing technical assistance and support during emergencies, the value of the incident command system, and the role of the forthcoming Office of Preparedness, Response, and Recovery.

DESIRED RESULT

Increased awareness of the technical assistance and support available to local health departments and their partners from NCEM, along with greater understanding of the incident command system and how it can strengthen response efforts during public health emergencies to improve coordination. Improved coordination between NCEM, NCDHHS, local health departments, and other community partners can strengthen partnerships between these entities, creating opportunities that can be leveraged by the forthcoming Office of Preparedness, Response, and Recovery.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force identified the need for increased awareness of the role of NCEM as a technical assistance and support provider, and the value of the incident command system (ICS) in promoting a standardized, coordinated response to emergencies. **Strategy 10.2a** is designed to ensure that local health departments, which are integral to county-level response efforts, are aware of state-level supports available from NCEM and prepared to adopt an ICS structure in the event of a public health emergency. **Strategy 10.2a** is also designed to increase awareness of the forthcoming Office of Preparedness, Response, and Recovery and resources that will be available as a result.

ADDITIONAL CONTEXT

Generally, an incident command system (ICS) allows local, state, and federal agencies to standardize and integrate their emergency response efforts. An ICS allows for flexibility and efficiency as various agencies respond to complex emergency situations.[43] In North Carolina, the state Emergency Operations Plan has adopted an ICS to effectively manage emergency response; the plan states that "these systems provide a rational model to prioritize and manage emergency operations in order for disaster response protocols to remain flexible." The ICS allows for the state to address the five critical mission areas when working on emergency preparedness and response: prevention, protection, response, recovery, and mitigation.[44]

Strategies 10.2b–10.2f were developed by the Communications, Misinformation, and Public Trust Work Group of the Carolinas Pandemic Preparedness Task Force.

The Communications, Misinformation, and Public Trust Work Group

The Communications, Misinformation, and Public Trust Work Group, which included 17 task force members and other key perspectives and experts representing multiple sectors, met three times between February and March 2022 to consider the communication challenges that were caused or exacerbated by the COVID-19 pandemic and develop recommendations and strategies to address these challenges. Chapter 6 (Data-Driven Decision-Making and Effective Communications with the Public) includes additional recommendations developed by the Work Group that are designed to strengthen the communications infrastructure and capabilities of state and local health departments. The following sectors and organizations participated in the Work Group:

- **State and Local Government: North Carolina Department of Health and Human Services, North Carolina Department of Public Instruction, Davidson County Health Department, Durham County Health Department, Granville-Vance County Health Department, Henderson County Department of Public Health**
- **Business: The Biltmore Company; Hanesbrands, Inc.**
- **Health Systems, Associations, and Providers: North Carolina Healthcare Association, Mountain Area Health Education Center, Western North Carolina Health Network**
- **Community Advocates and Representatives: North Carolina Council of Churches, North Carolina Community Engagement Alliance**

STRATEGY 10.2b

Convene quarterly meetings to provide a forum for open discussion and strategic planning.

Local health departments and/or regional coalitions should convene quarterly meetings with local businesses, community-based organizations, faith-based leaders, and other community partners to strategize, develop, and update communication plans that can be leveraged before, during, and after public health emergencies.

DESIRED RESULT

Ongoing, sustainable collaboration and coordination between local health departments, local businesses, community-based organizations, faith-based leaders, and other community partners in the development and implementation of communication strategies that are tailored to their respective audiences with the goal of maximizing the reach of evidence-based public health messages within communities.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The Communications, Misinformation, and Public Trust Work Group emphasized that community perspectives are critical in the development and implementation of public health messages, which must be tailored to the needs of target audiences to be effective. **Strategy 10.2b** promotes collaboration and coordination between diverse perspectives and experts in communities to better understand those needs and develop responsive communication plans. Ongoing, sustainable collaboration and coordination is critical to ensure that communication plans are updated regularly as community needs evolve and to consider new strategies for maximizing the reach of messages. **Strategy 10.2b** also recognizes that local health departments and regional coalitions, where they exist , are central to bringing these partners together to strategize effective, evidence-based public health messages. The Work Group underscored that the capacity of local health departments to serve in a convening role depends on the existence of a robust communications infrastructure as described in **Chapter 6**, as well as on sustainable funding focused on communications and collaborations.

