WEBVTT

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00:01:57.810 --> 00:02:12.700

Anne Roubal: I'm happy to welcome you to today's presentation. Today's webinar charting the future of integrated behavioral health. As Danielle chatted in. We're just going to get started. Now let a couple of those stragglers come in who had meetings up until this time.

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00:02:13.220 --> 00:02:31.469

Anne Roubal: We're really excited today. The the Arc Academy as well as Ahrq, is really excited to present this webinar today about perspectives from the field with druniser and Dr. Little, some seminal researchers in our field, and then, having the opportunity to hear from them as well as ask them questions.

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00:02:35.770 --> 00:02:40.950

Anne Roubal: I'm gonna go over just a little bit of how the webinar is gonna go, since it's not a traditional webinar

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00:02:41.090 --> 00:03:02.489

Anne Roubal: today, and then and then we'll get started. So I'm going to give you just a little bit of overview of Ibh and the Arc Academy. We have a lot of people, new registrants today who didn't know what the Arc Academy was. So we want to give you a little bit of an overview of who we are and where we come from, and then I'll introduce both of our speakers, Druniser and Dr. Little.

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00:03:02.710 --> 00:03:11.950

Anne Roubal: and turn it over to them for them to give a couple remarks, about 10 min of remarks, each about the future of integrated behavioral health care.

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00:03:12.290 --> 00:03:19.080

Anne Roubal: Then we're going to turn, and we'll have about an hour for this of a moderated panel discussion. So we're really looking for your questions

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00:03:19.230 --> 00:03:38.829

Anne Roubal: in our Q&A. Boxes, and to facilitate that we have some that people put in as they registered. But the time is for us to ask the questions to the experts, and so please submit the questions you have, or, as you think of them during their remarks, put those in our Q&A. Box, and we'll conclude with just a couple of closing remarks.

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00:03:40.630 --> 00:03:44.389

Anne Roubal: So my name is Annie Robbel. I'm the project director of the Arc

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00:03:44.858 --> 00:03:54.720

Anne Roubal: Or of the Ark Academy for integration, and I'll be the Webinar host today, and I'm joined by Garrett Moran, who is the current pi of the project, but also

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00:03:55.020 --> 00:04:07.999

Anne Roubal: has been on the project since its integration, and was the Pd. For several years. And so he's going to join me a little bit later, when we go into the Q. And a part, and we'll sort of take turns asking your questions to our experts.

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00:04:10.450 --> 00:04:25.780

Anne Roubal: So we have a large number of people in the audience today who hadn't had didn't know what our Academy was. So we just want to sort of give a little level setting about how we think about integrated behavioral health as well as what the Academy is and what we do.

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00:04:26.070 --> 00:04:45.300

Anne Roubal: And so when we think about integrated behavioral health, we're really thinking about a team of primary care and behavioral health clinicians working together to improve outcomes so that could be things like improving or reducing costs, improving patient outcomes, really providing patient-centered whole person care for specific populations.

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00:04:45.500 --> 00:04:53.590

Anne Roubal: And you can see on the bottom bullet there, where we're the types of conditions that we're mostly interested in improving

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00:04:53.800 --> 00:04:58.529

Anne Roubal: and working working together with primary care, physicians and clinics to improve.

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00:04:58.710 --> 00:05:03.780

Anne Roubal: On the left you see our Academy Lexicon, which

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00:05:04.740 --> 00:05:07.609

Anne Roubal: you can see better on our website, but we have

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00:05:07.870 --> 00:05:26.110

Anne Roubal: in green and blue there, when those things work together well, we can achieve integrated behavioral health care and be really successful at it. So things like teamwork or collecting data efficiently and alignment of leadership models. So when all these work together, we can do effective, integrated behavioral health care.

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00:05:27.420 --> 00:05:36.409

Anne Roubal: And why is integrated behavioral health care important. I think many of us know this, and these aren't the only reasons. It's important, but these are some of the ones that have been studied.

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00:05:36.550 --> 00:05:46.479

Anne Roubal: And so we have improved patient satisfaction and provider satisfaction, as well as reduced cost. As I mentioned before, or reduced healthcare utilization.

