Updates from the CMO

Shannon Dowler, MD

December 2020
Top Priorities: Clinical, Quality, Pop Health

Non-Managed Care
- Evaluate telehealth use & Finalize permanent changes (post PHE)
- Annual Quality Report
- Health Equity scrub on CCP
- National Speaking on Telehealth
- Electronic Visit Verification
- Develop Physician Leadership
- Listening Sessions Future of Value Based Care
- BCCCP qualification change
- Family Planning modernization
- Creation of Easy Button for Clinical Policy coverage
- LTC and Vaccine COVID Response
- Launch time-limited payments:
  - Social Determinants screening and diagnosis
  - Health Equity

Managed Care
- Engagement: Fireside Chats & AMH Webinars
- Operationalize AMH changes
- Socialize:
  - Attestation Process for Clinical Policy
  - PCP Attribution
  - AMH Glidepath Requirements
- Partner with Specialty Societies
- Design Thinking: Oversight
- CMARC/CMHARP Transition
- Engage Providers: timely contracting, accuracy of practice information, establishing AMH level, PCP assignment accuracy, understanding attribution, maintaining continuity of care
Two Questions

What do you need in May to feel confident we are on a path to success for a July launch?

How will you know in mid-July the transition to Managed Care was successful?
REFRESHER: Advanced Medical Homes

Goal: provide a pathway for practices to have a larger role in managing the health outcomes and cost for their patient populations

Guiding principles

1. Preserve broad access to primary care services for enrollees
2. Strengthen the role of primary care in care management, care coordination, and quality improvement
3. Provide clear incentives for practices to become more focused on cost and quality outcomes, increasing accountability over time

Expectations are high:
- Penetration rates are much higher than current
- Location of care is designed to be highly community-based
- Need to address the continuum of care needs from rising risk to high risk to unmet social needs

AMH program represents an opportunity for providers to fund population health investments critical to a VBP environment!
NEW Program Incentives and Supports

The Department considered the best ways to help AMH Tier 3 practices prepare for launch.

Changes will:

- Add new payment stream for practices in the run-up to launch
- Emphasize importance of data exchange to support AMH Tier 3
- Provide options for practice supports prior to launch
- Standardize quality measures and reporting
- Protect Care Management Rates
AMH Tier 3 Glide Path Payments

DHHS will implement a new $8.51 PMPM payment stream to AMH Tier 3 practices **90 days prior to the launch of Managed Care** to assist with and incent Tier 3 preparation.

**Tier 3 Glide Path Payment Eligibility Criteria**

1. AMH Tier 3 within NC Tracks
2. **Contracting completed** with at least two PHPs
3. **Data exchange testing successfully completed** with at least two PHPs
4. Practice has completed attestation in NC Tracks provider portal that items 2-3 complete.

*DHHS will release additional details on the above criteria prior to launch.*

Payments will flow to practices in the same way as current CA II Payments. Qualifying practices will receive $8.51 PMPM direct from NC Tracks for each month in which they meet the conditions shown at left, up to three times.

- **April 2021** — “Opportunity 1”
- **May 2021** — “Opportunity 2”
- **June 2021** — “Opportunity 3”
- **July 2021** — Launch

To reinforce the importance of AMH Tier 3 data exchange, DHHS is also adding a new liquidated damage (enforceable after launch) on PHPs for failure to transmit a beneficiary assignment file or claims to an AMH Tier 3 practice (or CIN/Other Partner) within the Department’s published data specifications.
NC AHEC will offer practice support and education aligned with the AMH program.

AHEC practice supports will include:

**AMH Practice Coaching**
- Starting in January, AHEC coaches will work with individual practices to accelerate adoption of Tier 3 standards and facilitate transition, starting with a standardized assessment tool
- Available to primary care practices who are in network with at least one Standard Plan
- PHPs may refer practices that need assistance meeting AMH standards

**Education**
- AHEC will offer webinars, tip sheets, bulletins and other mass communications on the AMH program
- Education will be geared toward all interested Medicaid practices

First webinar: December 10, 2020. Registration information will be posted [here](#).
AMH Quality Measures

DHHS has streamlined the AMH Measure Set to simplify AMH quality reporting and performance incentive payment arrangements. **PHPs will be required to use only these measures to develop AMH performance incentive payments.**