ADDITIONAL CONTEXT

The North Carolina Institute of Medicine convened a Task Force on the Future of Local Public Health in 2021–2022. This task force also recognized the need for enhanced communications training, staffing, and infrastructure in local public health. Its recommendation, in a forthcoming report from the NCIOM, states: Strengthen capabilities and build trust to communicate effectively with diverse community members, media, and policymakers. Strategies outlined in the recommendation include building a community of practice to improve upon collaboration; developing a communication certification program in local public health; and investing in a robust local public health communications framework to better utilize trusted messengers to raise awareness about the role of public health.

Local Public Health in North Carolina

North Carolina has a decentralized local governmental public health system with 86 local health departments serving 100 counties, each governed locally rather than at the state level. There are six district health departments throughout the state that serve two or more counties. Each health department is served by a health director and their staff, and is responsible for essential public health services codified in state statute. The Eastern Band of Cherokee Indians has responsibility for public health services within the Qualla Boundary in Western North Carolina and works with health departments serving counties that border Tribal land. In addition, health departments often collaborate for regional initiatives to enhance and expand their reach while also maximizing resources.

Local health departments fund their work from a variety of sources, such as federal, state, and local appropriations; health insurance payments for services provided; grants; fees; and donations. Of these sources, local health departments rely heavily on local, state, and federal funds, which vary widely across the state.

Along with local and state health departments, public health in North Carolina is served by a variety of essential partners, such as other governmental agencies, nonprofits, community organizations, faith institutions, businesses, schools and academic institutions, and philanthropies.

Source: North Carolina Institute of Medicine, Report from the Task Force on the Future of Local Public Health, Morrisville, NC: Ahead of Print www.nciom.org/publications/

STRATEGY 10.2c

Provide compensation to community-based organizations and community partners for their time, expertise, and contributions.

The North Carolina Department of Health and Human Services, North Carolina Healthcare Association, North Carolina Medical Society, Old North State Medical Society, North Carolina Medical Group Management Association, Western Medical Group Managers Association, and philanthropic organizations should work together to identify sustainable funding sources to provide compensation to partners working in community-based organizations, including consumers, patients, and people with relevant lived experiences, for their time, expertise, and contributions.

DESIRED RESULT

The identification of sustainable funding sources to ensure that partners working in community-based organizations in order to provide diverse and important perspectives are adequately compensated for their time, expertise, and contributions with the goal of ensuring their ability to continue to work alongside the North Carolina Department of Health and Human Services and health care systems and professional associations across the state. Promoting ongoing collaboration between state, regional, and local partners would serve to strengthen coordination during times of crisis, which is essential in the absence of a coordinated federal response strategy.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force recognized that the thoughtful and intentional inclusion of consumers, patients, and others with lived experiences provides invaluable insight into the perspectives and needs of the groups they represent. During the COVID-19 pandemic, community partners have also supported communication strategies, helped to deliver public health messages as trusted messengers, and addressed questions and concerns that have arisen within their communities, which has helped to reduce the impact of misinformation. **Strategy 10.2c** aims to bring NCDHHS and representatives from health care associations across the state together to identify sustainable funding sources to enable the compensated inclusion of key community-level perspectives in state and regional initiatives before, during, and after public health emergencies.

ADDITIONAL CONTEXT

The North Carolina Department of Health and Human Services, the North Carolina Healthcare Association, North Carolina Medical Society, Old North State Medical Society, North Carolina Medical Group Management Association, Western Medical Group Managers Association, and philanthropic organizations are the entities involved in **Strategy 10.2c**.

Over the course of the pandemic, many initiatives aimed at building partnerships with state and local agencies and community organizations arose in order to combat misinformation, identify priority strategies for reducing risk of infection and death, and provide needed services, such

as increased testing and vaccine distribution, in an equitable way. For example, Healthier Together: Health Equity Action Network is a public private partnership between NCDHHS and the NC Counts Coalition that aims to increase the number of Black, Indigenous, and People of Color (BIPOC) and other members of historically marginalized populations who receive COVID-19 vaccinations across the state. Funded by federal COVID-19 relief dollars, Healthier Together works with organizations led and supported by BIPOC communities to increase vaccine access in these communities through outreach, education, vaccine events, and assistance with scheduling, transportation, and interpretation needs. The initiative also provides grants directly to community-based organizations to work on these goals within their communities. According to NCDHHS, "as we move from COVID-19 response to recovery, we will extend this program's infrastructure as a foundation for a longer-term framework for health equity."[45] The task force recognized the importance of sustainable funding for building such partnerships between government and other organizations, as well as the need for funding directly to these organizations to ensure that strategies are driven by community identification of assets, strengths, and challenges.

