

# Division of Public Health

## Agreement Addendum

### FY 20-21

Buncombe County Health and Human Services,  
Department of Health

**Local Health Department Legal Name**

543 ELC Enhancing Detection Activities

**Activity Number and Description**

01/20/2020 – 05/31/2021

**Service Period**

07/01/2020 – 06/30/2021

**Payment Period**

- Original Agreement Addendum**  
 **Agreement Addendum Revision #** \_\_\_\_\_

Epidemiology / Communicable Disease Branch

**DPH Section / Branch Name**

Vanessa M. Greene 919-546-1658  
vanessa.greene@dhhs.nc.gov

**DPH Program Contact**

(name, phone number, and email)

**DPH Program Signature**

**Date**

(only required for a negotiable agreement addendum)

**I. Background:**

The primary mission of the Communicable Disease Branch (CDB) is to reduce morbidity and mortality resulting from communicable diseases that are a significant threat to the public through detection, investigation, testing, treatment, tracking, control, education, and care activities to improve the health of people in North Carolina.

The Public Health Emergency Preparedness (PHEP) CARES Crisis Cooperative Agreement and Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) CARES Cooperative Agreement awards have been critical in supporting North Carolina's response to the coronavirus pandemic. With the addition of the ELC Enhancing Detection award, the primary focus of all three CDC funding sources is: 1) direct allocation to local health departments, 2) enhanced laboratory testing capacity, 3) increasing workforce by hiring temp staff, 4) supporting epidemiology and surveillance activities and 5) expanding informatics and IT infrastructure to increase electronic data exchange. The ELC Enhancing Detection Award includes new activities centered around contracts to external partners to support contact tracing, and strategic planning and project management.

The Division of Public Health (DPH), Communicable Disease Branch (CDB), is making an allocation of these ELC Enhancing Detection funds available to all local health departments through the “CDC-RFA-TP18-1802, Cooperative Agreement for Emergency Response: Public Health Crisis Response, COVID-19 Crisis Response Cooperative Agreement – Components A and B Supplemental Funding” to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities.

Health Director Signature

(use blue ink)

Date

Local Health Department to complete:	LHD program contact name: _____
(If follow-up information is needed by DPH)	Phone number with area code: _____
	Email address: _____

**II. Purpose:**

This Activity is for the Local Health Department to work to prevent, prepare for, and respond to Coronavirus Disease 2019 (COVID-19) by carrying out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities.

**III. Scope of Work and Deliverables:****A. Allowable Activities**

All of the activities the Local Health Department performs under this Agreement Addendum shall be informed by local data and trends, the NC DHHS COVID-19 Guidance for Health Care Providers, the ELC Enhancing Detection: North Carolina testing plan located at <https://www.hhs.gov/coronavirus/testing-plans/index.html#nc>, and any subsequent revisions to that plan.

Activities undertaken by the Local Health Department (LHD) and funded through this Agreement Addendum shall address the following allowable activities, 1-6:

**1. Enhance Laboratory, Surveillance, Informatics, and other Workforce Capacity**

- a. Build expertise for healthcare and community outbreak response and infection prevention and control (IPC) among local health departments.
- b. Train and hire staff to improve the capacities of the epidemiology and informatics workforce to effectively conduct surveillance and response of COVID-19 (including contact tracing) and other conditions of public health significance.
- c. Implement NC DHHS strategies for COVID-19 case investigation and contact tracing:
  - i. Assure that all contact tracers hired locally complete the North Carolina Area Health Education Centers (NCAHEC) COVID-19 Contact Tracing Onboarding for NC Local Health Departments training within the first two weeks of hire and prior to contact tracing activities.
  - ii. Implementation and workflow improvements for case investigation and contact training using state-supplied technology, including but not limited to:
    - 1) COVID-19 Community Team Outreach (CCTO) tool.
    - 2) NC EDSS/NC COVID reporting tool.
    - 3) Softphone: DPH is exploring whether there is technology that will allow consistent caller identification that will increase success in contact tracing. This is known as softphone technology. The objective is to provide a consistent and recognizable caller identification across all contact tracers within the state/local public health system.
    - 4) Other technology applications that may improve prevention/containment/mitigation.
- d. Build expertise to support management of the COVID-19 related activities within the service area (e.g., additional leadership, program and project managers, budget staff).
- e. Increase capacity for timely data management, analysis, and reporting for COVID-19 and other conditions of public health significance.

**2. Strengthen Community Laboratory Testing**

- a. Establish or expand or assure capacity to quickly, accurately, and safely test for COVID-19/SARS-CoV-2 among all symptomatic individuals, and secondarily expand capacity to achieve community-based surveillance, including testing of asymptomatic individuals.

