SOUTH CAROLINA COVID-19 VACCINE ADVISORY COMMITTEE
February 17th, 2021
Noon – 2:00 p.m.

Attendees:
Beth Morgan                          Dr. Robert Saul                          Matthew Bartels
Brenda Knece                        Faith Dupree                              McColloch Salehi
Cassandra Harris                    Graham Adams                              Myra Reece
Chaunte McClure                    Greg Barabell                              Patricia Witherspoon
Crystal Page                        Humna Fayyaz                              Richard Foster
Danielle Bowen Scheurer             Jeff Perez                                Ronald Summers
Delores Dacosta                    JT Gary                                    Ryan Brown
Dr. Divya Ahuja                    Katherine Plunkett                        Tanya Russo
Dr. James Bradford                 Kim Wilkerson                              Teresa Arnold
Dr. Jane Kelly                     Kimberly Tissot                           Valarie Bishop
Dr. Jeff Cashman                   Kristy Fryar                              Vic Carpenter
Dr. Linda Bell                      Leigh Bragg                               Warren Bolton

Opening- Committee Business- Dr. Linda Bell

• Welcome to any new attendees
• Motion and approval of January 3rd meeting minutes

Review Successes, Challenges and Action Steps- Group Discussion

SOUTH CAROLINA COVID-19 VACCINE ROLLOUT
VACCINE ADVISORY COMMITTEE
SUCCESSES AND CHALLENGES REVIEW

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<th>SUCCESSES</th>
<th>ACTIONS</th>
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<td>Faith-Based Community Outreach - engages across faith groups, educational levels, etc.</td>
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<td>• Incredible resiliency of hospital workers despite the many challenges they have faced throughout the pandemic.</td>
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<td>• Cooperation of hospitals and facilities in sharing allocations to transfer doses and keep administration going.</td>
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<td>• Most nursing home and assisted living facilities in CVS/Walgreens have had initial clinics, some have had a second.</td>
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<td>• Uptake comparable to nationwide. More residents willing to receive vaccine than staff.</td>
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<td>• Many staff waiting for second clinic. Seeing more staff uptake at the 2nd clinic.</td>
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From payor perspective things are very consistent regarding policies and procedures the processes in place should not be a barrier to getting shots in arms.

Payor Treatment of Vaccine Administration:
A. Payors released billing codes along with the reimbursement rates (DHHS mirror the Medicare Part B rates):
   a. DHHS Bulletin released 12/23/2020
   i. Reminds providers to bill only for administration of vaccine, not the cost of the vaccine itself.
   ii. Vaccine administered in FQHC or HHC will be paid at a billable rate.
   iii. Will reimburse pharmacy providers through pharmacy benefit at Medicare Part B rates (DHHS).
   iv. Coverage available for family planning members and COVID-19 only members (DHHS)
      1. COVID only covers testing and vaccination administration.
   B. DHHS has provided semi-official guidance to MCOs regarding how the vaccine administration will be funded. This is consistent with Blue Cross:
      a. Payments will be allowed to any qualified, enrolled provider, whether par or non-par.

• Medicaid is looking at DHHS for messaging, continued availability of those messages is important to reference in communications with beneficiaries
• Apply for COVID-19 Limited Benefit Coverage | COVID-19 (scdhhs.gov)
• Application for Coverage for Vaccine Administration Coverage
• SC Rural Health Care Resource Dashboard (rHCnet.com)
Other than people 70y.o. and HCP, the majority of People Living with HIV/AIDS (PLWHA) have no access to the vaccines now; SC has not placed PLWHA in any prioritized category unless they qualify by age or a short list of comorbidities.

In the HIV community, there is a lot of frustration with the rollout pace.

PLWHA noting other states have at least given an expected appointment date, some have received 1st and 2nd dose. If they have comorbid conditions but are not over 65. Prevaling mood for PLWHA is frustration, not with the as-yet unavailable process of scheduling, but with lack of information and perceived pace of the rollout.

911 employees and prison employees highly susceptible due to factors limiting mask-wearing and ability to physically distance.