NCDHHS also designed the NC Community Health Worker (CHW) Program and Support Services Program (SSP) to provide an equitable coordination of services, including social services and material goods, that individuals with COVID-19 may need while ill and isolating or in quarantine. As cases rose in the spring and summer of 2020, and disparate impacts across historically marginalized communities were identified, the CHW and SSP program were linked through a technology platform, allowing community health workers to act as resource navigators, connecting those in need with support services programs. Implementers of the program have identified "building on local capacity, trusted partners, and longstanding relationships," as well as the prioritization of "historically marginalized populations in program design, implementation, and ongoing monitoring," as key to the success of the program. Sustaining an infrastructure for compensated partnerships can help ensure that this and other programs are able to maintain these goals.[46]

STRATEGY 10.2d

Provide funding to support community engagement and partnerships in order to support meaningful inclusion of key community perspectives.

The North Carolina General Assembly should (1) provide additional state appropriations to support state and local public health infrastructure, including positions focused on community engagement, small business support, and partnerships, and (2) provide state appropriations to increase capacity among community-based organizations to engage and partner with local health departments; the Departments of Health and Human Services, Commerce, Labor, and Agriculture and Consumer Services; the Economic Development Partnership of North Carolina; and other organizations.

DESIRED RESULT

Expanded capacity among state and local health departments to meaningfully engage and partner with community-based organizations, small businesses, and other key partners, as well as funding to provide compensation to community partners for their time, expertise, and contributions. Please also see final report from the Task Force on the Future of Local Public Health for additional recommendations and context on local public health funding, available at www.nciom.org/publications/

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force identified the need for additional state appropriations to ensure that NCDHHS and local health departments have dedicated staff focused on community engagement, small business support, and building and maintaining cross-sector partnerships in communities as part of a robust public health infrastructure. The task force also identified the need for additional state appropriations to ensure that community-based organizations and other key partners in communities (including consumers of services and/or persons with lived experience) have the capacity to work with state and local entities before, during, and after public health emergencies.

STRATEGY 10.2e

Establish an advisory group to ensure the inclusion of business and private-sector emergency management representatives in preparedness, response, and recovery planning.

The North Carolina Department of Health and Human Services, North Carolina Association of Local Health Directors, North Carolina Emergency Management, North Carolina Department of Commerce, and NC Chamber should establish an advisory group charged with developing strategies to ensure the ongoing, sustainable inclusion of business and private-sector emergency management representatives in public health emergency preparedness, response, and recovery planning.

DESIRED RESULT

The meaningful inclusion of business and private sector emergency management representatives in public health emergency preparedness, response, and recovery planning to promote alignment and increased understanding of needs and priorities.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The task force and the Communications, Misinformation, and Public Trust Work Group both elevated the need for business representatives to be meaningfully and sustainably included in public health emergency preparedness, response, and recovery planning. To achieve this goal, both groups encouraged the formation of an advisory group to strategize the engagement and inclusion of business and private-sector emergency management perspectives in planning processes. The Work Group also described the Lowe's Emergency Command Center as an example of private sector emergency preparedness, response, and recovery planning, emphasizing this work as a potential opportunity for alignment with local and state-level agencies.[47]

ADDITIONAL CONTEXT

The North Carolina Department of Health and Human Services, North Carolina Association of Local Health Directors, North Carolina Emergency Management, North Carolina Department of Commerce, and NC Chamber are the entities involved in **Strategy 10.2d**.

During the pandemic, innumerable initiatives have aimed to ensure effective connection and partnerships between state agencies, health systems, and business interests. These collaborations have generally provided opportunities for cross-organization learning about the impacts of COVID-19—including from the impacts of mitigation strategies such as closures and of financial and material relief to businesses from federal and state sources. Initiatives such as the Business Pulse Survey, launched through the North Carolina Department of Commerce in partnership with the NC Works Commission and myFutureNC, with additional support from the Duke Energy Foundation, aim to understand the ongoing experiences of businesses, particularly with regard to conditions and staffing impacts.[48] Other state agencies, including NCDHHS and the North Carolina Pandemic Recovery Office, have coordinated with the NC Department of Administration's Historically Underutilized Business Office (HUB office) to ensure that historically underutilized small businesses have full access to economic recovery assistance and supports.[49]

However, the Work Group recognized the need for sustained and ongoing connection between business and policymakers, particularly during the development of emergency plans and mitigation policies at the beginning of, and throughout, a public health emergency. While recognizing efforts to alleviate economic and other impacts on businesses after they occur, the Work Group also encouraged state agencies to ensure the incorporation of business perspectives and leadership throughout the planning and implementation phases of emergency response.

