The Task Force to Strengthen the Health and Promote the Environment of South Carolina

2100 Bull Street
Columbia, SC 29201

Health Subcommittee

August 31, 2021

Minutes

The SHaPE SC Health Subcommittee met on **August 31, 2021**, at **3:00 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), Lathran Woodard, Lillian Mood.

Attending virtually:

Connie Munn, Brenda Murphy, Juana Slade, Thornton Kirby, Alan Hughes, Dr. Jeffrey Korte, Bishop Samuel Green Jr., Richele Taylor,

Not in attendance:

Dr. Thaddeus Bell, Gwen Thompson, Dr. Brannon Traxler, Dr. Graham Adams, Eric Bellamy, Patricia Moore-Pastides, Kim Wilkerson.

Also in attendance were Bernie Hawkins, Facilitator (SHaPE SC), 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 August 6, 2021 Minutes

Ms. Mood made a motion, seconded by Ms. Woodard, to approve the minutes as written. The motion carried by unanimous consent.

Item 3: Taskforce Debriefing

Dr. Pearson stated that the subcommittee will be moving forward with developing recommendations to be presented at the full Task Force meeting on September 17, 2021. Unlike the other subcommittees, the Health subcommittee did not make specific recommendations at the August 10, 2021, full Task Force meeting. Rather, the subcommittee identified the strengths, opportunities, and challenges that will form the framework of its recommendations during the facilitated discussion at the meeting. These recommendations should be mission-driven and mindful of the other entities potentially affected by them.

Item 4: Discussion of the Subcommittee Report

Dr. Pearson requested comments from the attending members.

Ms. Woodard noted the commonality of the workforce and questioned whether the focus should be on building up DHEC or another organization rather than on collaboration between partners. You don't necessarily have to hire staff to make something happen when there are others that can do the work.

Dr. Pearson agreed that DHEC is more of a gap-filler than a healthcare provider. Ms. Mood observed that DHEC fills the gaps by providing access to the care needed. What would more staff do? There needs to be an understanding through epidemiological evidence where the issues are and work together to resolve them. This is a different staff development issue.

Ms. Slade appreciated the historical perspective provided by several of the members. She shared that no one size fits all so there needs to be a look at overall public health needs, determine what we're doing and what isn't working, and then support plans to enrich either DHEC or others to meet these additional needs.

Mr. Hughes noted his Long-Term Care (LTC) background and stated that this has been an educational process on just how much of an enormous responsibility DHEC has. This Task Force came about due to criticism of the agency, but it will allow the development of benchmarks and measures to improve performance.

Dr. Korte agreed that this was a learning process on public policy. Related to filling the gaps, he feels that DHEC has become more of a provider as a result. There are funding issues, so hopefully this will provide a platform for discussion and generate the strong evidence needed to provide the funds to address these gaps. Mr. Kirby agreed that this was a daunting task.

Ms. Taylor found these discussions useful and encouraging that there were issues being agreed upon. Dr. Pearson thanked Ms. Taylor for compiling information from the meetings in order for him to develop the presentation he made at the August 10, 2021, Task Force meeting.

Bishop Green stated that he was still catching up on all of the material presented, but that he was concerned that the issues of health disparities and access to health care providers in rural and marginalized communities needed to be addressed. The African-American and religious communities have their own perspectives to contribute. Dr. Pearson assured him that health disparities and access

to care were frequent topics of discussion within this subcommittee and he would forward some of the relevant documentation.

Mr. Hughes stated that he was impressed with the way that DHEC staff provided testing and delivered supplies to the LTC community. They successfully developed models to predict the needs.

Ms. Mood noted that DHEC found itself in a situation that no one ever wanted to be in, but the pandemic shined a light on what rarely gets noticed. No one else does this level of assessment, surveillance, population data collection, analyzing geographic differences, etc. She also specifically identified the DHEC Lab as providing unique services that most people are unaware of.

Dr. Pearson stated that he led the public health team for the UofSC COVID-19 response and the DHEC Lab was active 24/7 to assist. He noted that the Lab serves both the health and environmental sides of the agency, so if there was to be an agency split there would be a need to create lab services for both. Ms. Mood agreed that Environmental Health is heavily dependent on the Lab.

Bishop Green stated that he had had a less positive experience with DHEC's COVID-19 response. There was less testing in the communities he serves and there was a lot of bureaucracy involved in trying to get testing set up. Requests got filtered to multiple parties, delaying a response for weeks. There were also few DHEC staff assigned when they did take place. They were forced to contract with an out-of-state organization to meet the need. He suggested that there needed to be a greater focus on community orientation by using local community-based teams.

Mr. Hughes noted that there were initial challenges in obtaining adequate supplies, but unlike local emergencies we normally deal with like hurricanes this was a nationwide crisis. Supplies were low and it took time to establish supply routes while we were competing with every other state for those same resources. We take care of our own and don't like to have to rely on outsiders to help, so we need a strong public health home front to do so.