**Updated AMH Measure Set**

- Adolescent Well-Care Visit
- Childhood Immunization Status (Combination 10)
- Immunization for Adolescents (Combination 2)
- Screening for Depression and Follow-up Plan
- Well-Child Visits in the First 15 Months of Life
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- Controlling High Blood Pressure
- Plan All Cause Readmission-Observed to Expected Ratio

**Other Measures**

PHPs will also be required to share total cost of care information with AMH practices. DHHS will publish additional guidance on sharing total cost of care information with practices at a later date.
The Department has finalized several policies regarding Year 1 AMH Tier 3 payments:

1. **Guaranteed care management fees**—PHPs may not place Tier 3 practices’ care management fees at risk based on AMH performance or any other metrics. PHPs must pay the full negotiated care management fee amount to all contracted Tier 3 practices.

2. **Use of AMH Measure Set for Tier 3 Performance Incentives**—PHPs must offer performance incentive payments in all Tier 3 contracts. These payments must be based only on the AMH measure set, and may not factor in performance on measures beyond those included in the AMH measure set.
NC Electronic Verification Visit (EVV) Implementation Update

• What is it:
  – method used to verify visit activity statewide for services delivered as part of home- and community-based service programs.
  – EVV offers a measure of accountability to help ensure that individuals who are authorized to receive services in fact receive them.

• NC DHHS awarded a contract to Sandata Technologies, LLC on Sept. 24, 2020 and will begin on statewide on Jan. 1, 2021.

• The system is an Open Model which means, State Plan PCS, CAP/DA, and CAP/C Providers can use the Sandata EVV System free of charge or elect to use a system they have chosen. LME/MCOs and PHPs will select an EVV vendor and submit encounter/claims for aggregation.

• NC Medicaid provided an initial training on November 12, for providers on the Alt EVV process and will continue to work closely with providers though the pre-launch and post launch phases.

• Provider Training for Regular EVV began November 30 and will continue through post launch Phase.

• NC will go-live with PCS services in Medicaid Direct (FFS) and CAP C and CAP D/A waiver programs January 1, 2021

• NC will go-live with all MC programs (LME/MCOs and PHPs) July 1, 2021.

### Timeline Phase Milestones

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Phase</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct - Dec 2020</td>
<td>Pre-Launch</td>
<td>Initial provider training and credentialing, SIT, UAT testing, Provider Survey and Registration</td>
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<tr>
<td></td>
<td></td>
<td>Vendor Outreach, Creation of Vendor Interface, Sandata Vendor Support, Vendor Credentialing and testing, EVV Data Deliveries</td>
</tr>
<tr>
<td>Jan- Mar 2021</td>
<td>Launch</td>
<td>EVV System Go-live; On-going Training; Evaluation (first KPI report)</td>
</tr>
<tr>
<td>Apr-Jun 2021</td>
<td>Post Launch</td>
<td>System implemented with full functionality for FFS</td>
</tr>
<tr>
<td>April 2021</td>
<td>MC Launch</td>
<td>PHPs and LME/MCOs go-live</td>
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Agenda

- Status of Vaccine Development
- NC Vaccine Response Principles
- Priority Groups
- Overview of Plan
- Provider Enrollment
- Communications
- Questions
The COVID-19 Vaccine Development Process

Developing, Manufacturing and Distributing a COVID-19 Vaccine

Multiple COVID-19 vaccines are being developed. Thousands of people have volunteered as part of research trials to see if a vaccine prevents COVID illness and to learn more about its safety in these overlapping steps. Promising vaccines are being manufactured at the same time they are being tested, so there will be an initial supply ready to go right away when the science shows which vaccines are found to be safe and effective. Once we have a vaccine or vaccines, it will still be some time before it is widely available to everyone. States will receive limited supplies at the start. North Carolina is drawing upon the experience and expertise of leaders from historically marginalized communities to develop and implement its vaccine distribution plan.

PHASE 1 & 2: Safety & Dosing
10s-100s of healthy volunteers
• Are there any side effects? How many volunteers experience side effects?
• What is the best vaccine dose to create an immune response with the fewest tolerable side effects?

PHASE 2 & 3: Safety & Efficacy
>30,000 of volunteers
• Does the vaccine prevent COVID-19 infection?
• What are the most common side effects?
• Do the benefits of the vaccine outweigh the risks?