STRATEGY 10.2f

Explore state-level opportunities to improve collaboration and coordination with entities outside of North Carolina.

The North Carolina Department of Health and Human Services should (1) consider opportunities to strengthen the partnership between state and local public health and the Centers for Disease Control and Prevention (CDC) to increase awareness of resources and tools needed locally, regionally, and statewide, and (2) engage with entities receiving CDC funding to promote coordination.

DESIRED RESULT

Improved collaboration and coordination between state and local health leaders and the CDC to increase awareness of North Carolina-specific needs at the federal level, along with improved engagement between entities receiving CDC funding outside of North Carolina to promote cross-state learning.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

The Communications, Misinformation, and Public Trust Work Group emphasized that the lack of a coordinated national response to the COVID-19 pandemic caused fragmentation and variation in state and local efforts to mitigate the spread of the virus in North Carolina and across the United States.[50] The Work Group also shared that throughout the pandemic, CDC guidance has often changed without adequate notice, making it difficult for states, counties, and cities to prepare for an influx of questions from the media and their communities around the interpretation and translation of new or revised guidance into practice. The task force noted that in some cases, this led to different counties or local health departments giving advice that conflicted with neighboring counties or state agencies. Work Group members noted that on several occasions, local health departments became aware of evolving CDC guidance when media outlets reached out for comment. **Strategy 10.2f** encourages the North Carolina Department of Health and Human Services, as the state's lead public health agency, to explore opportunities to strengthen communication between public health agencies across the state and the CDC in anticipation of future outbreaks of infectious disease and other public health emergencies.

> **"The U.S. government's structure meant that much of the pandemic response was left up to state and local leaders. In the absence of a strong national strategy, states implemented a patchwork of largely uncoordinated policies that did not effectively suppress the spread of the virus. This caused sudden, massive spikes of infections in many local outbreaks, placing enormous strain on health care systems and leaving no region untouched by the disease. 'Every district, every county, every state could make decisions and keep them to themselves,' [Dr. Monica] Gandhi says. 'And we just have uneven applications of public health recommendations in a way that I can't imagine any other country does.'"[51]** ***– Lewis T. How the U.S. Pandemic Response Went Wrong—and What Went Right—during a Year of COVID. Scientific American.***

ADDITIONAL CONTEXT

The North Carolina Department of Health and Human Services is the organization involved in **Strategy 10.2f**.[52] NCDHHS, in its Interim Response Report, noted that guidance received from the CDC was at times insufficient to guide how individuals and sectors should develop effective policies or make day-to-day decisions about risk and response. NCDHHS pointed to specific guidance it developed and distributed across sectors, including early care and education, K–12 schools, higher education, small and large businesses, and high-risk workplace settings, as well as individuals at higher risk. In the report, NCDHHS noted the lessons learned regarding this guidance, including the need for "concrete, specific advice that could support (stakeholders) in making hard calls."[53]

The Work Group also recognized the need for coordination on communicating this sort of guidance across local public health and other sectors. This aligns with recommendations from the 2021–2022 North Carolina Institute

of Medicine Task Force on the Future of Local Public Health, which has recommended several strategies to strengthen capabilities and build trust in order to communicate effectively with diverse community members, media, and policymakers. These strategies will serve to build the capacity of local public health to coordinate and effectively communicate messages across the state and within and between counties.[h]

RECOMMENDATION 10.3

RECOMMENDATION 10.3

Sustain and strengthen partnerships between school districts, local public health departments, and community partners.

Strategy 10.3a: The North Carolina General Assembly should amend § 115C-81.30(f) to define school health coordinators as employed by public schools and charter schools, also known as Public School Units (PSU), for the purposes of (1) providing support for any portions of the comprehensive health education programs for public and charter schools, (2) serving as liaisons between the local health department and public and charter schools, and (3) providing support for the policy recommendations that School Health Advisory Councils (SHACs) develop.

