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

2nd Meeting of the Full-Task Force

Aug. 10, 2021

Welcome

Bernie Hawkins

Task Force Facilitator

SHaPE SC

Opening Remarks

Larry A. Martin

Task Force Chair

SHaPE SC

Agenda

- Welcome
- Opening remarks
- Overview
- Subcommittee report outs
  - Environmental Protection
  - Behavioral Health
  - Health
- Facilitated discussion
- Next steps and closing remarks

Environmental Protection Subcommittee

Interim Report

Tommy Lavender, Subcommittee Chair

Aug. 10, 2021

Subcommittee Chair and Members

Tommy Lavender, Chair

Members:

Jeffery Allen, PhD
Art Braswell
Emily Cedzo
John Durst
Michael Fields
Todd Glover
Rebecca Haynes
Sara Hazzard
Erika Hollis
Clint Leach
Jill Miller
Harold Mitchell Jr.
Mark Nix
Myra Reece
Ken Rentiers
Gary Spires
Bill Stangler

How are we presently doing in delivering services?

Current Strengths

- A **strong process and focus on building stakeholder input** surrounding environmental issues.
- Recent **improvements in communications** with external partners.
- An enhanced internal coordination of customer service through efforts like e-Permitting.
- The **leveraging of limited resources** to enhance environmental protection.

Current Challenges

- A **severe lack of sustainable funding and resources** allocated to the environmental programs**,** which is furthered by an increase in regulatory mandates.
    - **Example:** EPA program support grant funding has not increased in ~20 years, while responsibilities for states have increased.
- **Low salaries across many professional categories**, such as engineers and geologists, provide challenges impacting capacities to provide services and recruit and retain subject matter experts.
- **Recent centralization of internal agency support services** within DHEC has unintentionally resulted in a decreased focus on mission critical services being provided at the regional (local) level.

Current Gaps

- Historic **internal processes built over the years** at times can cause lack of needed flexibility for client support services.

- **Clarification needed concerning the role of local government (**MS4s) **and DHEC** (e.g., stormwater issues and challenges).

- Need for **full-time dedicated environmental toxicology position(s) within Environmental Affairs** to provide a more focused response to environmental health issues.

- With limited resources, there exists a need for agencies to **clearly define and focus on the delivery of mission critical services**.

What are our greatest future challenges?

Navigating the Road Ahead

- Continued economic development and population growth will require **expanded staffing and resource capacities** to keep up.
- **Built-in capacity** to respond to increasing federal environmental mandates and emerging contaminants.
- **Adequate funding and resources** continue to be a challenge.
- **Embedded internal support service**, to some degree, at the local level to provide more efficient, effective, and meaningful mission critical services for the public.
- Need to **review internal processes and cross-agency collaboration.**

What are the initial recommendations?

Initial Recommendations and Discussions

- Provide **funding for full-time dedicated environmental toxicologist(s) within Environmental Affairs** to address environmental health issues.

- Conduct cross-analysis of critical agency positions to determine needed **competitive salaries** with the private sector.

- Evaluate effectiveness of current centralized structure of support functions, such as IT, HR, and Finance, and **consider restructuring to embed those support functions within the mission-focused deputy areas**.

Proposed Structural or Functional Changes

- **De-centralize support functions such as IT, HR, and Finance/Budget**
  - **For example:** specific technical skills needed for permitting and other environmental management positions may not be fully understood by agency HR staff, whereas **dedicated support positions familiar with the subject matter area needs** can overcome hiring and retention challenges.

- Consider **separate budget process for environmental programs**
  - Currently, budget requests from Environmental Affairs are merged into the agency's overall budget request.
  - This appears to obscure the actual resource needs for adequately implementing environmental programs.

Proposed Realignment of Agencies and Services

- **Reassigning food service** and **rabies control** to a more appropriate program or agency, as they do not appear to be directly related to environmental protection.

- Some discussion has taken place regarding **consolidation of the water planning functions** into DHEC.
  - While there has been support for this consolidation effort from the regulated community, other stakeholders expressed concern regarding potential delays in the ongoing water planning process that might be occasioned by consolidating these functions to DHEC.
  - **No consensus** has been reached on this specific topic.