Approval & Distribution
• FDA reviews the safety and efficacy data to determine if benefits are greater than risks
• An independent, non-FDA scientific committee reviews findings
• Vaccine is authorized and recommended for use (may only be for certain populations)
• Vaccine is labeled for use, benefits, side effects

Manufacturing Preparation: Manufacturing development, scaling up, quality-control testing

Large-Scale Manufacturing: Making millions of vaccine doses for nationwide distribution, continued quality-control testing of vaccine batches and manufacturing facilities, FDA and CDC continually monitor vaccinated patients for safety

Availability: Limited availability in the beginning. More widely available over time.

https://files.nc.gov/covid/documents/Vaccine-Timeline.pdf
## Two Leading COVID-19 Vaccine Candidates

<table>
<thead>
<tr>
<th>Pfizer Vaccine</th>
<th>Moderna Vaccine</th>
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<tbody>
<tr>
<td><strong>Preliminary Efficacy Data</strong></td>
<td><strong>Timing of EUA</strong></td>
</tr>
<tr>
<td>Nov 18 Press Release data analysis reported 95% effectiveness in preventing illness. 162/170 cases were in placebo group 9/10 severe cases were in placebo group Phase 3 trial included over 43,000 participants, 42% with diverse backgrounds.</td>
<td>November 30 Press Release data analysis 94.1% effectiveness in preventing illness. 185/196 cases were in placebo group 30/30 severe cases were in placebo group Phase 3 trial included 30,000 adult participants, 37% with diverse backgrounds.</td>
</tr>
<tr>
<td><strong>Temperature and Storage</strong></td>
<td>Applied for EUA 11/20/20  FDA Review Dec 8-10</td>
</tr>
<tr>
<td>Requires ultra-cold storage (-75 degrees Celsius). Lasts up to 5 days at refrigerated temperatures.</td>
<td>Requires storage at -20 degrees Celsius (similar to the chickenpox vaccine). Lasts up to 30 days at refrigerated temperatures.</td>
</tr>
<tr>
<td><strong>Dosing</strong></td>
<td><strong>Type of Vaccine</strong></td>
</tr>
<tr>
<td>2-dose schedule Administered 21 days apart.</td>
<td>Both vaccines use mRNA technology from the coronavirus’s own genes to have people's cells make viral proteins to trigger immune system to produce antibodies against the COVID virus. mRNA vaccines can be made faster than older vaccines and require frozen storage to remain stable</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
</tr>
<tr>
<td>No reports of serious safety concerns in either vaccine in either the clinical trials. Temporary reactions (e.g., fever, soreness at site of injection, fatigue) noted 24-48 hours after vaccination</td>
<td></td>
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</table>
# Updates on Remaining Operation Warp Speed Candidates

<table>
<thead>
<tr>
<th>Type</th>
<th>AstraZeneca</th>
<th>Johnson &amp; Johnson</th>
<th>Sanofi</th>
<th>Novavax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Non-replicating viral vector</td>
<td>Non-replicating viral vector</td>
<td>Protein Subunit</td>
<td>Protein Subunit</td>
</tr>
<tr>
<td>Phase</td>
<td>Phase II/III</td>
<td>Phase III</td>
<td>Phase I/II</td>
<td>Phase II/III</td>
</tr>
<tr>
<td>Doses Required</td>
<td>Doses: 2 (testing half-dose: full-dose regimen v. two full doses) First interim analysis 90% effective with first half-dose</td>
<td>Doses: 1 or 2 (testing both)</td>
<td>Doses: 1 or 2 (testing both)</td>
<td>Doses: 1</td>
</tr>
<tr>
<td>Transport Temp</td>
<td>36°F - 46°F</td>
<td>36°F - 46°F</td>
<td>36°F - 46°F</td>
<td>36°F - 46°F</td>
</tr>
<tr>
<td>Storage Temp</td>
<td>36°F - 46°F</td>
<td>36°F - 46°F</td>
<td>36°F - 46°F</td>
<td>36°F - 46°F</td>
</tr>
<tr>
<td>Target Supply</td>
<td>3B</td>
<td>1B in 2021</td>
<td>1B by mid 2021</td>
<td>2B+ in 2021</td>
</tr>
<tr>
<td>At Risk US Government Purchase</td>
<td>400M</td>
<td>100M</td>
<td>100M</td>
<td>100M</td>
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</table>

Sources: BioPharma Dive, NIH, ClinicalTrials.gov, Johnson & Johnson News, Sanofi News
Provider agreement language updated to reflect that the vaccine must be provided at no cost to recipient; Vaccine cost covered by federal government; administrative costs covered by Medicare, Medicaid, and commercial insurance; HRSA will reimburse providers for COVID-19 vaccines administered to uninsured individuals.

