Health Subcommittee

July 1, 2021

Minutes

The SHaPE SC Health Subcommittee met on **July 1, 2021**, at **2:30 pm** at the office of Nelson, Mullins, Riley, and Scarborough, 1320 Main Street, Columbia, SC 29201 and virtually via Zoom. The meeting was called to order and the following members were in attendance:

Attending in person:

Dr. Lee Pearson (Subcommittee Chair), Richele Taylor, Lathran Woodard, Lillian Mood.

Attending virtually:

Dr. Thaddeus Bell, Dr. Jeffrey Korte, Patricia Moore-Pastides, Connie Munn, Brenda Murphy, Juana Slade, Kim Wilkerson.

Not in attendance:

Dr. Graham Adams, Bishop Samuel Green Jr, Eric Bellamy, Thornton Kirby, Gwen Thompson, Dr. Brannon Traxler, Alan Hughes.

Also in attendance were Bernie Hawkins, Facilitator (SHaPE SC), Nick Davidson, Senior Deputy for Public Health (DHEC), Saad Howard, Director of Continuous Improvement, Office of Operational Excellence (DHEC), Jessica Cornish, Senior Consultant, Office of Operational Excellence (DHEC), Les Shelton, CQI Coordinator, Office of Operational Excellence (DHEC), and members of the public attending virtually.

Item 1: Call to Order/Welcome

Chairman Dr. Lee Pearson called the meeting to order and welcomed members and attendees to the subcommittee meeting. He stated that public notice of the meeting had been provided.

Item 2: Approval of the June 17, 2021 Minutes

Richele Taylor made a motion, seconded by Lillian Mood, to approve the minutes as written. The motion carried by unanimous consent.

Item 3: Discussion of the Subcommittee Input Document

Dr. Pearson opened the floor for discussion on how to strategically address the recommendations due back from the subcommittee by the end of July. Lil Mood suggested several areas of focus in the form of several key questions including: What are DHEC's actual responsibilities? What do we want to preserve or expand? and What input is needed from local-level staff to provide the regional viewpoint.

Ms. Mood noted that the recent PHAB Accreditation letter stated that organizational structure, a key focus of this Task Force, was identified as an agency strength. The agency has a local presence statewide, instead of everything being managed from a central office, so there is a trust relationship with citizens who expand the agency's surveillance capabilities (i.e., food outbreaks and other diseases). There is also a recognition of the interrelationship between public health and the environment.

Patricia Moore-Pastides stated that the information provided following the initial subcommittee meeting had been helpful in answering her questions about the agency's structure and how they are doing. In particular, the PHAB Accreditation was an objective independent analysis. However, the major issue in her experience with DHEC was the question of staffing; are they capable of recruiting and retaining the appropriate staff?

Dr. Pearson said that he had concerns about the dependence on grant-funding and temporary positions and the inherent lack of stability. He asked Mr. Hawkins if this issue had been raised in any of the other subcommittee discussions. Mr. Hawkins stated that it had not arisen directly, but the question had been asked about staffing from 2008 until now in terms of the number of service delivery staff lost and supervisors in the field versus support positions. If the subcommittee wanted to formulate a question about funding changes over time (i.e., appropriations vs. grants vs. fees) he would get the answer. Nick Davidson indicated that he would address at least the Public Health funding issue in his presentation.

Dr. Pearson noted that realignment is an option under consideration because of the perception that the agency is too big, and asked the group to consider the fundamental elements that need to be preserved.

Lathran Woodard reminded the group that any look at staffing should be done at the local level rather than through statewide totals, since aggregating the data masks local issues. Some local health departments are well staffed while others are not .

Ms. Woodard noted that everyone is looking at health care delivery systems post-Covid. She also requested that the term 'residents' be used in discussions rather than 'citizens' since there are a number of people living in the state who are not US citizens.

Item 4: Overview of Public Health Bureaus

Dr. Brannon Traxler was unable to attend the meeting so Nick Davidson, Senior Deputy for Public Health, provided her presentation (attached). Mr. Davidson highlighted the functions of each of the Bureaus and Offices. Each year, their 2,275 employees see more than a half-million clients in health departments, perform

over three million lab tests, and file over a quarter-million birth and death records. In the past year, they also oversaw seven million Covid tests and three million vaccinations. Of their $455 million FY 20 expenditures, 58 percent were federally funded, 18 percent came from state appropriations and the remainder came from other sources.

Item 5: Overview of Regions

Mr. Davidson directs Community Health Services, which includes the local county health departments. Approximately 1,400 staff offer services at 76 public health facilities and 16 Vital Records offices. Not all clinic locations operate full-time, due to a combination of demand and staff-sharing. The Covid-19 pandemic significantly altered their operations, driving down in-clinic visits in lieu of testing and immunization support.

Ms. Woodard stated the difficulties faced by the smaller and more rural county health departments, citing the Bamberg Health Department relying on an Obstetrician from Orangeburg County, and stated that there needed to be more partnerships. Mr. Davidson agreed that they would like to do more if they had the facilities and staff. He noted that they have received an exception from the State Board of Nursing to allow Expanded Role Nurses in rural communities, allowing them to perform additional services that would otherwise be outside their scope of practice.

Ms. Woodard asked how the Bureau of Population Health Data & Informatics shares their information with partners. Mr. Davidson said that it was their newest Bureau, but they had been doing data walks in the local communities, managed the Covid-19 data and visuals, and they have a robust website that includes life expectancy by zip code.

Ms. Mood reiterated that the Region Directors needed to be included in the discussions to offer their point of view. Dr. Pearson stated they would be invited to participate.

