SCBHC
South Carolina Behavioral Health Coalition
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Behavioral Health/Primary Care Outpatient Alignment
Work Group Notes

1. **Welcome:**
    a. Dr. Liggett opened the breakout session by welcoming everyone. He stated that there have been and continue to be so many important and great ideas that it is hard to capture them all. He referred us all to the Action Planning Tool document that was handed out.

2. **Recurring Ideas:**
    a. **Incentivizing the physical and mental health communities to work together:**
        i. We do not know if the state has the resources to do so but we can make a recommendation. However, it may involve private insurance.
    b. **Telehealth**: Dr. Bank stated that the most promising practice is telehealth, but we still need the necessary equipment. He thinks that possibly the Telehealth Alliance can help but we still need psychiatrists to participate.

    c. **Collaborative Care Model** spreads across to psychiatrists. Can the state establish a registry requiring monthly input? Other state Medicaid programs are requiring this. This model with its checks and balances could handle it. Dr. Liggett stated that it is about $100-$120 increase per member per month and savings would have to be part of the equation. What is included in the $100-$120 per member per month? This is a question we need to take to Milliman. A cultural change is required. We should capitalize using screenings and continuity of care between physical and mental health. A suggestion was made to utilize the free online resources that are available regarding therapies and screenings. Could the state compile and showcase all those free resources? There are limited funds. We need financing. What can this group do to advocate for resources? There needs to be a "return on investment" part of the conversation. Dr. Liggett stated that we need budget development and that another state "going first" would be helpful. North Carolina just began with collaborative care, but they are in the early stages.

    d. A **health information exchange** was suggested, and Dr. Bank stated that SCMA is promoting an exchange and that Dr. Platt should be able to provide more information on it. They are looking for a group to step forward. That may be a good area to focus our efforts. Dr. Bank relayed his experience in exchanging information with 2 primary care practices and that it is difficult relying on faxes. Dr. Fields asked if there is an intent for Medicaid to pay for collaborative codes? Dr. Liggett said that is not currently in the plan. We need a legislative champion.

3. **Strategy 1: Single Resource Directory**
    a. Family Connections is one example of such a resource. Their software is such that if information is not kept current, it is removed from the directory. It is geared more

towards providers. We also need to work with 211 which is geared more towards patients. 211 can be confusing. It is alphabetical, and people just start calling numbers without realizing that a service is not available in the area. Dr. Foster mentioned that Family Connections is working with Alaska. The directory can be sorted geographically, and it can also manage referrals. The point was made that providers will not provide services if they are not going to be paid and there should be some sort of compensation for working in a collaborative care model. Ultimately the entire coalition can take recommendations forward. It cannot be just Medicaid. If you want us to pay for screening and brief intervention, we can make a recommendation. It would be nice to reconcile the LIPS manual. It would be a simple fix to reconcile Medicaid manuals. FQHC manual needs to catch up. One provider was told to, "strike through that part of the manual."

4. **"Recommendations Subcommittee" Formation**: We had 5 people sign up to be in a subgroup called, to make recommendations about payment. Dr. Fields will be the chair of this subgroup. Dr. Foster stated that SCHA can help with details like arranging call in numbers and things such as that.

5. **Strategy 2**: **Subgroup Formation**
   - **a.** Resource Directory, (web resource piece)
   - **b.** Collaborative Care
   - **c.** Medical Information Sharing
   - **d.** Existing Operational Models

   Comments: Dr. Foster asked if it would be helpful to have web-based trainings. Dr. Fields said there are a lot of free trainings available. It was noted that we could also be supportive of those partners that are willing to do it and leverage them to provide platform. Dr. Liggett offered QTIP as an example of a coalition of pediatric practices to pursue best practices. Dr. Platt pointed out that it also offers a child psychiatrist for consultant as part of the QTIP budget and it is not very expensive. It must be 24-hour access 7 days per week with someone always on call. Dr. Fields stated that it is not a FFS so it doesn't have to be a Medicaid-licensed provider. Dr. Fields discussed the ECHO program. Dr. Platt suggested that she present it to the Family Practice Association next June. Dr. Fields mentioned physician burnout and a lack of specialized training. If we offer trainings, we could reduce burnout, reduce malpractice and get a 5% discount on malpractice rates.

We ran out of time, so Dr. Liggett said we would form subgroups to focus on specific issues and asks each of us to participate in at least one subgroup. The point was brought up that worksite and schools are becoming good sites to target because it is where people spend most of their hours. One final point that was made is that HOP Coordinators (Palmetto HOP Coordinator and Providence HOP Coordinator) have no link to DMH to get help for those who are uninsured. Dr. Bank offered to forward the issue.

Dr. Bank and Dr. Liggett asked for feedback regarding the strategy list (Action Planning Tool) that was given out.