- i. Strengthen ability to quickly scale testing as necessary to assure that optimal utilization of existing and new testing platforms can be supported to help meet increases in testing demand in a timely manner.
  - ii. Build local capacity for testing of COVID-19/SARS-CoV-2 including within high-risk settings or in vulnerable populations that reside in their communities.
- b. Enhance laboratory testing capacity for COVID-19/SARS-CoV-2 outside of public health laboratories.
  - i. Establish or expand capacity to coordinate with public/private laboratory testing providers, including those that assist with surge and with testing for high-risk environments.
  - ii. Secure and/or utilize mobile laboratory units, or other methods to provide point-of-care (POC) testing at public health-led clinics or non-traditional test sites (e.g., homeless shelters, food processing plants, prisons, Long Term Care Facilities (LTCFs)).
- c. Enhance data management and analytic capacity in public health laboratories to help improve efficiencies in operations, management, testing, and data sharing.
  - i. Improve efficiencies in laboratory operations and management using data from throughput, staffing, billing, supplies, and orders.
  - ii. Improve the capacity to analyze laboratory data to help understand and make informed decisions about issues such as gaps in testing and community mitigation efforts. Data elements such as tests ordered and completed (including by device/platform), rates of positivity, source of samples, type will be used to create data visualizations that will be shared with the public, state health department, and community partners.

### **3. Advance Electronic Data Exchange at Public Health Labs**

- a. Enhance and expand laboratory information infrastructure, to improve jurisdictional visibility on laboratory data (tests performed) from all testing sites and enable faster and more complete data exchange and reporting.
  - i. Enhance laboratory test ordering and reporting capability.
    - 1) 100% of results must be reported with key demographic variables including age/gender/race via the NC COVID reporting tool (NC COVID).
    - 2) Report all non-Electronic Lab Reporting (ELR) positive test results to the state health department using NC COVID.

### **4. Improve Surveillance and Reporting of Electronic Health Data**

- a. Use NC COVID to assure complete, up-to-date, automated reporting of morbidity and mortality to NC DHHS of COVID-19 and other conditions of public health significance by:
  - i. Establishing or enhancing community-based surveillance, including surveillance of vulnerable populations, individuals with severe illness, those with recent travel to high-risk locations, or who are contacts to known cases.
  - ii. Monitoring changes to daily incidence rates of COVID-19 and other conditions of public health significance at the county or zip code level to inform community mitigation strategies.
- b. Establish complete, up-to-date, timely, automated reporting of individual-level data through electronic case reporting to NC DHHS via NC COVID.

- i. At the health department, enhance capacity to work with testing facilities to onboard and improve electronic laboratory reporting (ELR), including to receive data from new or non-traditional testing settings. Use alternative data flows and file formats (e.g., CSV or XLS) to help automate where appropriate. In addition to other reportable results, this should include all COVID-19/SARS-CoV-2-related testing data (i.e., tests to detect SAR-CoV-2 including serology testing).
  - ii. Assist NC DPH in the process of automating the receipt of Electronic Health Record (EHR) data once it is available, including Electronic Case Reporting (eCR) and Fast Healthcare Interoperability Resources (FHIR)-based eCR to generate initial case report as specified by NC DPH for the reportable disease within 24 hours, and to update over time within 24 hours of a change in information contained in the CDC-directed case report, including death.
  - iii. Utilize eCR data, once it is available, to assure data completeness, establish comprehensive morbidity and mortality surveillance, and help monitor the health of the community and inform decisions for the delivery of public health services.
- c. Improve understanding of capacity, resources, and patient impact at healthcare facilities through electronic reporting.
- i. Assist NC DHHS with required expansion of reporting facility capacity, resources, and patient impact information, such as patients admitted and hospitalized, in an electronic, machine-readable, as well as human-readable visual, and tabular manner, to achieve 100% coverage in service area and include daily data from all acute care, long-term care, and ambulatory care settings. Use these data to monitor facilities with confirmed cases of COVID-19/SARS-CoV-2 infection or with COVID-like illness among staff or residents and facilities at high risk of acquiring COVID-19/SARS-CoV-2 cases and COVID-like illness among staff or residents.
- d. Enhance systems for flexible data collection, reporting, analysis, and visualization.
- i. Make data on case, syndromic, laboratory tests, hospitalization, and healthcare capacity available on health department websites at the county/zip code level in a visual and tabular manner.
- e. Establish or improve systems to assure complete, accurate and immediate (within 24 hours) data transmission to NC COVID and open website available to the public by county and zip code, that allows for automated transmission of data to NC DHHS via NC COVID.
- i. Submit all case reports in an immediate, automated way to CDC for COVID-19/SARS-CoV-2 and other conditions of public health significance with associated required data fields via NC COVID.
  - ii. Provide accurate accounting of COVID-19/SARS-CoV-2 associated deaths. Establish electronic, automated, immediate death reporting with associated required data fields via NC COVID.
  - iii. Establish these systems in such a manner that they may be used on an ongoing basis for surveillance of, and reporting on, other threats to the public health and conditions of public health significance.