Ms. Mood indicated that there is a need to assess and survey what the issues are because as policies are developed, they determine priorities. There is a need to assure that the appropriate level of needed services are being delivered. DHEC started providing home health services because it was a Medicare benefit that private entities were not providing; the market has since responded. DHEC also used to perform a significant amount of prenatal care until it became a Medicaid benefit, and more physicians began providing it. Likewise, many locations now provide immunizations.

Dr. Thaddeus Bell asked for an explanation on what DHEC is doing regarding health disparities. Mr. Davidson stated that equity is a core tenant of the agency and they incorporate data regarding disparities into their daily activities. They use Health Educators to identify local needs. He cited the WIC disparities statewide; there are challenges not only in the poor rural counties but pockets of low-income urban dwellers equally in need. The agency focused on providing Covid-19 services in needy communities rather than a standard response statewide. The agency worked with the NAACP to arrange transportation.

Dr. Bell stated that he had a differing viewpoint. He has been working on health disparities in private practice for over 20 years and does not feel that adequate progress is being made. This was his motivation for serving on the Task Force, wanting DHEC to increase their focus. We have done some good things, but our national ranking remains very low, and we need to take a serious look at what can be done to raise the bar. He would favor a special commission to assess the issue.

Ms. Moore-Pastides asked if DHEC was still participating in the CHIP Program. Mr. Davidson stated that the agency is no longer doing enrollments. They do work with SCDHHS to get persons eligible for the Partners for Healthy Children insurance program enrolled through the health department offices.

Ms. Moore-Pastides then asked how the agency is responding to the needs of counties without an OB/GYN. Since DHEC stopped providing prenatal care, she asked if this is something that should be looked at to see if there is now a need to restart providing this service? She also asked whether the percent of children covered by insurance has increased since 2008.

Mr. Davidson said that he would have to defer that question to someone with more direct knowledge. Ms. Woodard stated that if a county health department didn't provide a service, they were required to have a referral agreement in place for it. Ms. Mood noted that nurse practitioners can supplement physician services and midwives are licensed to deliver babies.

Ms. Woodard stated that there was still a need to focus on systemic racism. You can have diversity yet still have old policies in place that perpetuate racism, and you cannot be afraid to talk about it just because it makes people uncomfortable.

As DHEC continues to collect data, Ms. Mood indicated the need for the agency to identify where the gaps are occurring and address why they are happening.

Ms. Woodard identified another issue for consideration. When should DHEC be in the forefront versus in the background? It needs to be acknowledged that not everyone trusts DHEC or wants to talk to them. They need the input from local health department staff on how they decide whether they or their partners should be taking the lead.

Item 6: Other Items

Dr. Pearson stated that the Task Force had a July 30, 2021 target for the subcommittee to share their initial recommendations with the full taskforce. Since the need for regional input and a discussion on health disparities have been identified, he would like to have an additional subcommittee meeting within the next two weeks.

Ms. Woodard noted the issue of clients with behavioral health and substance abuse comorbidities falling through the cracks because there is no clarity on who should accept primary responsibility for them. Dr. Pearson reminded the subcommittee of the prior request for a joint meeting with the Behavioral Health subcommittee. While this meeting should take place, he felt it should occur after July 30. Richele Taylor agreed, stating that the subcommittee had not gone into enough depth yet with their initial charge and needed to formulate the issues prior to any joint meeting.

Dr. Pearson reminded the subcommittee members that they were not bound to strictly follow the input document but should focus on the red-highlighted questions in order to generate an initial substantive response.

Ms. Woodard stated that the proposed actions needed to be realistic. There have been pushes at the local level for integrated care, but the agencies are siloed without integration policies. DHEC should avoid being a barrier.

Ms. Mood noted that the delivery of services is a product of staff availability and funding. The DHEC Regions were created to allow sharing of staff and services and then continued contracting down and merging into fewer regions due to budget cuts. As a result, you can get too distant from the local communities.

Ms. Mood also asked what are the key missions and management philosophies of DHEC, DMH, and DAODAS? Where does it make sense from the client's perspective for the agencies to be merged? It would help to generate actual scenarios to determine what could be needed from each of the three agencies and consider the pros and cons of whether they were merged or remained separate. Dr. Pearson agreed that such scenarios could be the focus of the joint meeting with the Behavioral Health subcommittee.

Juana Slade agreed, given that the amount of information the subcommittees have to consider can appear overwhelming, working from scenarios would be helpful to envision how the clients would encounter the system and be served rather than what the organizational structure looks like. When these scenarios are created, they need to consider both urban and rural clients since access to services differ.

Ms. Mood noted that the nursing perspective is different in a hospital than a public health environment. Instead of treating the individual, the focus is on determining who else has this issue and how can they be served in order to make a healthier community. Ms. Slade agreed, while noting that hospitals have an incentive to consider the full range of both pre- and post-care to avoid unpaid readmissions.

Dr. Pearson reminded the members that they would be scheduling another subcommittee meeting within the next two weeks, which will be a hybrid of in-person and virtual. He stated a plan to resend the input documents and then asked Bernie Hawkins if he had any final comments. Mr. Hawkins complemented the members' participation and depth of conversation.

With no further business, Dr. Pearson adjourned the meeting at 4:30 pm.

The members will be notified when the next Health Subcommittee meeting has been scheduled.

Recordings of Task Force and Subcommittee meetings can be found at scdhec.gov/shapesc.

Dr. Lee Pearson, Health Subcommittee Chair
July 1, 2021