Behavioral Health Subcommittee

Interim Report

Mark Binkley, Subcommittee Chair

Aug. 10, 2021

Subcommittee Chair and Members

Mark Binkley, Subcommittee Chair, Senior Executive Assistant to the State Director, SC Department of Mental Health

Laura Aldinger, Executive Director, Behavioral Health Services of South Carolina

Gayle Aycock, President and Chief Executive Officer, LRADAC

Jarrod Bruder, Executive Director, SC Sherriff's Association

Anna Marie Conner, Attorney/Team Leader, Disability Rights South Carolina

Lee Dutton, Chief of Staff, SC Department of Alcohol and Other Drug Abuse Services

Beth Franco, Executive Director, Disability Rights South Carolina

Sara Goldsby, Director, SC Department of Alcohol and Other Drug Abuse Services

William Grimsley, Secretary of Veterans' Affairs, SC Department of Veterans' Affairs

Elizabeth Harmon, Executive Director, SC Behavioral Health Coalition

Bill Lindsey, Executive Director, SC Chapter of the National Alliance for Mental Illness

Amy McCulloch, Probate Judge for Richland County, Probate Judges Association

Joseph McLamb, Chief of Staff, SC Department of Veterans' Affairs

Kenneth Rogers, State Director, Department of Mental Health

Kacey Schmitt, Director of Social Work, SC Department of Health and Environmental Control

Anne Summer, Co-Chair, Policy, Legislative & Regulatory Committee, SC Behavioral Health Coalition

Gerald Wilson, Chair, SC Behavioral Health Coalition

How are we presently doing in delivering services?

Current Strengths

Infrastructure:

- Comprehensive behavioral health services that include prevention, early intervention, crisis care, behavioral health care in emergency departments, management of inpatient behavioral health services and telehealth/telepsychiatry are available across the state.

- Strength of community-based services is evident through partnerships with schools, law enforcement agencies, courts, hospitals, community health centers and community coalitions, as well as other State agencies

- Organizationally, public mental health service delivery in South Carolina is coordinated under the jurisdiction of a single integrated state agency that allows for cohesive and consistent behavioral health practices throughout the state.

Current Strengths

Access:

- DMH services are generally accessible geographically through its 16 mental health centers and their associated clinic locations covering all 46 counties.

- DMH, through its mental health centers, operates a statewide mobile crisis program which offers emergency psychiatric screening and assessment services. Mobile crisis services are available 24/7/365 through a single statewide toll-free telephone number.

- DMH has also worked to expand access through mobile behavioral health clinics that bring mental health services to underserved communities throughout the state, known as Highway to Hope.

Current Strengths

Access (cont'd.):

- DAODAS has also worked to ensure the delivery of core, evidence-based substance use disorder (SUD) services in every county in South Carolina and has even expanded services in many communities.

- DAODAS has grown its extensive network to over 135 providers, including 72 community-based Narcan distributors and six (6) recovery sites/centers.

- Collectively, the work of DAODAS results in approximately 49,000 individuals positively impacted annually (with about 33,000 enrolled in treatment).

Current Strengths

Support Services:

- DMH aftercare and supportive services include assistance with patients' housing needs/rent support, vocational assistance, linkage to primary care and minimizing barriers to securing medications.

- Support services enable patients who are hospitalized to be discharged sooner than they would in their absence. Reducing lengths of stay in its State Hospitals enables DMH to treat more patients in its limited number of available beds.

- DMH also partners with the State Housing Authority and residential real estate developers of low and moderate housing to create additional affordable housing options for patients. To date, the agency has helped to create almost 3,000 units of affordable housing for its patients throughout the state.

Current Strengths

Collaboration:

- DAODAS collaborates with state agencies in supporting its mission; namely, the Department of Corrections in lowering the recidivism rate related to SUD and DHEC on a taskforce to address the opioid epidemic in South Carolina.

- Colocation, or proximity, of DHEC Health Departments and DMH and DAODAS sites makes it easier for DHEC Social Workers to refer more seamlessly.

- DAODAS has also fostered linkages with DMH through collaboration on the *SC Hopes* hotline.

Current Challenges

Staffing:

- Below market salaries at DMH makes recruitment and retention increasingly difficult.
- The high number of vacant positions reduces the functional capacity of its hospitals and prevents the agency from the ability to deliver its full array of community services.
- Turnover at DHEC, DMH and DAODAS County Authorities inhibits continuity and necessitates frequent reeducation of direct care staff.
- Social Work services provided by DHEC are limited to specific services including tuberculosis, children and youth with special healthcare needs, etc. Also, the Social Work workforce at DHEC is relatively small (2-5 Social Workers per Region).

Current Challenges

Collaboration:

- Some private hospitals don’t fully understand the involuntary commitment process for behavioral health patients admitted through the emergency admission process;

- Some ED patients in community hospitals are cleared medically and discharged without adequate coordination for needed behavioral health and/or SUD services.

Funding:

- Restrictive policies on some federal funding and funding mandates sometimes makes it difficult to plan for and execute an uninterrupted continuum of care for behavioral health services.