## **5. Use Laboratory Data to Enhance Investigation, Response and Prevention**

- a. Use laboratory data to initiate case investigations, conduct contact tracing and follow up, and implement containment measures.

- i. Conduct necessary contact tracing including contact elicitation/identification, contact notification, and contact follow-up. Activities could include traditional contact tracing and/or proximity/location-based methods, as well as methods adapted for healthcare-specific and congregate settings.
- ii. Utilize tools (e.g., geographic information systems and methods) that assist in the rapid mapping and tracking of disease cases for timely and effective epidemic monitoring and response, incorporating laboratory testing results and other data sources.
- iii. Identify cases and exposure to COVID-19 in high-risk settings or within vulnerable populations to target mitigation strategies.
  - 1) Assess and monitor infections in healthcare workers across the healthcare spectrum.
  - 2) Monitor cases and exposure to COVID-19 to identify need for targeted mitigation strategies to isolate and prevent further spread within high-risk healthcare facilities (e.g., hospitals, dialysis clinics, cancer clinics, nursing homes, and other long-term care facilities, etc.).
  - 3) Monitor cases and exposure to COVID-19 to identify need for targeted mitigation strategies to isolate and prevent further spread within high-risk employment settings (e.g., meat processing facilities), and congregate living settings (e.g., prisons, youth homes, shelters, farms).
  - 4) Work with NC DHHS to build local capacity for reporting, rapid containment and prevention of COVID-19/SARS-CoV-2 within high-risk settings or in vulnerable populations that reside in their communities.
- b. Implement prevention strategies in high-risk settings or within vulnerable populations (including tribal nations) including proactive monitoring for asymptomatic case detection.
  - i. Build capacity for infection prevention and control in LTCFs (e.g., at least one Infection Preventionist (IP) for every facility) and outpatient settings.
    - 1) Build capacity to safely house and isolate infected and exposed residents of LTCFs and other congregate settings.
  - ii. Assist with enrollment of all LTCFs into CDC's National Healthcare Safety Network (NHSN).
  - iii. Increase Infection Prevention and Control (IPC) assessment capacity onsite using Infection Prevention and Control Assessment Tool (Tele-ICAR).
  - iv. Perform preparedness assessment to assure interventions are in place to protect high-risk populations.
    - 1) Coordinate as appropriate with federally funded entities responsible for providing health services to vulnerable populations (e.g., tribal nations and federally qualified health centers)

## **6. Coordinate and Engage with Partners**

- a. Partner with NC DHHS to establish or enhance testing for COVID-19/SARS-CoV-2.
  - i. Acquire equipment and staffing to conduct testing for COVID-19/SARS-CoV-2.
  - ii. Support community partners to conduct appropriate specimen collection and/or testing within their service area.
  - iii. Build infection prevention and control and healthcare outbreak response expertise in LHDs.

**B. Requirements:**

1. The LHD shall assure capacity for a minimum of 5% of their service area's population to be tested for COVID-19 in a 30-day period, unless otherwise communicated in writing by NC DHHS to the LHD. This requirement will be assessed by NC DHHS staff using NC COVID and the CCTO reporting databases.
2. The LHD shall initiate 90% of contacting case attempt within 24 hours. This requirement will be assessed by NC DHHS staff using NC COVID and the CCTO reporting databases.
3. The LHD shall initiate 50% of contacting contacts of the case attempt within 48 hours when the difference between the specimen date and the report date of a positive COVID-19 case to public health is five (5) days or less. This requirement will be assessed by NC DHHS staff using NC COVID and the CCTO reporting databases.
4. Once the softphone technology has been developed, piloted, user-acceptance tested, and implemented, utilize the softphone technology to reach cases and contacts. This requirement will be assessed by NC DHHS staff using NC COVID and the CCTO reporting databases.
5. Use the COVID-19 Community Team Outreach (CCTO) tool for documenting close contacts. This requirement will be assessed by NC DHHS staff using NC COVID and the CCTO reporting databases.
6. The LHD shall assure that 100% of contact tracers hired locally (not using state-funded, state-contracted vendors) complete the North Carolina Area Health Education Centers (NCAHEC) COVID-19 Contact Tracing Onboarding for NC Local Health Departments training. Registration for this training is located online: <https://www.ncahec.net/courses-and-events/63430/covid-19-contact-tracing-onboarding-for-nc-local-health-departments>. The LHD must keep records of NCAHEC training completion certification in all contact tracing staff personnel files for desk audit review.
7. Assist in promoting enrollment among county providers in the Influenza-like Illness Surveillance Network (ILINet) when requested by the NC DPH Influenza Coordinator.