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00:05:46.620 --> 00:05:54.259

Anne Roubal: which can also, you know, reduce Ed visits, but really improved. Patient health outcomes in the end is is one of the main goals.

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00:05:56.240 --> 00:06:11.259

Anne Roubal: And what is the Integration Academy? So we're bringing you this webinar today that we're really excited about. But we don't just do webinars. We are an entire website. And you can see our website below there integrationacademy.hrq.gov.

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00:06:11.510 --> 00:06:27.080

Anne Roubal: and you can visit that to find resources about integration. We have things like our Ibh playbook that can help people wherever they are in their journey for integrated care. We also just recently published a topic brief on pediatrics.

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00:06:27.400 --> 00:06:34.800

Anne Roubal: That's really it's new within the last couple of weeks. So if you're working on integrated care with children that might be a place to start.

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00:06:34.930 --> 00:06:39.290

Anne Roubal: We also host a ton of, or we share our partners

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00:06:39.460 --> 00:06:48.730

Anne Roubal: who are doing integration, some of their events and resources as well. And so we really try to be a resource for you all, no matter where you are in the journey.

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00:06:48.860 --> 00:07:01.310

Anne Roubal: and we love to hear from you. So if there's things or resources that feel like they're missing, we would love to hear that if there's resources that you find really helpful, we would love to get that feedback as well, and we also provide newsletters that come out

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00:07:01.820 --> 00:07:02.599

Anne Roubal: as well

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00:07:03.210 --> 00:07:09.049

Anne Roubal: monthly or weekly, depending on when we have things to come out. And so you can definitely stay in contact with us.

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00:07:11.400 --> 00:07:23.660

Anne Roubal: So without further ado, I'm going to introduce our speakers and turn to the interesting part of the presentation here. So we're really excited, as I mentioned, to have Dr. Unitser and Dr. Little here to talk to us today.

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00:07:26.210 --> 00:07:33.449

Anne Roubal: they are leaders in the field, as we all know, and I just want to share a little bit about their backgrounds.

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00:07:33.940 --> 00:07:36.380

Anne Roubal: So Doctor Units are sorry

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00:07:37.840 --> 00:07:49.750

Anne Roubal: my mouse appears to stop working apologies for that. Okay, so Dr. Unitzer is currently the chair of Psychiatry and Behavioral Health Sciences at the University of Washington, and the director of the Garvey Institute for Brain Health Solutions.

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00:07:49.850 --> 00:08:17.390

Anne Roubal: and his work focuses on integration of Mental health Services and general medical care on translating research, on evidence-based mental health interventions into effective clinical and public health practice. He's published over 300 scientific papers and has received numerous Federal and foundation grants and awards for his research on integrated behavioral health care. And he's 1 of the founders of integrated behavioral health care and has really pushed it forward.

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00:08:17.500 --> 00:08:39.150

Anne Roubal: and then, after he gives his remarks, Dr. Little will give hers, and she is a co-founder of concert health and a co-founder and coo of 0 overdose national expert in integrated care, the collaborative care model and suicide prevention. And she's going to draw on some lessons learned from implementing, scaling integrated care and suicide prevention efforts across diverse healthcare settings

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Anne Roubal: on top of those accomplishments. She's also worked. She also previously worked 22 years as the Senior Vice President for a large federally qualified Health Center network in New York and oversaw over 300 behavioral health and community staff.

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00:08:53.250 --> 00:08:59.710

Anne Roubal: So I'll turn it over to Dr. Unitzer for his remarks about the future of integrated behavioral health care.

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00:09:01.270 --> 00:09:01.860

Jurgen Unutzer: Well.

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00:09:02.910 --> 00:09:24.560

Jurgen Unutzer: good afternoon, everybody. Thank you for the nice invitation to speak with you all today, thanks to Hrq. And thanks to Westat and the Integration Academy for that opportunity. I'm going to make a few comments just to help us get started. As you heard. I'm a psychiatrist. I've been doing that for a little over 30 years.