**Medicaid**
- As long as a state is claiming enhanced Medicaid match as part of the Public Health Emergency, the state must cover, without cost sharing, “any testing services and treatments for COVID-19, including vaccines;” this extends to vaccines authorized via EUA.

**Medicare**
- The CARES Act mandated that Medicare Part B cover a COVID-19 vaccine without any cost sharing in cases where “such vaccine is licensed under section 351 of the Public Health Service Act”; a vaccine authorized by an EUA would not meet this standard.
- To address this gap, CMS announced a new rule on October 28th guaranteeing Medicare coverage for a vaccine approved via EUA; this guarantee applies to beneficiaries enrolled in both traditional Medicare and Medicare Advantage.

**Uninsured**
- HRSA will reimburse providers for COVID-19 vaccines administered to uninsured individuals, once a COVID-19 vaccine receives either an EUA or full licensure from the FDA. Provider Relief Fund (https://www.hrsa.gov/CovidUninsuredClaim)
- Consistent with HRSA’s prior guidance regarding treatment services, an individual with public or private health coverage will be deemed “uninsured” for purposes of the HRSA Program if the individual has a form of health coverage that excludes vaccines (e.g., individuals enrolled in a limited Medicaid family planning program).

**Commercial**
- Current law and regulations require vaccines recommended by ACIP to be covered as an Essential Health Benefit without cost sharing.

**COVID-19 Vaccine Toolkit**
NC COVID-19 Vaccination Plan: Vision of Success

GOAL
Immunize every person living in North Carolina who is eligible and wants to receive a COVID-19 vaccine

GUIDING PRINCIPLES

- All North Carolinians have equitable access to vaccines
- Vaccine planning and distribution is inclusive; actively engages state and local government, public and private partners; and draws upon the experience and expertise of leaders from historically marginalized populations
- Transparent, accurate, and frequent public communications is essential to building trust
- Data is used to promote equity, track progress and guide decision-making
- Appropriate stewardship of resources and continuous evaluation and improvement drive successful implementation
Advocates

• COVID-19 Vaccine Advisory Committee
  • **Purpose:** Provide updates from industry and stakeholders to ensure alignment
  • Group of >60 stakeholders

• Historically Marginalized Populations Advisory Group
  • **Purpose:** Identify and address issues related to HMP in the COVID pandemic response
  • Vaccine team presents regularly to HMP Advisory Group for input and partnership opportunities
  • Group of >80 internal and external stakeholders

• COVID-19 Vaccine Communications Advisory Group
  • **Purpose:** Enhance the development of North Carolina’s COVID-19 Vaccine Communications Plan and to serve as dissemination partners to extend the reach of the communications efforts, especially to prioritized, critical, and historically marginalized populations
COVID-19 Vaccinations: Those most at risk get it first.

A tested, safe and effective vaccine will be available to all who want it, but supplies will be limited at first. Independent state and federal public health advisory committees have determined that the best way to fight COVID-19 is to start first with vaccinations for those most at risk, reaching more people as the vaccine supply increases from January to June. Keep practicing the 3W’s—wear a mask, wait six feet apart, wash your hands—until everyone has a chance to vaccinate.

1. Health care workers fighting COVID-19 & Long-Term Care
   Every health care worker at high risk for exposure to COVID-19—doctors, nurses, and all who interact and care for patients with COVID-19, including those who clean areas used by patients, and those giving vaccines to these workers.

   Long-Term Care staff and residents—people in skilled nursing facilities and in adult, family and group homes.

2. Adults at highest risk of severe illness and those at highest risk for exposure
   Adults with two or more chronic conditions that put them at risk of severe illness as defined by the CDC, including conditions like cancer, COPD, serious heart conditions, sickle cell disease and Type 2 diabetes, among others.

   Adults at high risk of exposure including essential frontline workers (police, food processing, teachers), health care workers, and those living in prisons, homeless shelters, migrant and fishery housing with 2+ chronic conditions.

   Those working in prisons, jails and homeless shelters (no chronic conditions requirement).

3. Adults at high risk for exposure and at increased risk of severe illness
   Essential frontline workers, health care workers, and those living in prisons, homeless shelters or migrant and fishery housing.