People with disabilities (including high risk medical conditions) not being prioritized.

People on HCBS waivers living in the community are not prioritized.

Caregivers providing care to this population should also be prioritized.

Unsuitable plan to accommodate people who are unable to leave their home to reach access vaccination.

The fact that some VAC members were not aware of some actions and plans that DHEC has taken is a challenge in and of itself and is a communications issue.

- Provide guidance at a lower reading level e.g. with short supply of vaccine use analogies, there aren’t enough supplies available, who gets them?
- Enhanced communication regarding vaccine allocations and utilization rates.

Some communities interpreting 1a/1b to include “all public safety”. Interpretation differs county to county.

Confusing/inconsistent messaging regarding phases and who is included in each from federal, state and DHEC posted guidance.

Materials not available so others know where they fit in getting the vaccine.

- Clearly define who within systems are getting vaccines.
- Improve outreach to seniors who have no access to high-speed internet.
- AARP proposes partnering with SC Thrive and DHEC to reach seniors with landlines only to sign them up for appointments. Will conduct a

b. Prior authorization will not be required.

c. There is no cost-sharing for members at least during the PHF.

d. Pharmacy guidance on actual billing procedures is ongoing at DHHS.

Community-based vaccination events have been well-received.

- Staff and residents in large congregate facilities for people with developmental disabilities got vaccine.
- Parents of children with some high-risk medical conditions given priority.

DHEC staff has been quick to answer questions and eager to speak to education stakeholders regarding vaccine.

Phase 1A included school nurses and certain therapists and trainers who work in schools. The communication to these groups was not well coordinated on the state level but fortunately due to the small number of these individuals, vaccination has gone well.

- Faith-Based Community Outreach engages across faith groups, educational levels, etc.

FQHCs - Primary care focuses on preventive care and are ready to be major player in the solution in prevent the spread of COVID

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<th>CHALLENGES</th>
<th>Vaccine Access (reported by multiple groups)</th>
<th>ACTIONS</th>
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<td>Availability of the vaccine in rural areas has been limited</td>
<td>Targeting vaccines where they are needed most is the mission VAC</td>
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<td>There is confusion as to where the vaccine is available</td>
<td>Adjust distribution given we don’t have abundant vaccine.</td>
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<td>Kaiser Family Foundation reports that 60% of older Americans don’t know where to get the vaccine; 50% of people are frustrated with the process; 25% are angry</td>
<td>Consider how populations behave when there is a supply limitation. It requires the entire population to have the same values, we do not.</td>
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<td>Transportation remains a difficulty for many insurance beneficiaries</td>
<td>Vaccine strategies need to maximize the impact of patient-centered medical home (PCMH) model used at FQHCs and other primary care entities.</td>
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<td>Scarcity in rural areas mentioned by multiple groups</td>
<td>Optimizing logistics around primary care practices</td>
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<td>Inequitable vaccine access, not always reflective of risk, ensuring we are looking out for those most in need</td>
<td>Equity-driven plan to deploy vaccines to rural areas and based on a RIV</td>
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<td>Scarce vaccine must be distributed using a formula that takes into account factors that make populations more at risk for infection and death.</td>
<td>Need to ensure rural access and access for those interfacing with vulnerable populations.</td>
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Health disparities for Medicaid population make the virus even more deadly.
| Policy | DHEC Office of Media Relations and Office of Outreach Communications is working to make website ADA compliant. Provide guidance at a lower reading level e.g. with short supply of vaccine use analogies there aren't enough apples available, who gets them? Need to encourage community conversations to combat misinformation. Desire to organize a community conversation/virtual town-hall to reach constituents. Provide prepared response regarding the new direction of the VAC. Encourage community conversations to combat misinformation. Community Health Workers educational session helped many of the attendees to understand better, challenge the myths and now be spokespersons in their communities. Organize a community conversation/virtual town-hall to reach constituents. Enhanced communication regarding vaccine allocations and utilization rates. Messaging for MCN members is expected to follow DHEC guidance. Get vaccinated, following DHEC guidelines posted on website or at clinic center - DONE. Get both vaccinations within the appropriate timelines; if unable to do so, get it whenever possible - just get vaccinated. Messaging on limited supply is required - DONE. A web-based approach must be strongly supported by a call center with the capacity to handle the large loads with acceptable response times – NEW CALL CENTER ACTIVATED. | DHEC will continue to evaluate how best to make allocations. |