**IV. Performance Measures/Reporting Requirements:****A. Performance Measures**

1. **Performance Measure # 1 Linked to Scope of Work and Deliverables 2 and 6:** The LHD shall have a plan to assure access to COVID-19 testing, specifically for vulnerable populations, for all symptomatic persons and for those who have had close contact to a known or suspected case of COVID-19 as defined by the CDC, and for those who request or require testing. This plan may be the same as the policy for AA 539.

Reporting Requirements: An electronic copy of this testing policy shall be provided to the Regional Communicable Disease Nurse Consultant no later than October 1, 2020.

2. **Performance Measure # 2 Linked to Scope of Work and Deliverables 2, 3, 4 and 5:** The LHD shall report cases of COVID-19 including deaths within 30 days of receipt of the report to the state via the NC COVID.

Reporting Requirements: Reporting will be done via the NC COVID

3. **Performance Measure #3 Linked to Scope of Work and Deliverables 1:** Contact tracers hired locally should be reflective of the county population and the target communities.  
Reporting Requirements: LHD will provide certain demographic data (race, ethnicity, and language(s) spoken) of locally hired contact tracers in quarterly reporting outlined below in Additional Reporting Requirements.
4. **Performance Measure #4 Linked to Scope of Work and Deliverables 1 and 5:** The LHD shall support tele-ICAR and infection prevention consultation with LTCF in their service area, in conjunction with the NC DHHS.  
Reporting Requirements: Reporting will be done via a yearly online survey.
5. **Performance Measure #5 Linked to Scope of Work and Deliverables 1-6:** The LHD shall review the LHD testing plan quarterly so it reflects most current recommendations from NC DHHS.  
Reporting Requirements: LHD shall submit updated plans in quarterly reporting outlined below in Additional Reporting Requirements.
6. **Performance Measure #6 Linked to Scope of Work and Deliverables 4 and 5:** The LHD shall report close contacts to COVID-19 into the COVID-19 Community Team Outreach (CCTO) Tool software for at least 60% of people infected with COVID-19.  
Reporting Requirements: Reporting will be done via the CCTO tool software.
7. **Performance Measure #7 Linked to Requirements 1 and 2:** The LHD shall complete the Final Monitoring Outcome variable for 90% of contacts entered after 14 days.  
Reporting Requirements: Reporting will be done via the CCTO tool software.

**B. Additional Reporting Requirements**

1. The LHD shall submit quarterly reports to CDB in a provided template.
  - a. Reports shall include:
    - i. The LHD’s local testing plan, if modified.
    - ii. Progress of work performed against each of the allowable activities and performance measures.
    - iii. Assurance that the LHD has reviewed data entered in electronic tools (e.g., NCEDSS, CCTO) for accuracy.
    - iv. Demographic data (race, ethnicity, and language(s) spoken) of locally hired contact tracers.
    - v. Financial reports to support use of funds and the monthly reimbursements drawn from the Aid to Counties system.
  - b. Reporting schedule:
    - 1<sup>st</sup> Quarter July 1 – September 30, 2020 submit by October 31, 2020
    - 2<sup>nd</sup> Quarter October 1 – December 31, 2020 submit by January 31, 2021
    - 3<sup>rd</sup> Quarter January 1 – March 31, 2021 submit by April 30, 2021
    - 4<sup>th</sup> Quarter April 1 – June 30, 2021 submit by July 31, 2021
2. Provide data, plans, and documents as requested by CDB that supports reporting the performance measures and deliverables from the ELC Enhancing Detection grant. Plans and other documents

must be consistent with state and federal requirements and must be specific to the LHD's local public health service area.

**V. Performance Monitoring and Quality Assurance:**

- A. The Technical Assistance and Training Program (TATP) Nurse Consultant will assess the Local Health Department's performance through reporting mechanisms within the NC EDSS. These reports will be run on a quarterly basis by the TATP Nurse Consultant.
- B. If the assessment results in compliance concerns, the TATP Nurse Consultant shall conduct conference calls with the Local Health Department to provide technical assistance in order to rectify the concerns.