   Adults 65+

   Adults under 65 with one chronic condition that puts them at risk of severe illness as defined by the CDC.

4. Students and critical industry workers
   College and university students.

   K-12 students when there is an approved vaccine for children.

   Those employed in jobs that are critical to society and at lower risk of exposure.

5. Everyone who wants a safe and effective COVID-19 vaccination
VACCINE DISTRIBUTION PRIORITIZATION FRAMEWORK

Risk-based prioritization based on National Academy of Medicine Framework for Equitable Allocation of COVID-19 and CDC Advisory Committee Immunization Practice. Refined by input by North Carolina Institute of Medicine Vaccine Advisory Committee. May be revised based on Phase III clinical trial safety and efficacy data and further federal guidance.

<table>
<thead>
<tr>
<th>Phase 1a:</th>
<th>Phase 1b:</th>
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</table>
| **Health care workers at high risk** for COVID-19 exposure based on work duties or vital to the initial COVID vaccine response  
  - High risk of exposure is defined as those caring for COVID-19 patients, cleaning areas where COVID-19 patients are admitted, performing procedures at high risk of aerosolization (e.g., intubation, bronchoscopy, suctioning, invasive dental procedures, invasive specimen collection, CPR), handling decedents with COVID, administering vaccine in initial closed or targeted vaccination clinics.  
  - Population includes: nurses, physicians, respiratory techs, dentists, hygienists, nursing assistants, environmental services staff, EMT/paramedics, home health workers, personal care aides, community health workers, health care trainees (e.g., medical students, pharmacy students, nursing students, etc.), morticians/funeral home staff, pharmacists, public health nurses, public health and emergency preparedness workers who meet the above definition of "high risk of exposure."  
  - **Long Term Care staff and Residents** (e.g., Skilled Nursing Facilities, adult care homes, family care homes, and group homes; individuals with intellectual and developmental disabilities who receive home and community-based services and the workers directly providing those services) | **Adults with high risk of complications** per CDC and staff of congregate living settings  
  **Operationally prioritize settings based on risk of exposure**  
  - Migrant farm and fisheries workers in congregate housing with 2+ Chronic Conditions* or ≥ age 65  
  - Incarcerated individuals with 2+ Chronic Conditions* or ≥ age 65 and jail and prison staff  
  - Homeless shelter residents with 2+ Chronic Conditions* ≥ 65 and homeless shelter staff  
  - Health care workers not included in Phase 1A with 2+ Chronic Conditions  
  - Frontline workers with 2+ Chronic Conditions at high risk of exposure (e.g., firefighters, police, workers in meat packing plants, seafood and poultry not in congregate housing, food processing, preparation workers and servers, manufacturing, construction, funeral attendants and undertakers not included in Phase 1A, transportation workers, retail workers (including grocery store workers), membership associations/org staff (e.g., religious orgs), education staff (e.g., child care, K-12 or IHE) and workers in government, public health, emergency management and public safety whose functioning is imperative to the COVID-19 response)  
  - Other Adults with 2+ Chronic Conditions*: |

- *Defined by [CDC as increased risk for COVID](https://www.cdc.gov/vaccines/COVID-19/prioritization-guidance.html)
## NC COVID-19 Vaccine Operational Plan: Overview

<table>
<thead>
<tr>
<th>Planning</th>
<th>Implementation</th>
<th>Adjustment</th>
<th>Transition</th>
</tr>
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<tbody>
<tr>
<td>Before vaccine is available</td>
<td>Begins when first vaccine doses are allocated to states</td>
<td>Large number of vaccine doses available</td>
<td>Sufficient supply of vaccine doses for entire population</td>
</tr>
</tbody>
</table>

### Populations

- Establish priority groups

### Vaccination Channels

- Through local health departments and on-site vaccination clinics (in closed settings)

### Enrollment/Ordering/Allotment

- Identify/enroll providers
- Expect CDC centralized distribution to providers

### Shipment

- Shipment minimum of 100 for most vaccines
- May require ultra-cold storage & 2-dose series

### Data

- Confirm capability for required functionality, data collection, and reporting

### Implementation

- Phase 1 populations
- Stabilize health care delivery system and protect individuals at highest risk

### Adjustment

- Continue to move through phased populations as vaccine supply allows

### Transition

- Offer vaccination to all populations through Phases 3 and 4
- Vaccination in established channels
- Fewer mass, mobile, or community-based clinics
- Ordering similar to annual seasonal flu vaccine campaign
- Move to high supply/lower demand
1. CDC/ Operation Warp Speed (OWS) provide pro-rata vaccine allotment to the state.