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00:09:24.600 --> 00:09:37.830

Jurgen Unutzer: My day job is a chair, a department of psychiatry. Here at the University of Washington we are. We are a school of medicine that serves a 5 state region here in the Pacific Northwest.

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00:09:37.970 --> 00:09:58.979

Jurgen Unutzer: Some of that region is urban. Much of it is rural, and 27% of the Us. Land mass are in that region and access to behavioral health care has always been a tremendous challenge. And that's 1 of the reasons why we got interested in this work quite a long time ago.

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Jurgen Unutzer: so I was able. I was fortunate enough to work on some teams, to conduct some of the early research on how we do this. And then, about 15 years ago, I helped found a center here at the University of Washington, called the Aim center and the aim center for those of us who are not familiar with it really is about helping organizations, implement evidence-based

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00:10:23.560 --> 00:10:37.170

Jurgen Unutzer: care. So my comments are basically going to reflect my experiences working in this space for about 3 decades. And and it's an area that's near and dear to my heart. And and I have a lot of passion for it.

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00:10:37.380 --> 00:10:55.939

Jurgen Unutzer: and although we are supposed to talk about charting the future, I'm going to do a very, very brief recap of, I think, what is important for us to to remember in terms of how we got here, and from my perspective in. And I think maybe from the perspective of Ahrq. That journey started about 3 decades ago.

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Jurgen Unutzer: and Hrq. Really has been a big part of this all the way from the Get-go. And you know in my mind that started in 1994. So about 31 years ago, when Hrq. Used to be called Ahcpr.

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Jurgen Unutzer: the agency for health, care, policy, and research, and they published in 1994 a seminal set of guidelines

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Jurgen Unutzer: on how we can improve the treatment for depression in primary care. And that set of guidelines, I think, is still a phenomenal piece of work. It's still highly relevant. It's been updated since then. But the core principles are still really, really relevant and important, and it really sort of generated a blueprint. That sort of told all of us that. Yes, we can do this, and then some of us have spent the last 2030 years to think about. How do we best do it?

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00:11:49.790 --> 00:11:56.890

Jurgen Unutzer: But I really want to call that out, I think what we all realized about at that time was that.

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00:11:57.830 --> 00:12:27.200

Jurgen Unutzer: you know, treatments for depression, for anxiety, for other common mental health problems that work in specialty care actually can also be delivered in primary care if there is enough support to do it well. So medications work just as well when they're prescribed by a primary care doctor than when they're prescribed by a psychiatrist. Evidence-based psychotherapies can not only be delivered in a mental health specialist's office, they can also be delivered in a primary care setting.

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00:12:27.270 --> 00:12:33.379

Jurgen Unutzer: And I think that's a really important opportunity. And I think what we have.

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00:12:33.900 --> 00:12:39.969

Jurgen Unutzer: You know, what we've learned what we've learned over the last 3 decades is the fact that

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00:12:40.280 --> 00:13:02.169

Jurgen Unutzer: mental health really is an important part of all health. You cannot really try to help someone's overall health if you're not paying attention to their behavioral health, to their addiction problems. And I think 30 years ago we were coming to grips with that now everybody really understands it. So the question now is, really, how do we go about delivering on that promise? And I think that

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00:13:02.690 --> 00:13:08.240

Jurgen Unutzer: you know that's what we have spent the last 2030 years doing research on.

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Jurgen Unutzer: And I would say, you know, when it comes to evidence base for things we do in medicine, not just in behavioral health, but in healthcare and medicine in general, some of the strongest, most mature evidence base we really have for what to do if you want to help somebody with a common behavioral health problem actually is

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Jurgen Unutzer: work that is pointing to the collaborative care model, which is basically an evidence-based model of delivering mental health, behavioral health services for common mental health and addiction problems in primary care. And I think that evidence base is now stronger than much of what we do in specialty care. Frankly.

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Jurgen Unutzer: So, as as we heard.