**VI. Funding Guidelines or Restrictions:**

- A. Requirements for pass-through entities: In compliance with 2 *CFR* §200.331 – *Requirements for pass-through entities*, the Division of Public Health provides Federal Award Reporting Supplements to the Local Health Department receiving federally funded Agreement Addenda.
  - 1. Definition: A Supplement discloses the required elements of a single federal award. Supplements address elements of federal funding sources only; state funding elements will not be included in the Supplement. Agreement Addenda (AAs) funded by more than one federal award will receive a disclosure Supplement for each federal award.
  - 2. Frequency: Supplements will be generated as the Division of Public Health receives information for federal grants. Supplements will be issued to the Local Health Department throughout the state fiscal year. For federally funded AAs, Supplements will accompany the original AA. If AAs are revised and if the revision affects federal funds, the AA Revisions will include Supplements. Supplements can also be sent to the Local Health Department even if no change is needed to the AA. In those instances, the Supplements will be sent to provide newly received federal grant information for funds already allocated in the existing AA.
- B. Expenses incurred from January 20, 2020 which are related to allowable activities may be reimbursed.
- C. As the LHD is a subrecipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); and/or the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) the LHD agrees as applicable to the award, to:
  - 1. comply with existing and/or future directives and guidance from the HHS Secretary regarding control of the spread of COVID-19;
  - 2. in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and
  - 3. assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation. In addition, to the extent applicable, comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS– CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC.



4. consistent with the full scope of applicable grant regulations (45 C.F.R. 75.322), the purpose of this award, and the underlying funding, the subrecipient is expected to provide to CDC, through NC DHHS, copies of and/or access to COVID-19 data collected with these funds, including but not limited to data related to COVID-19 testing. CDC will specify in further guidance and directives what is encompassed by this requirement.
- D. In addition to their local procurement rules/policies, the LHD shall comply with the following rules, applying the most restrictive standard where there is a difference between any of the standards:
1. Federal Uniform Administrative Requirements for Procurement, 45 CFR Part 75 §75.327-335, [https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5#se45.1.75\\_1326](https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5#se45.1.75_1326)
    - a. Appendix II to Part 75—*Contract Provisions for Non-Federal Entity Contracts Under Federal Awards* may be found here for incorporation into procurement contracts: [https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5#ap45.1.75\\_1521.ii](https://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5#ap45.1.75_1521.ii)
- E. Unallowable costs:
1. Research
  2. Clinical Care
  3. Publicity and propaganda (lobbying):
    - a. Other than for normal and recognized executive-legislative relationships, no funds may be used for:
      - i. publicity or propaganda purposes, for the preparation, distribution, or use of any material designed to support or defeat the enactment of legislation before any legislative body
      - ii. the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before any legislative body
    - b. See Additional Requirement (AR) 12 for detailed guidance on this prohibition and additional guidance on lobbying for CDC recipients: [https://www.cdc.gov/grants/documents/Anti-Lobbying\\_Restrictions\\_for\\_CDC\\_Grantees\\_July\\_2012.pdf](https://www.cdc.gov/grants/documents/Anti-Lobbying_Restrictions_for_CDC_Grantees_July_2012.pdf)
  4. All unallowable costs cited in CDC-RFA-CK19-1904 remain in effect, unless specifically amended, in accordance with 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles, And Audit Requirements for HHS Awards.

Supplement reason:  In AA+BE or AA+BE Rev -OR-  -

CFDA #: 93.323 Federal awd date: 05/19/20 Is award R&D? no FAIN: NU50CK000530 Total amount of fed awd: \$ 188951581

CFDA name: Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)  
 Fed award project description: CK19-1904 Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) – Enhancing Detection  
 Fed awarding agency: DHHS, Centers for Disease Control and Prevention  
 Federal award indirect cost rate: n/a %