2. State divides allocation of COVID-19 vaccines across providers based on prioritization, populations served, geography.

3. NC DHHS transmits orders to CDC/ OWS.

4. CDC/ OWS places orders with manufacturer/distributor for vaccines and ancillary kits/supplies.

5. Vaccines are transported by the manufacturer and/or McKesson to enrolled sites as indicated by the orders. McKesson distributes ancillary kits/supplies.

6. Upon receipt, providers store the COVID-19 vaccines in accordance with storage requirements.

7. Providers will organize vaccination clinics. Patients can register on CVMS (COVID-19 Vaccine Management System) and schedule an appointment or schedule with their provider to receive COVID-19 vaccine.

8. Provider administers the first vaccine dose and logs administration in CVMS. Appointments for second doses should be scheduled.

9. Provider monitors and reports adverse events using V-SAFE or VAERS in accordance with Emergency Use Authorization (EUA).

10. Patient receives a second dose reminder and schedules appointment if not already set up.

11. Provider administers the second vaccine dose and logs administration in CVMS. Continues adverse event monitoring.

Federal Responsibility
State Responsibility
Provider Level
NC’s provider enrollment strategy is based upon the prioritization strategy.
Vaccine: Federal long-term care pharmacy program

The federal government – in coordination with the CDC – has created the Pharmacy Partnership for Long-term Care (LTC) Program in partnership with CVS and Walgreens to vaccinate those in LTC settings.

**Program Details**

As part of this program, pharmacies will:

- Schedule and coordinate clinic dates with each facility
- Order vaccines and associated supplies
- Ensure cold chain management for vaccine
- Provide on-site administration of vaccine including patient information and consents as needed
- Report required vaccination data to local, state/territorial, and federal jurisdictions within 72 hours of administration

Allocation will come from state allocation starting with NC’s week 2 allocation.

**LTC ENROLLMENT DASHBOARD**

- ~498 Adult Care Homes (84%%)
- 427 Skilled Nursing Facilities (100%)

**KEY PROGRAM DATES**

- 12/7: Communicate to LTC facilities
- 12/21: Start pulling vaccines from allocation banks
- 12/28: Start administering vaccines

**LTC ENROLLMENT DASHBOARD**

- ~498 Adult Care Homes (84%%)
- 427 Skilled Nursing Facilities (100%)
Vaccine: First allocations

**Week of Dec 13-19**

- **85,800 doses** (88 increments)
  - Initial shipment goes to 53 hospitals
  - 11 early ship sites – Ultra-cold storage
  - 42 others distributed according to bed capacity, health care workers, and county population
  - Future allocations will factor in administration data and on-hand inventory

**Week of Dec 20-26**

- **175,900 doses** (increments of 100)
  - Pfizer shipments will focus on more hospitals & health systems
  - Doses TBD
  - Moderna focus initially on Long Term Care and then health departments and community providers

Initial shipment will go to 53 hospitals:
- 11 early ship sites – Ultra-cold storage
- 42 others distributed according to bed capacity, health care workers, and county population

Future allocations will factor in administration data and on-hand inventory
### Vaccine: COVID-19 Vaccine Management System (CVMS)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>11/23</td>
<td>CVMS Provider Enrollment Soft Launch invitation to:</td>
</tr>
<tr>
<td></td>
<td>• Goshen Community Health</td>
</tr>
<tr>
<td></td>
<td>• Carolina Family Health Centers</td>
</tr>
<tr>
<td></td>
<td>• Rural Health Group</td>
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<tr>
<td></td>
<td>• Realo Discount Drugs</td>
</tr>
<tr>
<td>11/30</td>
<td>CVMS Priority Access Preview attended by 120+ participants</td>
</tr>
<tr>
<td>12/8</td>
<td>CVMS MVP Soft Launch for subset of Phase 1a providers</td>
</tr>
<tr>
<td>12/10</td>
<td>CVMS MVP Go-Live And available to Phase 1a and Phase 1b providers</td>
</tr>
<tr>
<td>12/17</td>
<td>CVMS MVP R2 Go-Live Additional features released</td>
</tr>
<tr>
<td>TBD</td>
<td>CVMS R3+ Go-Live Future features and enhancements available within CVMS</td>
</tr>
</tbody>
</table>

### What is CVMS?
CVMS is a secure, cloud-based **vaccine management solution** for COVID-19 that **enables vaccine management and data sharing** across providers, hospitals, agencies, and local, state, and federal governments on one common platform.

