NCIOM and SC IMPH Carolina's Pandemic Preparedness Task Force Meeting 5

November 15, 2021
12:00 pm – 2:30 pm
Virtual Meeting

Meeting Attendees

Steering Committee Members: Graham Adams, Angel Bourdon, Cardra E. Burns, Tatyana Kelly, Ellen Essick, Emily Roach, Kathia Valverde.

Task Force Members: Jennifer Bailey, Lori Byrd, Lenora Campbell, Christine Carr, Sam Cohen, Jennifer Copeland, Rep. Carla Cunningham, Melanie Davis, Sara Davis, Laurel Edwards, Natalie English, Iris Peoples Green, Sara Goldsby, Lynn Harvey, Tessa Hastings, Erika Kirby, Vicky Ladd, Kathryn Lanier, Michael Leach, Norma Martí, Kathleen Martin, Eunice Medina, Sel Mpang, Connie Munn, Shannon Pointer, Ben Rose, Kathy Schwarting, Ivan Segura, Windsor Sherril, Drew Stanley, Shawn Stinson, A. Vernon Stringer, Richele Taylor, Hugh Tilson, Brannon Traxler, Erin Tyson, Franklin Walker, Amy Widderich

NCIOM and IMPH Staff: Marsha Bailey, Yair Centeno, Brie Hunt, Brienne Lyda-McDonald, Alison Miller, Maya Pack, Michelle Pendergrass, Katlin Phillips, Michelle Ries, Brittney Sanderson, Hunter Sox

Meeting Goals:

- Learn about each state's September and October developments
- Understand today's strategy for developing recommendations
- Develop a set of recommendations for each theme identified by your state
- Share each state's recommendations for large group discussion

I. Fostering Connections: 12:00 – 12:10 PM

Task force members were sorted into breakout rooms at arrival to connect with their colleagues before the opening of the meeting.

II. Welcome: 12:10 – 12:20 PM

Maya Pack, MS, MPA
Executive Director
South Carolina Institute of Medicine and Public Health

Ms. Maya Pack welcomed the task force members to the first joint task force meeting since August. She reviewed the importance of the task force work and elaborated on the recommendation development process.

III. Bringing the States Back Together, Timeline and Final Products: 12:20 – 12:30 PM

Maya Pack, MS, MPA
Executive Director

South Carolina Institute of Medicine and Public Health

Michelle Ries, MPH
Associate Director
North Carolina Institute of Medicine

Ms. Maya Pack and Ms. Michelle Ries facilitated a discussion that included a review of the task force timeline, report development process and hopes for the final reports. They explained that we are on track with the task force timeline and that meetings will resume in 2022 on January 24th. They also explained that the final two task force meetings in March and April will focus entirely on workshopping and finalizing recommendations for the June 2022 report release.

At this point, Ms. Maya Pack discussed the one-on-one interviews that Ms. Brie Hunt and Ms. Brittney Sanderson conducted over the course of October and November in lieu of the September and October meeting. She explained that the information gathered from the interviews is being compiled and synthesized into recommendations and materials for the upcoming meetings and will be shared before year's end. At this point in the process, some of the many common themes which have emerged include data, communications, education, behavioral health, access and social services. Ms. Michelle Ries then discussed how North Carolina has utilized Jamboard to collect information from their task force members in the past two meetings, but the exercise may be new to South Carolina task force members.

IV. Recommendation Development Discussion and Practice: 12:30 – 1:10 PM

Brie Hunt, MEd
Project Director
South Carolina Institute of Medicine and Public Health

Michelle Ries, MPH
Associate Director
North Carolina Institute of Medicine

Ms. Michelle Ries and Ms. Brie Hunt lead the group through a Jamboard practice focused on maximizing collaboration and coordination. The link to the Jamboard remained active throughout the meeting as task force members were encouraged to continue adding their thoughts and potential solutions to achieve effective collaboration and coordination in pandemic response efforts. Pertinent excerpts from the Jamboard include:

- The legislature should provide funding for a one-year project to track all organizations that provided services during COVID and what the services were. Stakeholders may include the United Way, Health People Healthy SC, and others.
- Planned, coordinated and scheduled routine communications (both ways) to ensure timely and accurate information sharing.
- Health Information Exchange (QHIN is HIE across several states)-level sets access to high quality healthcare and helps with real-time access to specialists (who would have all data on patients no matter where it was generated), keeps patients in hospitals, offices and school-based clinics closer to their communities (less travel for families) and provides comprehensive public health info (vaccine status, test results) for all providers in state.
- Adoption or connectivity between 'data and monitoring platforms' for consistency across counties / communities.

- Create a non-partisan project management office that coordinates and aligns the activities and interests of diverse stakeholders to maximize public health outcomes.
- Legislatures should reduce variability across programs / payers / etc. to the greatest extent possible to decrease bureaucratic inefficiency.
- County Health departments should work more concerted instead of like a standalone department.

V. Break: 1:10 – 1:15 PM

VI. Breakout Groups by State: 1:15 – 2:15 PM

Each state was divided into two separate breakout groups to engage in a Jamboard activity around key themes identified in past task force meetings and/or in key perspective interviews. North Carolina focused on building workforce capacity and increasing access to and utilization of care, while South Carolina addressed data and communication. Highlights from each thematic discussion are outlined below.