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Jurgen Unutzer: the core concept is pretty straightforward. So we're going to say that many patients, if not most patients, especially people in rural or otherwise underserved areas, are not going to find their way to a specialist, because, for example, in many of the areas that we work in here in the Pacific Northwest, there just are no specialists.

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Jurgen Unutzer: more than 50% of the counties in this 5 state region that we serve don't have a single psychiatrist, psychologist, social worker, or anybody who's got formal training in helping somebody with a mental health problem. So really, they go to their primary care, doctor, that could be a pediatrician that could be a family doctor that could be a nurse practitioner that could be a physician's assistant. That could be a family doctor.

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00:14:33.580 --> 00:14:46.989

Jurgen Unutzer: and that's where we have the opportunity to find them, to meet them, to engage them and to start them on a course of treatment that if it's well done, can make an enormous difference. And that's really, that's really the opportunity.

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00:14:47.360 --> 00:15:05.169

Jurgen Unutzer: Then the question is, how do we best do that. And if you look back at the evolution of how we've gotten to where we are today with the evidence base, it started by the idea of, you know. Maybe we should just bring a behavioral health provider into a primary care office. You know. What if we co-legated a psychiatrist

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00:15:05.180 --> 00:15:06.739

Jurgen Unutzer: or a psychologist

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00:15:06.750 --> 00:15:29.550

Jurgen Unutzer: or a clinical social worker, or a licensed marriage and family counselor into a primary care doctor's office. And I think that beginning of co-locating a mental health professional in a primary care. Doctor was very obvious. It was very effective, but it turned out it's pretty hard to scale that. There just aren't enough of us to really make that work at scale.

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00:15:29.560 --> 00:15:42.360

Jurgen Unutzer: and it ends up. And I've done a lot of this myself. I spend a lot of time working in primary care doctors, offices providing mental health care. But if there's just one of me, you know, I'm never going to be able to meet all of the needs

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00:15:42.390 --> 00:16:10.929

Jurgen Unutzer: that are going to show up. So I think along the way we learned about the chronic care model, we learned about the fact that for many health problems, you know, approaching this as a team care model where we take the roles, you know, and we divide them up across different team members, and we come together as a team and we deliver the care as a team. It could make a huge difference. It can reach more people. It can actually be more effective. And I think that's how we arrived at the current.

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00:16:10.990 --> 00:16:15.699

Jurgen Unutzer: You know, evidence based around the collaborative care model. And so

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00:16:15.910 --> 00:16:18.200

Jurgen Unutzer: that's a model where it's not just

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Jurgen Unutzer: one mental health professional who comes into primary care and does their thing. It's really a team approach where we use things like measurement based care. We use things like tracking people on a registry to make sure that people are not falling through the tracks.

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00:16:32.730 --> 00:16:39.580

Jurgen Unutzer: and we have consultation from a specialist available when things are not improving in primary care.

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00:16:39.940 --> 00:17:01.579

Jurgen Unutzer: and we have proven in research. Now, there's over a hundred studies that if you do this well, you can help people with a whole range of behavioral health problems, depression, anxiety. We recently did a very large study where we treated people with bipolar affective disorder and post-traumatic stress disorder. We have done this for people with a variety of substance use disorders.

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00:17:01.580 --> 00:17:14.440

Jurgen Unutzer: We have done this in person in primary care, but we've also done it where we have the behavioral health component added to primary care, using telehealth approaches and various combinations of those.

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00:17:14.599 --> 00:17:37.439

Jurgen Unutzer: And I think that the evidence base is strong. Implementing. A model like this can be a bit complicated, and I think we will talk a little bit more about that as we move on here today, we have developed billing codes that help primary care offices bill for this kind of care. Obviously a very important thing. Because if you can't get paid for it. How could you really implement it?

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00:17:37.620 --> 00:17:44.199

Jurgen Unutzer: And I think before we go into questions, I'll leave you with one other thought.