Strategy 10.3b: The North Carolina General Assembly should provide funding annually for dedicated school health coordinators for each PSU to carry out the responsibilities defined in Strategy 10.3a.

Strategy 10.3c: The State Board of Education should revise administrative code HSP-S-000 (The Healthy Active Children Policy) to require the following representation on School Health Advisory Councils: (1) the local public health department, (2) the office of the district's superintendent, and (3) the PSU school health coordinator.

STRATEGY 10.3a

Define the roles and responsibilities of school health coordinators to support their use by PSU.

The North Carolina General Assembly should amend § 115C-81.30(f) to define school health coordinators as employees of each PSU for the purposes of (1) providing support for of any portions of the comprehensive health education programs for public and charter schools, (2) serving as liaisons between the local health department and public and charter schools, and (3) providing support for the policy recommendations that School Health Advisory Councils (SHACs) develop.

DESIRED RESULT

Strategy 10.3a would allow for dedicated staff in PSU to foster communication and streamline collaboration between PSU, local public health departments, school health, NCDHHS, and local DHHS agencies.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

Contact tracing and the coordination needed to facilitate COVID-19-related mitigation efforts required coordination between a variety of local public health and school staff personnel.[54] School nurses were responsible for facilitating a large portion of the NCDHHS toolkits for safe return to schools in 2020 and 2021,[55,56] including enforcing mask guidance and quarantine and isolation policies, but the average school nurse-to-student ratio in North Carolina is 1:890,[57] and nurses are often responsible for multiple schools (see **Chapter 9**: Addressing Disparities to Promote Whole-Person Health and Economic Stability).[58] Defining school health coordinators as standalone positions (not a school nurse or other school staff functioning as a coordinator) would enable greater coordination between PSU, local public health departments, school health, NCDHHS, School Health Advisory Councils, and local DHHS agencies. This coordination and collaboration would streamline communication around rapidly changing guidance during public health emergencies, reduce redundancies across state and local agencies, and provide a coordinated whole-person health effort in PSU.

Table 2.[59] Coordinated School Health

Coordinated school health is a statewide model that has been used by states including Tennessee to streamline school health programs at the local level and promote consistency in services available to students. In 2021, the Tennessee Department of Education published a report on coordinated school health that explains the value of this approach:

"Coordinating the many parts of school health into a systematic approach enables schools to:

- eliminate gaps and reduce redundancies across initiatives and funding streams;
- build partnerships and teamwork among school health and education professionals;
- build collaboration and enhance communication among public health, school health, and other education and health professionals in the community; and focus their efforts on helping students engage in protective, health-enhancing behaviors and avoid risky behaviors."[59]

[h] *North Carolina Institute of Medicine. Task Force on the Future of Local Public Health: Report from the Task Force. Ahead of print. 2022.*

ADDITIONAL CONTEXT

Since 2006, Tennessee has allocated tens of millions of dollars annually to coordinated school health in order to promote evidence-based practices designed to create healthy school environments.[59] School health coordinators in Tennessee assumed the following additional responsibilities to support the state's COVID-19 response: contact tracing and support in schools; collecting COVID-19 case counts in schools; reporting school case counts to health departments; interpreting state and national guidelines; communicating those guidelines with staff and families; and ordering and distributing PPE to schools.[59] In North Carolina, most of those responsibilities were added to the existing workload of administrators, teachers, school nurses, and other school staff.[54]

Since 2003, every school district has been required to establish a School Health Advisory Council (SHAC)[i] composed of individuals from the community who represent various health and education entities, including but not limited to medical professionals, social service agencies, community-based organizations, the faith community, governmental officials, and school staff. SHACs are responsible for identifying areas for growth related to school health based on needs assessments, but often require organizations, businesses, and community-based organizations that are not members of the SHAC to carry out the recommendations they develop.[60] School health coordinators could participate in their district's SHAC; foster and develop relationships with health-related leaders in the community through that participation on the SHAC; and work with community members to lead the change around policy recommendations developed by their SHAC.

STRATEGY 10.3b

Provide funding to support school health coordinators in each PSU.

The North Carolina General Assembly should provide funding annually for a dedicated school health coordinator for each PSU to serve as the liaison to the local public health department and oversee the recommendations provided by School Health Advisory Councils in support of Strategy 10.3a.

