SOUTH CAROLINA COVID-19 VACCINE ADVISORY COMMITTEE

February 17th, 2021
Noon – 2:00 p.m.

Attendees:

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

SUCCESSES	ACTIONS
Faith-Based Community Outreach - engages across faith groups, educational levels, etc.	
• Incredible resiliency of hospital workers despite the many challenges they have faced throughout the pandemic. • Cooperation of hospitals and facilities in sharing allocations to transfer doses and keep administration going.	
• Most nursing home and assisted living facilities in the CVS/Walgreens have had initial clinics; some have had a 2nd. • Uptake comparable to nationwide. More residents willing to receive vaccine than staff. • Many staff waiting for second clinic. Seeing more staff uptake at the 2nd clinic.	
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 12/22/2020 i. Reminds providers to bill only for administration of vaccine, not the cost of the vaccine itself ii. Vaccine administered in FQHC or RHC will be paid as a bill-above 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. Payment will be allowed to any qualified, enrolled provider, whether par or non-par	• Medicaid is looking at DHEC 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 (arcgis.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 expedited 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. Prevailing 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 jail 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. • Unequitable plan to accommodate people who are unable to leave their home to reach access vaccination.	
Communications	
• 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 apples 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
• Digital literacy challenges. • Web-based is not available to 50% of small, elderly congregations.	• Improve outreach to seniors who have no access to high-speed internet. • APRP 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 PHE 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	
CHALLENGES	**ACTIONS**
Vaccine Access (reported by multiple groups)	
• Availability of the vaccine in rural areas has been limited • There is confusion as to where the vaccine is available • 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 • Transportation remains a difficulty for many insurance beneficiaries • **Scarcity in rural areas mentioned by multiple groups** • Inequitable vaccine access, not always reflective of risk. ensuring we are looking out for those most in need.	• Targeting vaccines where they are needed most is the mission VAC • Adjust distribution given we don't have abundant vaccine. • Consider how populations behave when there is a supply limitation. It requires the entire population to have the same values, we do not. • Vaccine strategies need to maximize the impact of patient-centered medical home (PCMH) model used at FQHCs and other primary care entities. • Optimizing logistics around primary care practices o Equity-driven plan to deploy vaccines to rural areas and based on a SVI • Scarce vaccine must be distributed using a formula that takes into account factors that make populations more at risk for infection and death. • Need to ensure rural access and access for those interfacing with vulnerable populations.
Groups at Risk	
• Health disparities for Medicaid population make the virus even more deadly	

	teletown hall to reach folks without internet and provide information on how to access the vaccine
• Unclear how much of the VAC work gets taken into consideration at the final approval level.	
• PLWHA question why SC has the lowest allocation of doses of any state so far, with no public discussion of this by DHEC or other state officials seen/heard. • the lack of ANY information directed to the HIV community, and nothing beyond a vague timetable for vaccination as a whole.	SC was not receiving the lowest allocation. Some calculations were based on entire population, not population >18 y.o indicated for vaccination. Reports may not have taken into account doses allocated to LTCFs. Allocations are now in line with SC population.
• No plain language materials produced • Website not accessible and alternative formats not available. • Need for Spanish-language material availability. • Confusion about vaccine availability and allocation - clearer messaging is needed. • Difficulty understanding information provided • Lack of understanding about the incredibly short supply and the need to prioritize vulnerable populations. • Some faith leaders are hesitant regarding the vaccine and convey that hesitancy to their congregations. • Misinformation on social media often cited by staff in nursing homes and assisted living facilities as reasoning for vaccine hesitancy.	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 MCO members is expected to follow DHEC guidance • Get vaccinated, following DHEC guidelines posted on website or at call 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**
Policy	
• Per capita vote by DHEC's board	DHEC will continue to evaluate how best to make allocations.

	• With a regional model we must still recognize differences in regions on who would receive vaccine based on social vulnerability. o Need to know who in the county is receiving vaccines 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 nurses, training, emergency supplies for adverse reactions, MOUs and 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, Premise (a Walgreens company servicing 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 *decisions* 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 on 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 HRSA's Bureau of Primary Care.	

• Hospitals vaccinating residents with Pfizer but nursing homes can't access Pfizer for 2nd dose. • Encouraging SNFs to become vaccine providers. • Unexpected expansions of vaccine eligibility, challenges hospitals requiring revision of large-scale processes.	
• County Administrators lack of information regarding state plan for homeless and shelter staff. COVID infection among small number of staff can potentially shut down this important service.	
• The "black market" of leftover doses.	• Develop a priority list so that leftover doses go to those at risk rather than "family and friends". "Shots in arms, and in the right arms". Need to hold systems accountable.
Data	
• VAMS is the primary challenge for hospitals. • For FQHCs - prioritization of VAMS updates/enhancements to include BOTH bulk demographic uploads and bulk vaccine administration uploads; VAMS documentation is federally required but results in 2x the documentation for clinical teams; estimate that running a vaccine clinic for 200 patients takes at least 3-4 hours (if all goes smoothly) of duplicative documentation; documentation burden results in VAMS utilization reports frequently being outdated or inaccurate	VAMS technical assistance and support framed around reducing clinical team burden and burnout with the COVID vaccine reporting process
• Contributor to low Hispanic vaccination rate in SC is age. The majority of the population is relatively young and don't qualify for 1a	
• Enhanced communication regarding vaccine allocations and utilization rates • Without publicly available data on who has received the vaccine, it is difficult to advocate on behalf of constituents and communities. Absent that data we are talking in "round numbers" rather than effectively addressing need.	• Provide county of residence of those vaccinated to track if vaccines sent to a particular county are given to residents of the same or different county. • Patient's residence (either analyzed by county or zip code) will be so important to monitoring vaccination efforts at the local level • Story Map Series was created with the Story Map Series application in ArcGIS Online. • uscgeography.maps.arcgis.com https://www.tandfonline.com/doi/full/10.1080/10255842.2020.1869221, this paper looks at surges in colleges around the country and includes Clemson data

- 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:
    - Difference in vaccine acceptance in men and women
    - 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.
    - 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

CDC 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