SCBHC
South Carolina Behavioral Health Coalition

Behavioral Health/Primary Care Outpatient Alignment
Meeting Date: October 12, 2017
Chair: Pete Liggett, PhD, DHHS
Co-Chair: Bob Bank, MD, DMH
Scribe: Sharon Mancuso

Dr. Bank touched on the 3 focal areas from our last meeting (9.14.17):
Clinical Data and Information Sharing; Access; Funding Platforms, Support and Resources. The plan is to break into the 3 smaller groups at the November meeting to narrow the discussions in these areas even further. We will survey via SCHA our group in regards to which of the 3 groups our attendees would like to participate in.

We had representatives at our meeting from Blue Cross, Molina, Select and Wellcare this month as well as a social worker from Newberry Hospital but are there other people/organizations missing from the discussion. We need "buy in" from the big hospital systems. Part of what we need to discuss is how to partner with and engage them. We also want to engage Care Coordinators from MCO's. We can reach out to GHS. Dr. Bank can bring it to the Executive Committee. We need to reach out to groups such as FQHCs, free medical clinics, rural crisis care centers and the SC Primary Care Association.

We ended the meeting discussing Workforce.

- Integrated care is not a traditional model.
- We need people to get training and carry it forward. We need policy changes. The Legal/Regulatory Advisory Committee will be looking at policy. We need social workers to work in doctor's offices but policy says we can't pay them. Clinical Social Workers are not getting paid for 75% of what they do. Some physicians are using part of their own salaries to pay a social worker to be in their offices.
- Lack of connection. If we create one successful model, how do we export it?
- Programs may not even know they are successful without feedback.
- Do we have a pilot for just ONE successful model?
- Pooling resources for workforce development would be helpful. (Could grants pay for people external to your entity?)
- Do not know if providers are aware of UMASS CIPC?

There was a major theme in the meeting that we don't know if providers are aware of what is already out there. A resource catalog was suggested. Resource capturing needs to be robust and broad enough to capture all areas. We need to catalog "us" as a start and catalog what we already know. As we break into our 3 smaller groups in the next session, maybe catalog what they know and start there – include what makes each resource useful.

Clinical Data and Information Sharing

- Getting the information to providers in a timely manner so there is a more complete record which will cause better decisions to be made. (Faxing is not a good way to share information and that is how it is primarily being done now.)
- Information sharing – SCHIEX. Need more comprehensive Information. Other states have HIEs.
- Every hospital has their own EHR and so does DMH - they don't *talk to one another*. It was noted that there is diversity in information systems. (Also, payers have claims systems)

- Claims data would be helpful.
- Pharmacy data is important.
- Clinical data is vital.
- If someone pays cash for a prescription or a mental health visit, there is no record of it.
- People other than the prescribers need access to the SCRIPTS system to see what is happening. Prescribers must register but they can register "proxies" as well? Can others check PDMP to look for "Doctor Shopping?"
- How many systems can we connect? If you can get into claims data, MCO data is there. That is a start. Can a health information exchange be available for research and not just to the treating provider?
- Information and Integration – education is needed on how to use what is out there.
- Firewalls prevent information from being shared. Substance use is extra protected.

Access

- Access to aligned care.
- Potential measures: Decreased ED/Readmissions.
- Increased utilization of core community support systems. EDS expanding. Need all community players involved. Need someone to set up initial consult to help them navigate it all.
- Need discharge/community resource navigators. Peer supports/warm handoffs.
- Cataloging in the workforce. IMPH is cataloging the workforce in January so Maya volunteered.
- Need to plan for increased capacity when needs become newly identified.
- FQHCs could offer Behavioral Health help to other FQHCs.
- Need to inventory but are we anticipating capacity?
- DMH is about to embark on a collaboration to reach out to Primary Care.
- Academic detailing should be a goal. If you could train someone in a primary care practice and get them comfortable, that could help.
- What are the models for integration? (e.g. co-location, telemedicine, etc.) Look for National models. Co-location doesn't necessarily mean Integration.
- Do MCOs have research? WellCare suggests taking it to the Alliance of Health Plans.
- Strong integration models are working. HOP, FQHCs need to go local.
- QTIP – who is connected to who? Need for social networking and mapping.
- "Grant pooling of information" final reports have to be written for grants so that data is available. Look at that data to see what worked and what didn't.
- Need to establish baselines for any outcomes measures.

Funding Platforms, Support and Resources

- Insurance, grants, in-kind, also, access to meds. For example, Dr. Bank touched on the use and access of long acting injectables in the treatment of schizophrenia. It is the first line of treatment. If we could somehow strip the cost and make it accessible it could often save weeks for the patient trying to get medicine. Some providers are not comfortable using these medicines.
- Some medicines are reimbursable and some are not.
- There are a variety of reimbursement policies.

- Care coordination. We need more access to this data. There was a suggestion about embedding care coordination in local providers.
- What about outplacement? There is a lot to be gained but people in the field need to work with providers.
- Primary care perspective – you could have a child from each insurer. "Help Me Grow" does service access across the board. Need to consider, what is best for families and providers.
- Can MCO's share a nurse?
- DMH is happy to split the cost.
- MCO representatives noted that there are multiple types of resources that providers aren't aware of. The need for education was noted.