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Jurgen Unutzer: The evidence for doing this is really strong when it's done. Well, it's an incredibly satisfying thing, just like we heard from Annie. When it's done. Well, patients feel like they're well cared for. Providers love it because they're able to do something that they might not be able to do on their own

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00:18:05.640 --> 00:18:25.789

Jurgen Unutzer: clinical outcomes are much better. We've shown that if you do this well, you can reduce total health care costs, and you improve a whole bunch of healthcare outcomes. But to do it well, is not that simple? And I'll leave you with kind of maybe a little bit of a goofy analogy. But if you think about it from a music perspective.

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00:18:25.930 --> 00:18:39.189

Jurgen Unutzer: If you're going to go and listen to somebody play a really beautiful instrument. So that's maybe the person that you're seeing, you know, who is going to be giving you counseling or prescribing you a medication.

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00:18:39.560 --> 00:19:01.199

Jurgen Unutzer: It might be really beautiful to listen to that music. If you're listening to an orchestra, where a whole bunch of people play different instruments and play them really beautifully together. It's really amazing. It can make an enormous difference. And a beautiful orchestra is probably going to be nicer to listen to, and maybe more engaging than a single instrument. But.

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00:19:01.200 --> 00:19:23.419

Jurgen Unutzer: on the other hand, if the orchestra doesn't play well together if everybody plays their thing, and it's not well coordinated, and it's not well organized. It can also be a really horrible experience. And so I think the strength of a good, integrated, collaborative care model is this team approach, but that could also be its weakness. You can also think about a sports analogy. So if we had.

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00:19:23.694 --> 00:19:36.029

Jurgen Unutzer: you know, a football team and everybody is a quarterback, we probably wouldn't win a lot of games if we have a team where everybody knows what their role is. They play well together. We could make a huge difference. And I think that's what

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00:19:36.060 --> 00:19:42.299

Jurgen Unutzer: the challenges in building a really good collaborative care team. And how do you really make that happen?

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00:19:42.370 --> 00:20:00.030

Jurgen Unutzer: So I think I will leave you with that analogy for now, and I will turn it over to my colleague, Verna. Little Verna has an enormous amount of experience, really taking these kinds of approaches to scale in a whole bunch of different settings. So I look forward to hearing from her.

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00:20:00.310 --> 00:20:01.100

Jurgen Unutzer: Thank you.

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00:20:01.100 --> 00:20:22.629

Virna Little: Well, thank you. I'm going to stick with the music, analogy and and concert health. That's kind of how we got there. So it's kind of funny that you say that, you know. And I actually was thinking, maybe I would, you know, start going going back a little bit and just sort of talk about some of the, you know, the lessons learned over the past decades.

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00:20:22.630 --> 00:20:32.539

Virna Little: And you know, when I think back to the 1st sort of thoughts around integration. When I was working in the Fqhc.

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00:20:32.830 --> 00:20:57.720

Virna Little: Trying to pull all of those pieces together, and even for the 1st time doing collaborative care. You know people will often ask me about that time, and I think it's sort of seen as a success, because it was, you know, replicated for the 1st time sort of in the real world, and we got good outcomes and providers loved it, and patients loved it. And yet I sort of I took it as a failure, because I never could get

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00:20:57.720 --> 00:21:08.819

Virna Little: paid for in the right way, which a lot of people don't actually know, that I sort of consider that sort of not not a success, and I think that sort of brings back to an important

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00:21:09.130 --> 00:21:30.760

Virna Little: sort of grounding, where all of the pieces have to be in place, and I think we've learned over the years what those pieces are and how important it is to try to reinforce them. You know we've done some learning around teams and and what really makes an effective team. And how do you pull them, you know, together to sort of play

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00:21:30.760 --> 00:21:40.969

Virna Little: that music? And I had the privilege today of spending some time with behavioral health leaders from around the country, and we were talking about teams and

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00:21:41.520 --> 00:22:06.479

Virna Little: some of the lessons learned, and some of the things that came out were, this idea of, you know, shared accountability and thinking about treat to target and measurement based outcomes. And still, to this day we talk about measurement based care over here for behavioral health, and we have quality measures and hedis measures over here. And yet, you know we still haven't sort of brought

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00:22:06.480 --> 00:22:29.989

Virna Little: them together in some really meaningful ways. And when I think about what you could do on an organizational level, how do you pick some of those measures? How do you prioritize them? And how do you bring them together, and then hold everybody accountable for them? We sort of know that this idea of care plans and shared care plans are really helpful.