DESIRED RESULT

Recurring funding for dedicated school health coordinators in each PSU would enable **Strategy 10.3a**.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

Coordinated school health efforts in North Carolina have been funded by grants from philanthropies and the federal government for decades.[61] To sustain coordinated school health, state funds are needed to cover the salaries and benefits of staff dedicated to this purpose in each PSU.

STRATEGY 10.3c

Ensure representation from key perspectives on School Health Advisory Councils.

The State Board of Education should revise administrative code HSP-S-000 (The Healthy Active Children Policy) to require the following representation on School Health Advisory Councils: (1) the local public health department, (2) the office of the district's superintendent, and (3) the PSU school health coordinator.

DESIRED RESULT

Strategy 10.3c would allow SHAC meetings to serve as an important space for discussions, policy recommendations, and dissemination of information during public health emergencies. Partnerships between the primary decision-makers at the local level for school health would be established prior to any emergency that occurred.

WHY DOES THE TASK FORCE RECOMMEND THIS STRATEGY?

SHACs are composed of a variety of members, and SHACs were designed to have flexible membership requirements in order to be responsive to community needs.[60] Maintaining that flexibility but requiring representation from the local public health department, the office of the school district's superintendent, and the participation of the PSU school health coordinator would allow for the primary school health decision-makers to be involved in the policy recommendation process while gaining input from other community representatives on the SHAC. Representation from local public health and the office of the school district's superintendent would increase regular communication between both entities, strengthen school health partnerships, and decrease redundancy of efforts around school health.

[i] *North Carolina State Board of Education HSP-S-000, Healthy Active Children Policy, https://studylib.net/doc/10701099/north-carolina-state-board-of-education-policy-manual-pol*