| Per capita vote by DHEC’s board | With a regional model we must still recognize differences in regions on who would receive vaccine based on social vulnerability. Need to know who in the county is receiving vaccine in order to plan appropriately and recognize disparities that exist. |

| Concerns about school/district knowledge of what is needed to successfully partner with an approved vaccine provider, e.g. medical orders for the school nurse, training, emergency supplies for adverse reactions, WO vs end legal review for liability. School districts are accustomed to planning well in advance; the lack of specificity and inability of DHEC to provide information on how to plan for an efficient rollout for Phase 1b has been frustrating. | Provide generic guidance to help schools safely develop partnerships. |

| Many manufacturers wondering how DHEC plans allocation in 1b. Many have or are signing up with 3rd Party Providers, e.g. Doctors Care, hospitals, Pharmacy (a Walgreens company serving BMW), etc.; want their provider to get enough for 50% of “Frontline essential” employees, and have to deliver the other 50% at some other time. Uncertainty if 1b shots will be by “appointment only”, whether through a 3rd Party Provider for a group, or a local pharmacy for 1b individuals? Identification of those eligible will be an issue for companies, though more so for 1a individual sign ups. Seeing new state-wide system coming and concerned how it will impact them. Companies approve of efficiency, but concerned about possible chaos for 3rd Party Provider agreements with established relationships. Abrupt change to an “all individual” system may delete existing 3rd Party relationship plans. Complexity of any further stratified industry designations, i.e. within the same company some employees qualify for the vaccine and others do not yet. Liability and HR Departments having to make judgement calls on risk. Major concern about the technical decision plants may have to make when choosing “higher risk” vs. “lower risk”, and liability impact. Retail pharmacy concerned about how to distinguish/determine/qualify individuals for eligibility. The banking group is concerned about the impact of smaller financial institutions, some have had to close branches. Big banks can shift business to other branches. Concerned about being 1c. | Address information gaps for Companies. |

| Reducing provider burnout and provider burden continues to be a national priority under the HHS’s Bureau of Primary Care. |
• Success: Weekly, ongoing CME meetings with Dr. Foster and other physician-presenters.
• Great steps made at last DHEC board meeting showing population by county and vaccine reception by county to assist in analyzing vaccine equity.
• Possible need for clarification on some of the information presented on the new dashboard, including:
  o Difference in vaccine acceptance in men and women
  o Role of rural pharmacies
• Access for individuals with HIV/AIDS with pace of rollout and lack of information.
• Lack of prioritization
• Difficulty scheduling and holding community events since DHEC does not know their allocation until the week before, often.
• DHEC to move forward with regional bodies- decisions being made on how the membership of each body will be determined.
• As with FQHCs, school districts are accustomed to planning well in advance.
• Providers will be needed for standing orders for vaccination in school districts.
• Schools as vaccination sites
• Complexities of furthering industry specifications, for example subcategorizing of employees within a specific business.
  o DHEC working to provide specific guidance for employers
• Ensuring that nursing home residents get their second doses
• Individuals experiencing homelessness
• The “black market” of leftover doses- what is the system and accountability?
• Variants- additional information needed including statistics on prevalence of each type in the state
ADC Resources*- For Information

- Customizable COVID-19 Vaccine Content for Community-Based Organizations Friday, February 12, 2021
- Health Equity Considerations and Racial and Ethnic Minority Groups Friday, February 12, 2021
- Social Media Toolkit Friday, February 12, 2021
- Ensuring Equity in COVID-19 Vaccine Distribution Tuesday, February 09, 2021
- COVID-19 Vaccine Communication Toolkit for Community-Based Organizations: Getting Started Tuesday, February 09, 2021

Adjourn – 1:40 pm

Next meeting: Wednesday 3/3/2021 from 12-2pm