Current Challenges

Funding:

- Lack of reimbursement for some public behavioral telehealth services limits expansion into new modalities.
- The Medicaid IMD Exclusion prohibits payment/coverage for Medicaid recipients in need of inpatient behavioral health services in a State hospital or private psychiatric hospital.
- The IMD Exclusion also indirectly limits the use of Medicaid waivers to create home and community-based mental health services.
- Federal Mental Health and SUD block grant funding structure prohibits the blending of block grant funds to address the behavioral health needs of co-occurring patients across the state.

Current Challenges

Support Services:

- Transportation challenges for clients and patients negatively impacts access to care for both DMH and DAODAS.

- Coordinating housing and employment opportunities often presents as a challenge for individuals completing behavioral health treatment.

Access:

- Long wait times for DMH forensic hospital admissions.

Current Gaps

- DAODAS-sponsored school-based services; such services are not currently in the appropriations for the agency.
- An opportunity exists to expand behavioral health services in jails and prisons across the state.
- Investments in workforce development for behavioral health and SUD professionals can be improved.
- Lack of system interoperability between behavioral health and SUD agencies makes it difficult to coordinate care for comorbid individuals.
- Prohibitions on sharing information from programs which provide SUD treatment as a result of federal law (42 CFR Part 2.)

What are our greatest future challenges?

Navigating the Road Ahead

- Competitive salaries, availability of sufficient qualified staff and other resource constraints are the greatest roadblocks to maximizing service delivery and integration.

- Stigma associated with receiving behavioral health services stands as a primary challenge to all providers of behavioral health services, and one that requires constant effort to combat.

- Insufficient integration of core behavioral health and general health services is also a major challenge, especially as it is a recognized means of improving both the effectiveness and efficiency of healthcare services.

Initial Considerations for a Brighter Tomorrow

Preserving What is Working

- Continue collaboration across agencies, community organizations and other stakeholders to minimize silos and promote the continuum of care.

- Continue to leverage partnerships and available resources that offer employment and housing support for individuals receiving behavioral health services.

- Increase the availability of diversionary courts, such as mental health courts and drug courts, to increase participation by defendants with behavioral health disorders in effective treatment and reduce criminal recidivism and court- and corrections-related costs.

Proposed Structural or Functional Changes

Co-location

- Identify and leverage opportunities to co-locate behavioral health and general health services in communities across the state. Co-location could do much to remedy the stigma challenges associated with receiving behavioral health care.

- Co-location would also improve the opportunities for the integration of primary and behavioral healthcare, making it easier to treat comorbid patients. Integration of primary and behavioral healthcare has been shown to significantly improve the overall health outcomes of patients while reducing health care costs.

Proposed Structural or Functional Changes

Co-location (cont'd.)

- Pursue future opportunities to co-locate county-based public health, mental health and publicly funded SU providers.
- Soft savings associated with co-location for citizens receiving services from both agencies (i.e., time savings, reduced transportation costs, increased satisfaction, etc.) should also be considered when developing a plan. As should differences when planning for co-location in urban communities versus rural communities.
- Co-location of support services, non-profit organizations, other partner agencies and primary care providers should also be considered wherever possible to maximize access to care for citizens, especially in rural areas.

Proposed Structural or Functional Changes

Information Technology:

- Address information-sharing roadblocks that would allow for easier communication between providers treating the same individual for their behavioral health and SUD needs.
- Explore ways to improve the ability for all State operated or supported healthcare providers, and specifically DHEC, DMH and DAODAS (including its county authorities) to share patient information electronically. At a minimum, secure direct messaging for care coordination, as needed.
- Recommendations would positively impact service delivery across the state by 1) improving timeliness of care, 2) improving quality of care, 3) integrating primary care and behavioral health services and 4) improving overall health outcomes across the continuum of care.

Proposed Structural or Functional Changes

Information Technology (cont'd.):

- Increased information availability will also improve providers' overall ability to assess, diagnose and appropriately prescribe treatment for patients.
- An evaluation regarding the appropriate platform for information sharing between DHEC and DMH would need to occur. The evaluation should include feasibility and usability.
- Although currently unknown, the cost of establishing an electronic platform for information sharing can become cost prohibitive, especially if it is applied broadly across all providers in the state that offer behavioral health services.

Proposed Structural or Functional Changes

Funding:

- Support to repeal or modify the federal IMD Exclusion that prohibits payment/coverage for Medicaid recipients in need of inpatient behavioral health services.
- Advocate for adequate reimbursement for behavioral health services provided in the private hospital setting; such action is likely to increase the availability and access for inpatient and residential behavioral heath services, when needed.

Staffing:

- Evaluate use of paraprofessionals and new innovative ways to staff behavioral health services (i.e., peer support specialists, community health workers, etc.).

Proposed Structural or Functional Changes

Collaboration:

- Leverage the state Behavioral Health Coalition to strengthen the relationship and collaboration with the state hospital association to maintain behavioral health services as a core priority.