1. Hathaway WR, Mims SR, Ellis D, et al. Pandemic-driven Community Collaboration in Western North Carolina: The Silver Lining Around the COVID-19 Cloud. *N C Med J*. 2021;82(4):259-265. doi:10.18043/NCM.82.4.259
2. Rozell MJ, Wilcox C. Federalism in a Time of Plague: How Federal Systems Cope With Pandemic: *https://doi.org/101177/0275074020941695*. 2020;50(6-7):519-525. doi:10.1177/0275074020941695
3. Haffajee RL, Mello MM. Thinking Globally, Acting Locally — The U.S. Response to Covid-19. *New England Journal of Medicine*. 2020;382(22):e75. doi:10.1056/NEJMP2006740/SUPPL_FILE/NEJMP2006740_DISCLOSURES.PDF
4. Bowling CJ, Fisk JM, Morris JC. Seeking Patterns in Chaos: Transactional Federalism in the Trump Administration's Response to the COVID-19 Pandemic: *https://doi.org/101177/0275074020941686*. 2020;50(6-7):512-518. doi:10.1177/0275074020941686
5. Huang J, Fisher BT, Tam V, et al. The Effectiveness Of Government Masking Mandates On COVID-19 County-Level Case Incidence Across The United States, 2020. *Health Aff (Millwood)*. 2022;41(3):445-453. doi:10.1377/HLTHAFF.2021.01072/ASSET/IMAGES/LARGE/FIGUREEX3.JPEG
6. Hanage WP, Testa C, Chen JT, et al. COVID-19: US federal accountability for entry, spread, and inequities—lessons for the future. *Eur J Epidemiol*. 2020;35(11):995. doi:10.1007/S10654-020-00689-2
7. AJMC Staff. A Timeline of COVID-19 Developments in 2020. Published January 1, 2021. Accessed September 2, 2022. https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020
8. NC Department of Health and Human Services. *COVID-19 Response Interim Review*.; 2020.
9. Sales C, Kim Y, Kim G, Lin B, Palaniappan L. Precision public health matters: An international assessment of communication, preparedness, and coordination for successful COVID-19 responses. *Am J Public Health*. 2021;111(3):392-394. doi:10.2105/AJPH.2020.306129
10. Malecki KMC, Keating JA, Safdar N. Crisis Communication and Public Perception of COVID-19 Risk in the Era of Social Media. *Clinical Infectious Diseases*. 2021;72(4):697-702. doi:10.1093/CID/CIAA758
11. National Institutes of Health. Statement on Misinformation about SARS-CoV-2 Origins. Published October 20, 2021. Accessed September 2, 2022. https://www.nih.gov/about-nih/who-we-are/nih-director/statements/statement-misinformation-about-sars-cov-2-origins
12. Nuzzo JB, Bell JA, Cameron EE. Suboptimal US Response to COVID-19 Despite Robust Capabilities and Resources. *JAMA*. 2020;324(14):1391-1392. doi:10.1001/JAMA.2020.17395
13. Federal Emergency Management Agency. *Building Private-Public Partnerships*.; 2021.
14. WNC Health Network. WNC Healthy Impact. Accessed August 8, 2022. https://www.wnchn.org/wnc-healthy-impact/about/
15. Centers for Disease Control and Prevention. "My Reason WNC" Regional COVID-19 Communications. Published February 28, 2022. Accessed September 2, 2022. https://www.cdc.gov/vaccines/covid-19/health-departments/features/campaign-western-north-carolina.html
16. Latin-19. What We Do. Accessed September 2, 2022. https://latin19.org/what-we-do/
17. Atrium Health News. Public-Private Partnership Commits to 1 Million Vaccinations by July 4. Published January 14, 2021. Accessed September 2, 2022. https://atriumhealth.org/about-us/newsroom/news/2021/01/public-private-partnership-targets-1-million-vaccinations-by-july-4
18. Honeywell. What You Should Know about 1 Million Vaccines in North Carolina. Accessed September 2, 2022. https://www.honeywell.com/us/en/news/2021/01/what-you-should-know-about-1-million-vaccines-in-north-carolina
19. North Carolina Collaboratory. COVID-19 Research Projects. Accessed September 2, 2022. https://collaboratory.unc.edu/covid-19-research/
20. Radwan R. The COVID-19 pandemic has devastated nursing homes. What should North Carolina's policy priorities be? Published 2021. Accessed September 2, 2022. https://collaboratory.unc.edu/wp-content/uploads/sites/476/2021/08/what-should-north-carolinas-policy-priorities-be-for-nursing-homes-during-the-pandemic.pdf
21. NC Policy Collaboratory. Identifying and Mitigating the Financial Impact on Water and Wastewater Utilities. Accessed September 2, 2022. https://collaboratory.unc.edu/wp-content/uploads/sites/476/2020/09/mullins-project-spotlight.pdf
22. Federal Emergency Management Agency. Stafford Act, as Amended vol. 1 . Published online May 2021:592.
23. Federal Emergency Management Agency. How a Disaster Gets Declared. Accessed September 2, 2022. https://www.fema.gov/disaster/how-declared
24. Federal Emergency Management Agency. National Response Framework. Accessed September 2, 2022. https://www.fema.gov/emergency-managers/national-preparedness/frameworks/response
25. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A, Appendix 1. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10959/download?attachment
26. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A, Appendix 2. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10961/download?attachment
27. NC Department of Public Safety, NC Emergency Management. *2021 North Carolina Emergency Operations Plan*.; 2021.
28. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A, Appendix 4. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10962/download?attachment
29. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A, Appendix 5. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10963/download?attachment
30. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A, Appendix 6. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10964/download?attachment
31. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A, Appendix 7. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10965/download?attachment
32. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A, Appendix 8. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10966/download?attachment
33. Payne-Hurley P. Creating a More Disaster-Resilient State . North Carolina Emergency Management . Accessed September 2, 2022. https://www.fhwa.dot.gov/Planning/freight_planning/talking_freight/july_2018/talkngfreight7-18-18pph.pdf
34. NC Healthcare Preparedness Program. About Us. Accessed September 2, 2022. https://hpp.nc.gov/about/
35. Federal Emergency Management Agence. Homeland Security Grant Program. Accessed September 2, 2022. https://www.fema.gov/grants/preparedness/homeland-security
36. NC Division Health Services Regulation, OEMS. Healthcare Preparedness Program (HPP). Accessed September 2, 2022. https://info.ncdhhs.gov/dhsr/ems/aspr/index.html
37. NC Department of Public Safety. Emergency Management. Accessed September 2, 2022. https://www.ncdps.gov/our-organization/emergency-management

