What key issues has this group identified?

There is a need to increase collaboration across agencies and entities. In South Carolina, rural areas need to be a priority, especially with workforce issues and lack of resources. In rural areas, there is a need for FQHC primary care alignment, integration and referrals. Spartanburg highlighted a success with collaboration with FQHC's.

A main issue is, what is the best scope of practice? York County, Keystone AOD Commission, discussed the "band aid" issue of not using evidence based approaches as treatment options. Drive thru's for medications are popping up, which is a concern for treatment providers.

We need to share success stories and practices across communities.

Overall, there are four areas the group focused on: safer prescribing, safe elimination of unused prescription drugs, access to naloxone and the expansion of treatment and recovery services.

What activities/programs/resources currently exist in South Carolina?

Safer prescribing should include updating prescriber guidelines (including treatment via telehealth). The use of the PDMP with best scope of practices was brought up in discussion. It would be nice if electronic health sharing was more accessible with patient information – such as communication if a patient had a previous overdose.

Some areas to consider is the creation of data driven guidelines for pregnant women, detox babies and vulnerable populations. The pharmacies need to be engaged with the education system of medical providers.

Safe elimination of unused prescription drugs brings up the issue of not disconnecting prevention. 60% of individuals who misuse prescription drugs obtain them from friends and family. We need to be consistent with messaging and sharing with communities around evidenced based practices. An idea was to increase screening around AOD, maybe looking at the possibility of standardizing SBIRT to go down to the pediatric level with the primary care physicians.

Looking at treatment services, we need to have programs that are culturally and linguistically appropriate to target high risk groups. If we focus on SUD in a certain demographics and have targeted interventions, we might see faster change.

As a committee, we need to look at local level interventions and document the gaps in current workforce; such as primary care comfort level with MAT. With high need communities, there is disconnect with MAT in criminal justice systems (waiting trials, reentry, etc).

What 2-3 data points are needed to support this workgroup?

There is a great interest in the PDMP for real time and exact data requests. With the usage of SCRIPTS, a few indicators could be easily pulled to help support this workgroup.

- Number and percentage of acute care hospitals with an EHR-Integrated system with SCRIPTS.
- Number of patient report requests prior to prescribing any scheduled drugs

Other indicators to consider are:

- Opioid related hospitalizations and ED rates (with demographics)
- Number of first responders and EMS who receive training on how to administer Naloxone
- Number of naloxone administrations
- Initiation and engagement of medicated assisted treatment, telehealth, etc.

The data team is making metric revisions after the initial BHC launch.