When the CVMS is launched on 12/10, providers will be able to:
- Enroll in the **COVID-19 Vaccine Program**
- Employees can **register** for vaccination
- Manage vaccine **inventory**
- Track vaccine **administration data**

### Who will use CVMS?
- State officials will **enroll providers** and verify provider eligibility along with **verifying site readiness**
- Providers will **verify patient eligibility**, **log dosage administration**, and track frequency and timing of **additional dosages**
- **Training** for Phase 1 providers started week of 11/30
- CVMS will be available to select providers for a **soft launch on 12/8** and the **remaining providers** will have access to the system on **12/10**

### Who won’t use CVMS?
- **Pharmacies**, such as CVS and Walgreens, **will not use CVMS** to administer and manage vaccines
- Pharmacies will to use their **current systems**
- Building capability to ingest vaccine data files from pharmacies into CVMS
COVID Vaccine Communications: North Carolina’s Commitment

Provide early, transparent, consistent, and frequent communications so that North Carolinians:

- **Trust the information** that they receive from NC DHHS and local health departments about COVID-19 vaccinations
- **Understand the benefits and risks** of COVID-19 vaccinations
- **Make informed decisions** about COVID-19 vaccinations
- **Know how and where** to get a COVID-19 vaccination
Communications Strategy Informed by Research

One in three North Carolinians say they will definitely get a COVID 19 vaccine once approved by the FDA and offered for free. Another one in four say they will probably get the vaccine.

**Less likely to say they will get vaccine**
- Blacks/African Americans
- Females
- High school or some college only
- Lower income groups
- Under age 35

**More likely to say they will get vaccine**
- Hispanic, Latinx
- Asians
- White Non-Hispanics
- Males
- College or higher educated
- Higher income residents
- Ages 65 and older

**Most common reasons for vaccine avoidance:**
- Concerned about side-effects
- Feel it hasn’t been tested enough
- Don’t want to be first to take the vaccine
Core COVID-19 Vaccine Messages

**PROCESS**
Great care has been taken to make sure COVID-19 vaccines are safe and effective.
- **Scientists had a head start.** Although the vaccines were developed quickly, they were built upon years of work in developing vaccines for similar viruses. Development time was cut without cutting corners.
- **Testing was thorough and successful.** More than 70,000 people participated in clinical trials for two leading vaccines to see if they are safe and effective. To date, the vaccines are nearly 95% effective in preventing COVID-19 with no safety concerns.

**EXPECTATIONS**
effective vaccine will be available to all who want it, but supplies will be limited at first. The best way to fight COVID-19 is to start first with vaccinations for those most at risk, then reach more people as the vaccine supply increases throughout 2021.

**INCLUSIVITY**
North Carolina is drawing upon the experience and expertise of leaders from historically marginalized communities to develop and implement its vaccine plan.

Communication Tools -
https://covid19.ncdhhs.gov/vaccines
COVID-19 Communication Tools

Developing, Manufacturing and Distributing a COVID-19 Vaccine

Multiple COVID-19 vaccines are being developed. Thousands of people have volunteered as part of research trials to see if a vaccine presents COVID-19 and to learn more about its safety. These ongoing trials are ongoing. Working in phases, vaccines are being manufactured in the coming months. As a result, a limited supply of COVID-19 vaccine is expected. The vaccine supply will be provided to health care providers who have signed a contract with the state. It will likely be some time before it is widely available to everyone. States will receive limited supplies at the start. North Carolina is drawing upon the experience and expertise of leaders from horizontally to vertically integrated communities to ensure donation and deployment of vaccine distribution plans. The state is working to provide equitable access to the vaccine.

COVID-19 Vaccinations: Those most at risk get first.

A limited, fair and equitable vaccine will be available to all who want it, but supplies will be limited at first. Independentiard and federal health officials and advisors have determined that the best way to fight COVID-19 is to want first with those who are the most vulnerable. This includes health care workers, first responders and people who are 65 or older. It's a matter of priority, and your health care provider has a plan to help you.

COVID-19 Vaccination 101

Overview Deck

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https://covid19.ncdhhs.gov/vaccines
Questions?