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00:22:29.990 --> 00:22:48.370

Virna Little: But you know, how do we have we really operationalize them or put them together in a way where we don't have behavioral health doing treatment plans and primary care, doing care plans like sort of what does that look like on the ground, and even some of the shared training and sort of how that looks like. So

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00:22:48.950 --> 00:23:12.419

Virna Little: when I think about all the learning we've done, and now that we sort of know what the ingredients are like, we know what instruments we need. We know how to play that music. How do we really take it forward in in some meaningful steps. And you know, in co-founding concert about 8 and a half years ago, and and we do collaborative care. We only do collaborative care.

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00:23:12.420 --> 00:23:22.140

Virna Little: And how do we figure out how to do collaborative scale, you know, at scale, what does that really look like? And how do you sort of overcome all of the barriers.

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00:23:22.140 --> 00:23:46.670

Virna Little: and I think we still do have a lot of those barriers, and as we go forward I think it's going to be important to really isolate some of them and sort of take them on, because I don't think we're going to be able to give the support and truly scale integrated care unless we tackle some of these individual challenges. And so, as I'm thinking about, you know what some of those look like.

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00:23:47.230 --> 00:24:10.599

Virna Little: it's really important to think about the training and how we're training some of the disciplines that are going into the field. If you were going to ask me for my own profession. I'm a psychologist and a social worker. I don't actually think we do a fabulous job of training people in my disciplines how to go out, and truly practice in integrated settings. I think there are pockets of schools

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00:24:10.600 --> 00:24:27.150

Virna Little: or places that do really good work, but I don't think we do it consistently, and I don't think we're doing it at the volume to which we're actually going to meet some of the workforce needs, particularly as we grow and scale some of these models.

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00:24:27.150 --> 00:24:30.879

Virna Little: And I think we need to think about some of the

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00:24:30.880 --> 00:24:54.020

Virna Little: the technology and working with some of the technology pieces. I know, you know. Oftentimes it feels like behavioral health is sort of still being a square peg in a round hole with some of the the electronic health records and and what that looks like in the field. And so I'm incredibly excited about sort of what the future holds. Now that we have figured out some of these pieces.

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00:24:54.020 --> 00:25:17.739

Virna Little: But I also want us to really think about what we've learned over the past decades. And how can we actually take that and move us forward in some meaningful ways. How can we reinforce it as we move into, you know, thinking about different payment models and technology and training. And so I'll end there off of some of Jurgen's

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00:25:17.760 --> 00:25:20.069

Virna Little: thoughts, and and just sort of summarize.

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00:25:22.800 --> 00:25:23.470

Anne Roubal: Cool.

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00:25:23.470 --> 00:25:46.120

Anne Roubal: Thank you both for those I love a good analogy, and I love that. We got to be reminded of where we've been, and then sort of thinking about where we are and where we're going. And I see questions coming into the chat or the Q&A box. So I want to remind people to continue to put questions in there, because that's what we're going to use the rest of the time today to do to pick your brains.

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00:25:46.230 --> 00:25:56.590

Anne Roubal: And right now I'm going to turn it over to Garrett to ask the 1st question and to get us started. But continue to please put those questions in the chat, because that's that's what we get to cover.

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00:25:57.710 --> 00:26:03.640

Garrett Moran: Thank you, Annie, and and thank you, Jurgen and Verna, for great, great, thoughtful comments.

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00:26:03.830 --> 00:26:11.220

Garrett Moran: So we've been working on this and and now for 30 years trying to advance this model.

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00:26:11.490 --> 00:26:25.519

Garrett Moran: Why is this still the right thing to do? And if it is the right thing to do, you know. Why? Why is it not more implemented on a more widespread basis? And I'll just let you all jump in on that one wherever you like.