Ms. Woodard said that the pandemic showed we were not prepared. DHEC staff had been gutted over the past decade, so they were already barely meeting basic requirements like contact tracing before the pandemic. The hospitals and Federally Qualified Health Centers (FQHC's) volunteered their help. Not all of DHEC knows how to trigger assistance. Using Hurricane Hugo as an example, everyone knew their roles in partnerships, it wasn't just DHEC mobilizing to deal with it. She stated that we should learn from the lessons.

Ms. Mood indicated that we need to be nimble and establish good emergency prep teams within communities that understand how to react. The purpose of community teams is to identify what the threats are and have a network in place to respond to them.

Item 5: Working Session on the Development of Draft Recommendations

Ms. Mood recommended the first-tier comments as a starting point for the discussions. To her, now is not the time to be splitting up resources. Instead, they need to be put together in the most effective way possible. Health hazards and threats affect both Public Health (PH) and Environmental Affairs (EA) and each have ties to the agency's overall mission. There is the need for appropriate work policies and public education.

She also identified the need for: the right capacity to carry out the agency's responsibilities; capable leadership with the proper expertise; increased salaries and staff retention; and a streamlined hiring process. All priorities on both PH and EA should be identified in the budgets process so the legislature is aware of them, and they don't get lost in the overall agency budget.

Ms. Mood also stated the need to assure access and responsibility to community needs. Agencies should know one another and establish contacts so they can find the right person, value community relationships, and improve both internal and external processes (ex. use of teleservices during COVID-19).

We also need to make sure that we don't lose the comments made by the public since they are affected by our decisions. The system is not constructed to respond to every comment but perhaps some sort of team should review and follow through. Finally, we should keep measures in front of the public (ex. air quality on weather reports) to remind them of what DHEC does on their behalf.

Dr. Pearson stated that, based on the agency's mission as the starting point, what should be our sense of comfort about the state of DHEC? Should it be kept, split, or revised?

Ms. Slade said that you get what you pay for when you compare health outcomes against the per capita expenditures for public health. It is unfair to expect the 'right answer' if we are not spending the right money on public health. The takeaway from COVID-19 is the data created shows what gets monitored and the importance of keeping outcome status in front of the public. However, without the right infrastructure organizational charts don't matter. We should be inspired by how the local community agencies reacted in the Upstate, learn lessons from them, and figure out how to keep these conversations going.

Dr. Pearson agreed regarding the poor outcomes and noted the difference between infrastructure and structure. Ms. Slade also noted the importance of data representing the population the agency serves (by race, socioeconomic status, etc.).

Ms. Woodard questioned how relevant the Task Force's recommendations were going to be. Had the decision already been made to split DHEC up and it was up to us to figure out what PH should look like afterwards? Dr. Pearson assured her that it was not a foregone conclusion because he was unwilling to waste all his time on 'window dressing,' and that he anticipated the topic would be debated by the Legislature next session. Mr. Hawkins confirmed, saying there were the three overarching questions they were charged to address, with their recommendations then presented to the DHEC Board, Governor's staff, and the General Assembly.

Dr. Pearson stated that the concern was more than just increasing funding, it was assuring that DHEC had the capacity to deliver what they can/should do and fill the gaps when needed.

Ms. Woodard noted that we should be looking at what the public accepts or expects from DHEC. Some parts of the public don't necessarily accept DHEC or the government 'checking up on them' so they need to find other partners to fill those roles. Ms. Mood compared it to the initial days of HIV contact tracing where there was resistance to someone asking them questions about their private lives. Ms. Woodward indicated that this was the role of partners, to take on outreach that DHEC can't.

Ms. Mood also identified school nurses as relying on public health guidance regarding avoidance, tracing, etc.

Ms. Woodard stated that it was first necessary to resolve whether EA needs to stay together with PH before they could answer any of the other questions asked. She noted that North Carolina has fluctuated back-and-forth and has now split them again. It would be difficult but not impossible to separate the agency, but there is concern about how clients could potentially fall through the cracks in any reorganization (ex. DMH and DAODAS having clients with comorbidities so it isn't clear who should be the primary agency taking care of them).

Ms. Mood noted the letters submitted by Doug Bryant, former DHEC Director, and Stan Shealy, Mayor of Chapin, relating to issues involving PH and EA coordination. These responses would have been more difficult to achieve if they'd had to go to multiple agencies with differing priorities, so there are benefits to them being under the same umbrella.

Bishop Green requested organizational charts so that he could see how the PH and EA sides compare, as well as budget allocations to compare them standing apart versus joined. Dr. Pearson stated that some of that information had already been provided and he would forward it to him directly.

Ms. Murphy identified the need to minimize the silos and have more engagement between the agency program areas. It can be challenging to access between them.

Mr. Hughes stated his concerns about the funding challenges that would be involved, and all the unnecessary costs involved in trying to create an entire separate entity. There is a need for greater collaboration between PH and EA, but the message of the pandemic was that it was more cost efficient and assured the resources would be there with the programs merged. He has an ongoing concern that mental health is not ranked highly as a public health priority.