Subrecipient	Subrecipient DUNS	Fed funds for This Supplement	Total of All Fed Funds for This Activity	Subrecipient	Subrecipient DUNS	Fed funds for This Supplement	Total of All Fed Funds for This Activity
Alamance	965194483	266,436	266,436	Jackson	019728518	136,395	136,395
Albemarle	130537822	890,572	890,572	Johnston	097599104	301,537	301,537
Alexander	030495105	130,555	130,555	Jones	095116935	100,795	100,795
Anson	847163029	116,755	116,755	Lee	067439703	154,457	154,457
Appalachian	780131541	371,745	371,745	Lenoir	042789748	150,199	150,199
Beaufort	091567776	140,266	140,266	Lincoln	086869336	179,734	179,734
Bladen	084171628	126,598	126,598	Macon	070626825	128,224	128,224
Brunswick	091571349	235,164	235,164	Madison	831052873	113,676	113,676
Buncombe	879203560	366,415	366,415	MTW	087204173	312,010	312,010
Burke	883321205	186,776	186,776	Mecklenburg	074498353	1,242,342	1,242,342
Cabarrus	143408289	311,447	311,447	Montgomery	025384603	119,245	119,245
Caldwell	948113402	178,188	178,188	Moore	050988146	195,234	195,234
Carteret	058735804	164,853	164,853	Nash	050425677	190,932	190,932
Caswell	077846053	115,071	115,071	New Hanover	040029563	335,904	335,904
Catawba	083677138	257,801	257,801	Northampton	097594477	111,830	111,830
Chatham	131356607	168,631	168,631	Onslow	172663270	300,425	300,425
Cherokee	130705072	120,996	120,996	Orange	139209659	244,133	244,133
Clay	145058231	102,343	102,343	Pamlico	097600456	104,144	104,144
Cleveland	879924850	194,969	194,969	Pender	100955413	155,823	155,823
Columbus	040040016	149,742	149,742	Person	091563718	132,572	132,572
Craven	091564294	199,685	199,685	Pitt	080889694	278,932	278,932
Cumberland	123914376	441,271	441,271	Polk	079067930	112,801	112,801
Dare	082358631	129,172	129,172	Randolph	027873132	242,557	242,557
Davidson	077839744	267,976	267,976	Richmond	070621339	137,857	137,857
Davie	076526651	135,503	135,503	Robeson	082367871	229,338	229,338
Duplin	095124798	153,286	153,286	Rockingham	077847143	187,140	187,140
Durham	088564075	419,458	419,458	Rowan	074494014	240,140	240,140
Edgecombe	093125375	145,824	145,824	Sampson	825573975	157,855	157,855
Foothills	782359004	301,546	301,546	Scotland	091564146	127,846	127,846
Forsyth	105316439	488,435	488,435	Stanly	131060829	157,052	157,052
Franklin	084168632	162,011	162,011	Stokes	085442705	139,204	139,204
Gaston	071062186	324,001	324,001	Surry	077821858	167,538	167,538
Graham	020952383	99,197	99,197	Swain	146437553	105,291	105,291
Granville-Vance	063347626	292,724	292,724	Toe River	113345201	324,777	324,777
Greene	091564591	112,260	112,260	Transylvania	030494215	127,180	127,180
Guilford	071563613	655,764	655,764	Union	079051637	336,133	336,133
Halifax	014305957	144,583	144,583	Wake	019625961	1,223,122	1,223,122
Harnett	091565986	231,002	231,002	Warren	030239953	111,246	111,246
Haywood	070620232	156,534	156,534	Wayne	040036170	222,035	222,035
Henderson	085021470	213,728	213,728	Wilkes	067439950	164,024	164,024
Hoke	091563643	147,167	147,167	Wilson	075585695	176,767	176,767
Hyde	832526243	95,504	95,504	Yadkin	089910624	130,341	130,341
Iredell	074504507	279,239	279,239				

Activity 543	AA	1175 878A HH	Proposed Total	New Total
Service Period		01/20-05/31 <del>2020-2021</del>		
Payment Period		02/20-06/30		
01 Alamance	* 0	461,821	461,821	461,821
D1 Albemarle	* 0	1,094,620	1,094,620	1,094,620
02 Alexander	* 0	149,184	149,184	149,184
04 Anson	* 0	147,534	147,534	147,534
D2 Appalachian	* 0	417,666	417,666	417,666
07 Beaufort	* 0	158,029	158,029	158,029
09 Bladen	* 0	192,882	192,882	192,882
10 Brunswick	* 0	292,783	292,783	292,783
11 Buncombe	* 0	534,940	534,940	534,940
12 Burke	* 0	420,718	420,718	420,718
13 Cabarrus	* 0	558,819	558,819	558,819
14 Caldwell	* 0	263,100	263,100	263,100
16 Carteret	* 0	181,749	181,749	181,749
17 Caswell	* 0	156,661	156,661	156,661
18 Catawba	* 0	380,837	380,837	380,837
19 Chatham	* 0	480,553	480,553	480,553
20 Cherokee	* 0	130,094	130,094	130,094
22 Clay	* 0	104,510	104,510	104,510
23 Cleveland	* 0	243,924	243,924	243,924
24 Columbus	* 0	306,136	306,136	306,136
25 Craven	* 0	296,294	296,294	296,294
26 Cumberland	* 0	773,988	773,988	773,988
28 Dare	* 0	137,837	137,837	137,837
29 Davidson	* 0	486,755	486,755	486,755
30 Davie	* 0	185,324	185,324	185,324
31 Duplin	* 0	576,115	576,115	576,115
32 Durham	* 0	1,296,740	1,296,740	1,296,740
33 Edgecombe	* 0	241,567	241,567	241,567
D7 Foothills	* 0	426,748	426,748	426,748
34 Forsyth	* 0	1,234,016	1,234,016	1,234,016
35 Franklin	* 0	242,158	242,158	242,158
36 Gaston	* 0	474,330	474,330	474,330
38 Graham	* 0	100,930	100,930	100,930
D3 Gran-Vance	* 0	650,568	650,568	650,568
40 Greene	* 0	152,117	152,117	152,117
41 Guilford	* 0	1,337,228	1,337,228	1,337,228
42 Halifax	* 0	231,228	231,228	231,228
43 Harnett	* 0	373,967	373,967	373,967
44 Haywood	* 0	182,094	182,094	182,094
45 Henderson	* 0	373,155	373,155	373,155
46 Hertford		0	0	0
47 Hoke	* 0	264,571	264,571	264,571
48 Hyde	* 0	96,370	96,370	96,370
49 Iredell	* 0	420,037	420,037	420,037
50 Jackson	* 0	155,457	155,457	155,457
51 Johnston	* 0	561,906	561,906	561,906
52 Jones	* 0	111,626	111,626	111,626
53 Lee	* 0	377,569	377,569	377,569
54 Lenoir	* 0	251,141	251,141	251,141
55 Lincoln	* 0	223,490	223,490	223,490
56 Macon	* 0	180,211	180,211	180,211
57 Madison	* 0	114,975	114,975	114,975
D4 M-T-W	* 0	360,964	360,964	360,964
60 Mecklenburg	* 0	3,563,564	3,563,564	3,563,564
62 Montgomery	* 0	186,395	186,395	186,395
63 Moore	* 0	304,840	304,840	304,840
64 Nash	* 0	289,707	289,707	289,707
65 New Hanover	* 0	445,076	445,076	445,076
66 Northampton	* 0	178,980	178,980	178,980
67 Onslow	* 0	352,846	352,846	352,846