Proposed Realignment of Agencies and Services

- It is the recommendation of the subcommittee that DMH and DAODAS remain autonomous while strengthening service delivery through joint trainings and continuing the routine meetings between the leadership of both agencies.
- Pursue opportunities to expand access to behavioral healthcare via paraprofessionals and leveraging technology to increase information sharing (to include DHEC).
- It is also recommended that representation from FQHCs, through the SC Primary Health Care Association, be included on the Behavioral Health Coalition on a permanent basis. FQHC involvement on the Coalition will serve to strengthen service delivery for patients that overlap public systems across the continuum of care.

Proposed Realignment of Agencies and Services

- The subcommittee also recommends advocacy for Medicaid payment policy improvements related to reimbursement rates for SUD and behavioral health treatment, including telehealth and telepsychiatry.

- It is also the recommendation of the subcommittee to continue implementation of recommendations listed in the *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health System* report.

Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems - IMPH

Proposed Realignment of Agencies and Services

- Recommendations in the IMPH report address each of the following areas of opportunity:
  - Increasing School Mental Health Services
  - Development of a Statewide array of Crisis Stabilization service
  - Discharge and Reentry Planning in the South Carolina Department of Corrections
  - Integration of primary and behavioral healthcare and Collaborative Care
  - Developing an Adequate Behavioral Health Workforce

Next Steps

- At its last meeting the Behavioral Health Subcommittee collectively determined that no more meetings are needed, but will instead be circulating a draft of its findings and recommendations for review before submitting its final report.
- Thank you!

Health Subcommittee

Interim Report

Lee Pearson, Subcommittee Chair

Aug. 10, 2021

Subcommittee Chair and Members

Lee Pearson, Chair

MEMBERS:

Graham Adams
Thaddeus Bell
Eric Bellamy
Samuel Green
Alan Hughes
Thornton Kirby
Jeffrey Korte
Lill Mood
Patricia Moore-Pastides
Connie Munn
Brenda Murphy
Juana Slade
Richele Taylor
Gwen Thompson
Brannon Traxler
Kim Wilkerson
Lathran Woodard

How are we presently doing in delivering services?

Current Strengths

- There is a mission-driven synergy that exists between the public health and environmental sides of the agency.
- The county-level presence of the agency throughout the state supports access to care and closer recognition of needs, but there are still significant concerns in areas of limited access.
- The leadership across the regions is both experienced and dedicated; there are strong community partnerships.
- The regional capacity drives much of the work of the agency with public health staff in the regions composing **41% of all DHEC staff** and **69% of all public health staff**.
- The pandemic prompted created approaches in the use of telehealth and through the use of Community Health Workers.

Current Challenges

- **There is a severe lack of funding.** State allocations currently represent ~23% of the agency budget. **SC ranks 32nd in per capita PH funding.**
- **There is a severe lack of capacity.** FTEs have been reduced by 1/3 in the past decade. This has a detrimental impact on provision of services.
- **Salaries are notably low across many professional categories**, and the recruitment and retention of staff are significant challenges impacting agency capacity and morale.
- The hiring process is both inefficient and unable to meet the needs of the agency. **Excessive vacancies are limiting capacity.**
- Frequent turnover in agency leadership in the past decade has had an enduring and negative impact on the agency.

Current Gaps

- Communication between central office and the regions is inadequate, particularly regarding agency-level directives.
- There is a lack of clarity as well as considerable variability in the county-level commitments in support of the agency.
- Inter-agency coordination is needed in key areas to eliminate gaps in services and to support improved outcomes.

What are our greatest future challenges?

Navigating the Road Ahead

- The growth in the state's population and the shifting demographics will require changing and expanding capacity in both health and environmental services.
- The reality of new and emerging infections will require continued agility on the part of DHEC and other related state agencies.
- The political neutrality and autonomy of public health are escalating challenges. This underscores the need to regain trust.
- Adequate funding is a perennial challenge, but this must be viewed through the lens of availability of services and access to care.

What are the initial recommendations?

Break

Facilitated Discussion

SHaPE SC

Next Steps and Estimated Timeline

Full-Task Force to Meet Again in September

- **Estimated Timeline:**
  - Continued subcommittee meetings on discussions and recommendations
  - Next full task force meeting confirmed by end of next week
    - Recommendations, Discussion, Adoptions/Rejection of Recommendations (***September)***
  - Report writing with subcommittee chairs ***(September – October)***
  - Draft report ***(Mid October)***
  - Presentation of the finalized report to full Task Force ***(Late October)***
  - Presentation and report to the Board, Legislature and Governor by late fall 2021



Closing Remarks

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