Dr. Pearson noted the challenge of trying to compare the known with the unknown. Any restructuring would result in paralysis while reorganizing/rebranding the pieces and parts. DHEC has already lost a third of their staff in the past 10 years. An entirely new entity might be more appealing to potential new hires but there is a risk of losing institutional knowledge if older employees decide to leave. It is also unknown how the different agency's missions would change in a merger.

Mr. Hughes said that he could envision competing budgets appearing in front of the legislature, fighting over who gets what.

Mr. Hawkins noted that they have asked for what the projected costs for splitting the agency would be but there are no official projections to share. According to Senator Martin, bills normally have a fiscal impact statement included but there isn't one for S.2.

Ms. Woodard suggesting discovering what went where in North Carolina's split. It could reduce the stigma of mental health and substance abuse if they were folded into a PH agency rather than being stand-alone organizations.

Ms. Mood agreed that we can learn from the experiences of other states, although the dynamics vary. Currently, the DHEC Executive Leadership Team (ELT) involves both PH and EA leaders on policy

development, etc., that affects both sides, which would be harder to replicate if the staff were in separate agencies.

Dr. Pearson asked if any of the other subcommittee members had any viewpoints they wanted to share on the question of separating DHEC.

Dr. Korte said that he would lean towards keeping them together, based on the potential costs of splitting them and the current synergies of them working together. However, if they were separated, they might wind up with more focused and specialized leadership who could be better advocates for their side. It is hard for a Director to be well versed in both PH and EA.

Dr. Pearson noted that there have been four confirmed Directors in the past decade along with several acting ones. Prior to then the agency used to groom future Directors in-house, but none of the latter leaders were familiar with the entirety of the agency. He also observed that there have been four PH Directors in the past eight years, but the EA Director has remained unchanged.

He further stated that DHEC is one of three states with combined PH/EA, as well as being only one of 13 states with a centralized PH structure (i.e., all the county health departments are under central office control). Contrast that with North Carolina, which has over 100 individual county health departments under local control. We would need to consider if this centralized arrangement would remain if the agency structure changed. Ms. Mood compared this with the autonomy and varying resources of South Carolina school districts. She also noted that during Hugo, the centralized structure allowed them to mobilize staff from other regions to assist so local staff could take care of their own issues.

Dr. Pearson stated that as a rural state, losing a centralized structure could negatively impact health disparities if counties are left to their own devices. This is another consideration.

He then asked what other high-level categories should be addressed.

Mr. Hughes saw access and information as issues. The programs should consider hiring competent individuals as community resource directors knowledgeable about their program areas who could help coordinate answers. This would improve PR by increasing access, because the public gets frustrated when the bureaucracy can't give them answers.

Ms. Woodard said that looking at it from the optics of the public she leans toward keeping the agency together. However, they need a workforce within the community, not adding more staff at the top. They need effective communication to all populations regarding access, testing, etc. They didn't give out the right information or realize that a single message wouldn't work to convey the message to all the different perspectives involved. Communities still remember issues like Tuskegee.

Ms. Murphy stated the need to look at the organizational structure and use feedback from the population as a basis of recommendations for what is needed. DHEC is not viewed as efficient so there is a need for care delivery improvements.

Dr. Pearson noted that a lengthy compilation of public comments has been received through the SHaPE website. He further noted that today is the last day for the public to submit comments, but

there are already a number of themes that have emerged. He acknowledged that public comments are important, but the subcommittee members need to remember that we were appointed to the Task Force because of our expertise so we don't want to discount our own ideas and perceptions.

Dr. Pearson identified four general areas of interest: infrastructure, structure, and organizational capacity; funding and capacity; collaboration and community outreach; and access coordination and resources. What else? What helps us improve, innovation?

Ms. Woodard stated that access to the public means more than just being open from nine to five.

She also questioned how to regain the public's trust, because the messages kept changing during the pandemic. How to rebrand as 'we are the voice of the community?'

Mr. Hawkins noted the impact of budget cuts, but also the need to preserve what is working regardless of what happens (i.e., rapid staff hiring, telemedicine/teleWIC, etc.).

Ms. Woodard said that there should be strong science-based decision-making, based on epidemiology and content-expert staff, along with their partners in a collaborative working environment.

Item 6: Next Steps

Dr. Pearson said that he did not wish to convene all 18 subcommittee members in order to write the proposed recommendations. Instead, he will ask for three or four volunteers to donate their time to drafting recommendations. He will then share the results with the entire subcommittee for comments before presenting them at the September 17, 2021, Task Force Meeting. He asked to be notified within the next 24 hours if anyone was interested in serving on the drafting committee, otherwise he would start contacting members directly. He then thanked all the members and staff for their participation and assistance.

Being no further business, Subcommittee Chair Dr. Pearson adjourned the meeting at 5:00 pm.

Recordings of Task Force and Subcommittee meetings can be found at the following web address: https://shapesouthcarolina.gov. .

Dr. Lee Pearson, Health Subcommittee Chair
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