North Carolina

Group One

Facilitator: Alison Miller, MA, MPH
Project Director
North Carolina Institute of Medicine

Building Workforce Capacity	*Increasing Access to and Utilization of Care*
· Support the expanding of healthcare workforce by providing competitive and livable wages, access to childcare that meets the flexible hours of a health care worker, built in mental health days to support health care workers. Paid leave to support mental health and burnout · Coordination of all stakeholders in the health care system that provide both physical and mental health services, as well as being inclusive by having some public stakeholders involved in the process. A diverse group of individuals from all walks of life. · Continue and expand support for community health workers · Power-building of communities, leaders and individuals, so they can integrate their expertise to enhance distribution of information in communities. · Ongoing dialog on a quarterly or more regular basis between stakeholders to stay abreast of ongoing changes during a pandemic or epidemic. · Develop and deploy an organization to coordinate health workforce planning	- Areas of focus: broadband infrastructure, health care coverage, improved connections to care through community health workers, whole-person care - Focus on improving access to health care in rural areas, both in terms of physical and behavioral health. Support efforts to lessen stigma in community around mental health. · Ensure quick and easy access to testing and vaccination for all, and consider “pop up” events to meet other health needs of communities. · Use community-based organizations and centers (physical locations) to serve as trusted places in the community to receive information and services by underrepresented populations. - Individuals utilizing services should feel heard, respected, and connected to health care services, and service provision efforts should not be a one- time occurrence, but a part of a concerted effort to overall health and well-being.

· Support curriculum changes that increase the focus on public and community health for all levels of health care workers. · Address scope of practice and other legal barriers to efficient team-based care · Enact policies that drive to integrated, whole person care including addressing the drivers of health	

Group Two

Facilitator: Michelle Ries, MPH
Associate Director
North Carolina Institute of Medicine

Building Workforce Capacity	*Increasing Access to and Utilization of Care*
· Health systems should partner with state leadership to invest in nursing education, with special attention to recruitment and retention strategies in rural NC · Increase Medicaid reimbursement to skilled nursing and other LTC facilities in order to increase wages and improve retention of workforce (with stipulation that reimbursement goes toward wages?) · Back to work incentives need to be implemented · Enhance child welfare collaborative to provide tuition reimbursement for social workers who choose child welfare for service · Increase the minimum wage. · Consider getting rid of staffing ratios. · Require companies to provide broadband services to each county (like electricity). · Provide grants to train healthcare workers. The graduates will not be required to repay if they work in the Carolinas. · Enact longevity pay	· NCGA should provide additional funding to NC DHHS' Community Health Worker training and recruitment programs, to ensure equitable access to timely and appropriate health care services. · Develop a key stakeholder quarterly meeting process led by the state with other key stakeholders involved to keep some of the conversations going to improve efficiency and processes/preparedness efforts. · State of NC agencies should work in collaboration with local frontline agencies to develop best practices for all health and human services based on lessons learned · Increase minimum wage. · NCDHHS should establish contracted services with local Latinx community agencies to respond during a crisis/pandemic, and allow local agencies to piggyback based on need · Evaluate health care data (ER usage) to determine the zip codes from each patient that visited. Use that data to allocate a resource person to help direct access to care

South Carolina

Group One

Facilitator: Brie Hunt, MEd
Project Director
South Carolina Institute of Medicine and Public Health

Communication	*Data*
· Begin regular media briefings as early as possible. December 2020 was too late in the context of the Coronavirus pandemic. · Create a permanent phone tree for public health organizations that tells people who to contact for questions and concerns · Create a resource depository so that there isn't duplication of efforts. · Create a pandemic strategy that is reviewed and updated every year, similar to state hurricane plans. · Public health communications are very important and we need to make sure we have diverse participants help to weigh in on communications from the start – not as an after thought. · Public health needs a PR team. · Facilitate a yearly forum for leaders on public health and infectious diseases.	· Transparency: If we don't know something in the beginning, public health officials need to be clear about that rather than giving contradicting information. · DHEC needs a new lab building and data infrastructure modernization. · Integrate data into a centralized data depository with integration that allows community leaders to add local and small area data to the depository via relational databases. · Stop working in silos.

Group Two

Facilitator: Maya Pack, MS, MPA
Executive Director
South Carolina Institute of Medicine and Public Health

Communication	*Data*
· Work with school districts to develop programs to increase health and scientific literacy among children and adolescents · Work with state agencies and news outlets to develop intentional health communication strategies that are based in best practices	· Add tutorials to the data displays so people understand parameters and implications. · When reporting the data, allow it to be presented in a way that can reach all educational levels · Creating a statewide, open access data depository that providers and state agencies are required to contribute to in the same way they are required to report to federal agencies

· Expand resources and funding for public health in rural communities, long term care facilities, jails, and prisons. · Include local radio stations as means to communicate, especially in rural areas · Develop a central "incident command" approach to communication that has covers a wide swath of intended audiences, stakeholders, and trusted voices · Create a committee of faith leaders across the state who agree to working with state leaders as needed to communicate important health information with their congregation · Consider using the techniques akin to polling surveys to get a pulse perspections, questions, concerns segmented by different groups / populations / geographies areas. · Installation of Internet access in rural areas should be a priority.	· When data is requested from an Agency, business, adequate resources in funding should be given to that Agency or group to achieve the goal. · Require usability testing for online data sharing platforms to ensure that the public can effectively access the information · When the pandemic hit it took a large amount of time to determine data collection sets. Determining important baseline data sets, that we can add to as needed, would be helpful. A starting point for a public health crisis. · Improved aesthetic of data to better engage the audience. Care when updating pages that the information can be found in new locations or format. · Need IMPH to quickly make recommendations RE health data exchange and analytics before the GA meets in January and appropriates the $5 billion to other programs. It's a unique opportunity that cannot wait until June

VII. Large Group Discussion: 2:15 – 2:30 PM

Brie Hunt, MEd.
Project Director
South Carolina Institute of Medicine and Public Health

The full group returned and discussion moderators provided highlights and key takeaways from the small group discussions. The meeting concluded with a recognition of the work completed.

Adjourned: 2:30 PM