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00:26:25.790 --> 00:26:35.097

Jurgen Unutzer: Yeah, I'll I'll I'll get it started. And I'm gonna actually do that with one more analogy. And that's a medical analogy. So

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00:26:35.780 --> 00:26:46.469

Jurgen Unutzer: if you look at the impact of behavioral health conditions on on health related disabilities, so the kinds of things that make us not be able to do the things we'd like to do with our lives.

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00:26:46.630 --> 00:26:55.079

Jurgen Unutzer: The the data is now very clear, very strong, for example, that behavioral health conditions, especially if they're not treated

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00:26:55.390 --> 00:27:05.040

Jurgen Unutzer: cost 10 to 20 times more health related disability than things like diabetes, heart disease, or cancer. Now, if you think about that for a moment.

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00:27:05.150 --> 00:27:25.340

Jurgen Unutzer: you know what what we have learned about treating those conditions is that they are either chronic or recurrent. They're not short term acute problems that you can just bat at once, and it will go away. So when you treat them you have to treat them in a pretty significant way, and usually have to treat them in a team. It's very rare that.

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00:27:25.490 --> 00:27:55.210

Jurgen Unutzer: you know. If you're getting cancer care, there isn't a whole team of people that are all playing something very important, very well together that they're actually sticking with you until your cancer is in remission. You know, you don't just give somebody a little bit of a light touch of chemo and say, Let's hope this goes away that would not cure anybody. So I think there are a lot of things that you know, I've learned from working alongside my colleagues in other parts of medicine where I'm like, you know, that's probably what it takes for us to be really successful, too.

111

00:27:55.230 --> 00:27:57.570

Jurgen Unutzer: So I think that

112

00:27:57.850 --> 00:28:21.120

Jurgen Unutzer: yes, it's absolutely still the right thing to do. I think we have learned that a single provider cannot help that. Many people. None of us are so good as behavioral health professionals where we don't need anybody else's help to get everybody well. So if we can play as a good team if we can make it an effort where we're not. Just

113

00:28:21.230 --> 00:28:28.060

Jurgen Unutzer: give you a little bit of care and hope that it works. But we're going to give you a full course of treatment that really helps you get well enough

114

00:28:28.220 --> 00:28:44.039

Jurgen Unutzer: where you say I can live with this. Now I have this under control. That's what it takes. And I think that we need to do that just as well and just as seriously as the way we treat other serious health problems like cancer, like diabetes like heart disease.

115

00:28:44.430 --> 00:28:48.610

Jurgen Unutzer: And so that's another little analogy.

116

00:28:48.720 --> 00:29:09.010

Jurgen Unutzer: I think the bottom line is even more so than I think we appreciated 20 or 30 years ago. It's absolutely the right way to go if we want to reach more people with effective treatment. Now, we could spend a whole bunch of time, and we probably will spend a bunch of time thinking about the challenges, the barriers.

117

00:29:09.110 --> 00:29:21.479

Jurgen Unutzer: Verna mentioned some of them, but maybe I'll hand off to Verna here before we go on to the barriers to think a little bit about. Why do we think this is the right way to go today?

118

00:29:22.360 --> 00:29:24.630

Virna Little: You know, I think

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00:29:24.830 --> 00:29:49.740

Virna Little: we continue to see outcomes, and we've had the opportunity to really look at outcomes across rural populations, adolescents, you know, across different payer mixes. And I think we continue to see good outcomes. We continue to see cost savings. And now we're really fortunate to have health plans, putting out cost saving data to have

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00:29:49.740 --> 00:30:12.109

Virna Little: states that are sharing that information. And there is so much information out there now, not randomized control trials, but just people who are reporting and doing research from the field. Hey? This is what the outcomes that we're seeing in our women's health population, you know, a topic that's near and dear to me. Suicide care. We've been really able to show

121

00:30:12.110 --> 00:30:18.699

Virna Little: positive outcomes across multiple organizations and large populations with suicide care.