68 Orange	* 0	412,225	412,225	412,225
69 Pamlico	* 0	108,477	108,477	108,477
71 Pender	* 0	200,446	200,446	200,446
73 Person	* 0	157,266	157,266	157,266
74 Pitt	* 0	444,424	444,424	444,424
75 Polk	* 0	133,163	133,163	133,163
76 Randolph	* 0	580,039	580,039	580,039
77 Richmond	* 0	216,704	216,704	216,704
78 Robeson	* 0	601,478	601,478	601,478
79 Rockingham	* 0	236,095	236,095	236,095
80 Rowan	* 0	558,560	558,560	558,560
D5 R-P-M		0	0	0
82 Sampson	* 0	405,227	405,227	405,227
83 Scotland	* 0	169,002	169,002	169,002
84 Stanly	* 0	206,872	206,872	206,872
85 Stokes	* 0	175,162	175,162	175,162
86 Surry	* 0	285,808	285,808	285,808
87 Swain	* 0	116,122	116,122	116,122
D6 Toe River	* 0	341,239	341,239	341,239
88 Transylvania	* 0	134,111	134,111	134,111
90 Union	* 0	581,772	581,772	581,772
92 Wake	* 0	2,156,722	2,156,722	2,156,722
93 Warren	* 0	149,803	149,803	149,803
96 Wayne	* 0	771,365	771,365	771,365
97 Wilkes	* 0	383,669	383,669	383,669
98 Wilson	* 0	361,321	361,321	361,321
99 Yadkin	* 0	223,484	223,484	223,484
Totals		35,000,000	35,000,000	35,000,000

Sign and Date - DPH Program Administrator <i>J. M. [Signature]</i> 7/23/20	Sign and Date - DPH Section Chief <i>[Signature]</i> 07-23-20
Sign and Date - DPH Contracts Office <i>Grensko Stuart</i> 7/23/2020	Sign and Date - DPH Budget Officer Patricia Ward Digitally signed by Patricia Ward Date: 2020.07.28 08:19:06 -04'00'