38. Lazere E, Hinh I. *How States Can Best Use Federal Fiscal Recovery Funds: Lessons From State Choices So Far*.; 2022. https://apnews.com/article/ap-norc-poll-people-of-color-covid-19-economy-
39. NC Emergency Management. *2020 North Carolina Emergency Operations Plan*.
40. Cooper R, Cohen M. Letter to NCDHHS Partners and Stakeholders. Published online April 15, 2021.
41. NC Department of Public Safety. North Carolina Emergency Operations Plan Annex A. Published 2021. Accessed September 2, 2022. https://www.ncdps.gov/media/10960/download?attachment
42. Michener L, Aguilar-Gaxiola S, Alberti PM, et al. Engaging With Communities — Lessons (Re)Learned From COVID-19. *Prev Chronic Dis*. 2021;17. doi:10.5888/PCD17.200250
43. United States Department of Agriculture. ICS 100-Incident Command System. Accessed September 13, 2022. https://www.usda.gov/sites/default/files/documents/ICS100.pdf
44. NC.gov. North Carolina Emergency Operations Plan . Published online December 2020.
45. NC Department of Health and Human Services. Healthier Together — Health Equity Action Network. Accessed September 1, 2022. https://covid19.ncdhhs.gov/HealthierTogether
46. North Carolina Department of Health and Human Services. *The North Carolina Community Health Worker and Support Services Programs: Promoting Safe Quarantine and Isolation for COVID-19 Marginalied Populations*.; 2021. Accessed September 13, 2022. https://www.pih.org/sites/default/files/lc/LT-CRC_case_study_NC_march_2021_Final.pdf
47. Lowe's Corporate. Lowe's teams ready as Hurricane Harvey hits Texas coast. Accessed September 2, 2022. https://corporate.lowes.com/newsroom/stories/inside-lowes/lowes-teams-ready-hurricane-harvey-hits-texas-coast
48. NC Commerce. Business Pulse Survey. Accessed September 1, 2022. https://www.nccommerce.com/data-tools-reports/economic-development-reports/business-pulse-survey
49. Office of the Governor. Governor Cooper Signs Executive Order to Address Disproportionate Impact of COVID-19 on Communities of Color. Published June 4, 2020. Accessed July 24, 2022. https://governor.nc.gov/news/governor-cooper-signs-executive-order-address-disproportionate-impact-%EF%BB%BF-covid-19-communities
50. Altman D. Understanding the US failure on coronavirus. *BMJ*. 2020;370:m3417. Doi:10.1136/BMJ.M3417
51. Lewis T. How the U.S. Pandemic Response Went Wrong—and What Went Right—during a Year of COVID. Scientific American. Accessed September 2, 2022. https://www.scientificamerican.com/article/how-the-u-s-pandemic-response-went-wrong-and-what-went-right-during-a-year-of-covid/
52. LaFraniere S, Weiland N. Walensky, Citing Botched Pandemic Response, Calls for C.D.C. Reorganization. *The New York Times*. https://www.nytimes.com/2022/08/17/us/politics/cdc-rochelle-walensky-covid.html?smid=nytcore-ios-share&referringSource=articleShare. Published August 17, 2022. Accessed September 1, 2022.
53. North Carolina Department of Health and Human Services. *COVID-19 Response Interim Review*.; 2022. Accessed September 2, 2022. https://covid19.ncdhhs.gov/media/3773/open
54. North Carolina Department of Health and Human Services, Division of Public Health. Staffing Healthcare in Schools for COVID-19. Published May 2021. Accessed July 6, 2022. https://www.dph.ncdhhs.gov/wch/cy/docs/StaffingHealthCareinSchoolsforCOVID.pdf
55. NC Department of Public Instruction. *Lighting Our Way: North Carolina's Guidebook for Reopening Public Schools*.
56. North Carolina Department of Health and Human Services. StrongSchoolsNC public health toolkit (K-12) : interim guidance - State Publications II - North Carolina Digital Collections. Published June 2020. Accessed July 6, 2022. https://digital.ncdcr.gov/digital/collection/p16062coll9/id/700937
57. Nichols A, Essick E. Specialized Instructional Support. In: *Child Fatality Task Force*. ; 2022.
58. Program Evaluation Division, North Carolina General Assembly. *Meeting Current Standards for School Nurses Statewide May Cost Up to $79 Million Annually*.; 2017.
59. Tennessee Department of Education. *Coordinated School Health: 2020-2021 Annual Report*.; 2021.
60. State Board of Education NCDPI NCDHHS. *Effective School Health Advisory Councils: Moving from Policy to Action*.; 2003.
61. North Carolina Department of Health and Human Services, Division of Public Health. School Health Unit. *History of the School Health Program in North Carolina*.; 2020.