SCBHC
South Carolina Behavioral Health Coalition

South Carolina Behavioral Health Coalition
Core Leadership Team Meeting Minutes

Wednesday, August 16, 2017
2:00pm – 3:00pm
SCHA Felts Board Room

Welcome & Updates
Dr. Gerald Wilson, Chair, reiterated that both the Coalition and the CLT gives everyone the opportunity to be heard. If your voice or input has not been, please put it in writing and send it to us. The Coalition is to be non-partisan to a specific agency or entity's goals.

Finance Committee
Dr. Wilson discussed the need to have a finance committee with which the CLT members agreed. It is the role of the CLT to set the priorities, the Finance Committee will set the budget. The Finance Committee will need to arrange a time to meet to set up a budget. SCHA submitted a grant to The Duke Endowment to help fund the Coalition. The request is $300K for three years. If awarded, funding will begin in the December cycle. A site visit from Lin Hollowell with TDE to learn more about the Coalition is August 22. Awards will be announced December 15.

Committee members include, Kester Freeman, Executive Director, IMPH; Sara Goldsby, Director, DAODAS; Thornton Kirby, President & CEO, SCHA; Pete Liggett, Deputy Dir. LTC & BH, DHHS; April Richardson, MD Medical Director, Companion Benefit Alternatives (of BCBSSC); and Gerald Wilson, MD, Chair SCBHC will serve as ex-officio.

> Commentary. Discussed on several occasions was the need to take advantage of bridging with programs already being funded. For example, the Children's Trust has started a health coalition for adolescents (Melissa Strompolis and Sue Williams). MUSC has received funding from agencies for academic detailing (Dr. Kathleen Brady). Also discussed was the power of persuasion in numbers.

Breakout Session Briefing and Discussion
Crisis Stabilization/Acute Care Management: Geoff Mason and Bill Lindsay

- Potential continuum of services
- Need a funding package - look at metrics, need return on investment to show value to get more partners; cost/cost avoidance, include ROI in telepsychiatry; data positive in terms of diversion (show hospitals value and get more (CSU) participation);
- Lots of energy, will be interesting to see who comes next time
- EMTALA is seen as a barrier, IMD waiver
- Sheriffs listen to each other like physicians do (Ex. All cannon to talk to his peers)
- This effort needs a community liaison (such as Debbie Blalock) to be successful in building partnership

Behavioral Health/Primary Care Outpatient Alignment: Pete Liggett, PhD. and Dr. Bob Bank

- Looking at the feedback and will see what comes up, in the meantime
    a. Providers to do screening test during physicals

b. Opening CT codes for screening children and mothers
c. Provide behavioral health CMEs to physicians
d. How do we impart the importance of screenings to primary care providers *be creative, use SCMA – Margie Heggie offered SCMA has a robust CME program*
e. DMH EHR, SCRIPTS, SCHIEX – all need to be able to talk to each other and share information *tying this together will be difficult; without it, information will not be shared POTENTIAL FOCUS GROUP ON DATA SHARING*
f. Need to address payor issues. *(Create an initiative to id chronic patients with co-occurring problems & develop a payor source for services. If people were deemed disabled under the law, they could be on Medicaid, need to invest in getting laws changed.)*

Substance Use Disorder Prevention and Treatment: Sara Goldsby and George McConnell

- Collected a lot of information, a lot of strong opinions, will catalogue input
- Need to look at national recommendations; what is being done (what are we doing) to drive them; suggestions will float to the top to ID early, actionable items
- Resource data mapping; start with what is available then expand on it
- MAT education metrics to show its low hanging fruit
- As payment for MAT increases, is more accessible, will be used more
- Data team to look at baseline MAT
- Proactively create a quality program for providers
    a. Brown Medical School –Tan Platt, MD is leading the effort in SC (8-9 residency training on m.h. need to keep it/them active)
- *Need to find the best evidence-based practices then share (replicate) them with various groups (ex. pediatricians and geriatricians)*
- *Bridge programs, groups, and resources (ex. Children's Trust started a health coalition for adolescents, have funding – Melissa Strompolis and Sue Williams)*

Commentary. BCBS is getting provider pushback for limiting prescriptions on opiates. Are prescribers interested in signing something pledging to decrease writing prescriptions for opioids? Look at all methods of post-surgery pain relief. LLR is releasing new prescribing guidelines.

The IMPH is embarking on a huge workforce effort to include behavioral health and are looking at a range of professional ancillary repore. Will need advice and guidance of the CLT. It was noted that FQHCs do a better job of coordinated care than private practices – private practices need to do a better job of *team based approach. Coordinated care involves workforce.* From the data aspect: What is the range of workforce with training? Where do they fit into a practice? Can they connect with telepsych?

Data and Analytics Update: Andrew Fogner and Auynika Moonan

Each chair received a rough draft of metrics prior to the breakout session. A data team representative participated in each work group. There was open dialogue in each of the workgroups.

- Look at low-hanging fruit
- Look at severity ex. ED

Commentary. The data team will need common language, operational definitions and senior leadership approval of data definitions.