*[Signature]* 07/27/2020

Activity 543	AA	1175 878A HH	Proposed Total	New Total
Service Period		01/20-05/31 <del>2020-2021</del>		
Payment Period		02/20-06/30		
01 Alamance	* 0	-195,385	-195,385	266,436
D1 Albemarle	* 0	-204,048	-204,048	890,572
02 Alexander	* 0	-18,629	-18,629	130,555
04 Anson	* 0	-30,759	-30,759	116,775
D2 Appalachian	* 0	-45,921	-45,921	371,745
07 Beaufort	* 0	-17,763	-17,763	140,266
09 Bladen	* 0	-66,284	-66,284	126,598
10 Brunswick	* 0	-57,619	-57,619	235,164
11 Buncombe	* 0	-168,525	-168,525	366,415
12 Burke	* 0	-233,942	-233,942	186,776
13 Cabarrus	* 0	-247,372	-247,372	311,447
14 Caldwell	* 0	-84,912	-84,912	178,188
16 Carteret	* 0	-16,896	-16,896	164,853
17 Caswell	* 0	-41,590	-41,590	115,071
18 Catawba	* 0	-123,036	-123,036	257,801
19 Chatham	* 0	-311,922	-311,922	168,631
20 Cherokee	* 0	-9,098	-9,098	120,996
22 Clay	* 0	-2,167	-2,167	102,343
23 Cleveland	* 0	-48,955	-48,955	194,969
24 Columbus	* 0	-156,394	-156,394	149,742
25 Craven	* 0	-96,609	-96,609	199,685
26 Cumberland	* 0	-332,717	-332,717	441,271
28 Dare	* 0	-8,665	-8,665	129,172
29 Davidson	* 0	-218,779	-218,779	267,976
30 Davie	* 0	-49,821	-49,821	135,503
31 Duplin	* 0	-422,829	-422,829	153,286
32 Durham	* 0	-877,282	-877,282	419,458
33 Edgecombe	* 0	-95,743	-95,743	145,824
D7 Foothills	* 0	-125,202	-125,202	301,546
34 Forsyth	* 0	-745,581	-745,581	488,435
35 Franklin	* 0	-80,147	-80,147	162,011
36 Gaston	* 0	-150,329	-150,329	324,001
38 Graham	* 0	-1,733	-1,733	99,197
D3 Gran-Vance	* 0	-357,844	-357,844	292,724
40 Greene	* 0	-39,857	-39,857	112,260
41 Guilford	* 0	-681,464	-681,464	655,764
42 Halifax	* 0	-86,645	-86,645	144,583
43 Harnett	* 0	-142,965	-142,965	231,002
44 Haywood	* 0	-25,560	-25,560	156,534
45 Henderson	* 0	-159,427	-159,427	213,728
46 Hertford		0	0	0
47 Hoke	* 0	-117,404	-117,404	147,167
48 Hyde	* 0	-866	-866	95,504
49 Iredell	* 0	-140,798	-140,798	279,239
50 Jackson	* 0	-19,062	-19,062	136,395

51 Johnston	* 0	-260,369	-260,369	301,537
52 Jones	* 0	-10,831	-10,831	100,795
53 Lee	* 0	-223,112	-223,112	154,457
54 Lenoir	* 0	-100,942	-100,942	150,199
55 Lincoln	* 0	-43,756	-43,756	179,734
56 Macon	* 0	-51,987	-51,987	128,224
57 Madison	* 0	-1,299	-1,299	113,676
D4 M-T-W	* 0	-48,954	-48,954	312,010
60 Mecklenburg	* 0	-2,321,222	-2,321,222	1,242,342
62 Montgomery	* 0	-67,150	-67,150	119,245
63 Moore	* 0	-109,606	-109,606	195,234
64 Nash	* 0	-98,775	-98,775	190,932
65 New Hanover	* 0	-109,172	-109,172	335,904
66 Northampton	* 0	-67,150	-67,150	111,830
67 Onslow	* 0	-52,421	-52,421	300,425
68 Orange	* 0	-168,092	-168,092	244,133
69 Pamlico	* 0	-4,333	-4,333	104,144
71 Pender	* 0	-44,623	-44,623	155,823
73 Person	* 0	-24,694	-24,694	132,572
74 Pitt	* 0	-165,492	-165,492	278,932
75 Polk	* 0	-20,362	-20,362	112,801
76 Randolph	* 0	-337,482	-337,482	242,557
77 Richmond	* 0	-78,847	-78,847	137,857
78 Robeson	* 0	-372,140	-372,140	229,338
79 Rockingham	* 0	-48,955	-48,955	187,140
80 Rowan	* 0	-318,420	-318,420	240,140
D5 R-P-M		0	0	0
82 Sampson	* 0	-247,372	-247,372	157,855
83 Scotland	* 0	-41,156	-41,156	127,846
84 Stanly	* 0	-49,820	-49,820	157,052
85 Stokes	* 0	-35,958	-35,958	139,204
86 Surry	* 0	-118,270	-118,270	167,538
87 Swain	* 0	-10,831	-10,831	105,291
D6 Toe River	* 0	-16,462	-16,462	324,777
88 Transylvania	* 0	-6,931	-6,931	127,180
90 Union	* 0	-245,639	-245,639	336,133
92 Wake	* 0	-933,600	-933,600	1,223,122
93 Warren	* 0	-38,557	-38,557	111,246
96 Wayne	* 0	-549,330	-549,330	222,035
97 Wilkes	* 0	-219,645	-219,645	164,024
98 Wilson	* 0	-184,554	-184,554	176,767
99 Yadkin	* 0	-93,143	-93,143	130,341
Totals		-15,000,000	-15,000,000	20,000,000

Sign and Date - DPH Program Administrator <i>Andi Cameron for John Peoples</i> 08/07/20	Sign and Date - DPH Section Chief <i>Me Lu</i> 08-07-20
Sign and Date - DPH Contracts Office <i>Grensko Stuart</i> 8/7/2020	Sign and Date - DPH Budget Officer

*SH* 08/07/2020