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00:30:18.700 --> 00:30:47.289

Virna Little: And so I think, as we continue to go forward now, looking at some of the chronic illnesses and starting to see some not just the cost savings, but also to see some really good outcomes. And so I think more and more we continue to know. It's a good idea we continue to renew it right, or to have it reinforced that we're on the right track, where you know we should keep doing what our hearts told us to do, you know, 30 years ago. And so, and I think that's just going to keep mounting.

123

00:30:49.250 --> 00:30:52.800

Garrett Moran: Great Annie, you had.

124

00:30:52.800 --> 00:31:13.889

Anne Roubal: Yeah, thank you for those comments. So I think you started to allude to it. And I see a couple of questions building off it in the chat. But I'll ask a big the big question here, which are, what are some of the biggest challenges? And I I see in the chat particularly around workforce being brought up. So I don't know, Verna, if you want to start with that. But I know that's not the only challenge. So

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00:31:13.890 --> 00:31:14.540

Anne Roubal: hmm.

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00:31:14.560 --> 00:31:38.539

Virna Little: So I think there's a couple of pieces, you know, to workforce. One of the, you know. Wonderful pieces about collaborative care is that you actually have the ability to have a little bit more of a diverse workforce that you have, you know, collaborative care really was sort of meant to be telephonic and remote kind of from day one. Because all of the the frequent contacts and and the follow up.

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00:31:38.540 --> 00:32:03.529

Virna Little: and that really allows you to hire individuals that are hybrid or that are remote. To be able, particularly in rural areas, to, you know, fill some of those positions that maybe you wouldn't be able to fill otherwise, and I think it also allows us to incorporate trainees into the service model and have them practice, and then, oftentimes, you know, become part of those

128

00:32:03.530 --> 00:32:29.379

Virna Little: teams, and so I am pretty excited about the ability to continue to grow a workforce that specializes in working in integrated care. So I also think that it has allowed us to bring in other professions, such as addiction, medicine, and be able to develop some expertise there so that they can actually serve in the role for some populations where

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00:32:29.470 --> 00:32:53.220

Virna Little: we're working in Matt programs. And that so I do think that there are a lot of opportunities there. Not that, you know, workforce is certainly a challenge across the board, but I think it allows us for the flexibility to be able to be a lot more creative about solving some of the workforce problems than we might have been able to do, particularly before the dedicated Cpt codes were put in place.

130

00:32:56.820 --> 00:33:06.870

Jurgen Unutzer: Yeah, maybe I'll just add just a few thoughts to this, since we're sticking on workforce. So yes, I think one of the major challenges is, always has been and is going to be.

131

00:33:07.130 --> 00:33:23.939

Jurgen Unutzer: How do we find enough qualified staff to do this? And if you think about how we train behavioral health professionals. We haven't changed things very much since I trained in psychiatry 30 years ago. We're teaching psychiatrists and psychologists who do what we call a 50 min hour.

132

00:33:24.030 --> 00:33:40.569

Jurgen Unutzer: which is, you know, you sit down with a client in person, and you you make a nice relationship. You engage with them. You ask a bunch of questions. You develop a formulation for what's going on. You maybe work on a treatment plan together, and then you try to wrap that up

133

00:33:40.945 --> 00:34:08.409

Jurgen Unutzer: you know, with about 10 min to go, so you can write a chart note, maybe go use the restroom, have a cup of coffee, and then you do another one of those. And that's a really important core skill that I think we all teach. We all learn as behavioral health professionals, but it doesn't scale terribly well, you know you can only do a handful of these 15 min hours with a handful of clients, and it's not going to reach that many people. So I feel like

134

00:34:08.520 --> 00:34:32.380

Jurgen Unutzer: we are still training people in skills that are important that are foundational. But they're not really learning how to work great in a team. We're teaching people how to play one instrument, really. Well, I'm sorry I'm going back to my music analogy, and they're becoming virtuosos in playing that one instrument. But then you put a whole bunch of those people together in a busy primary care practice, and they don't know how to make music together.

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00:34:32.380 --> 00:34:54.899

Jurgen Unutzer: Everybody does their thing and says, I just need my, this, I just need my, that. And so I think that's the challenge, you know. And I think if we want to change that, we need to actually have people train in places where they're seeing good team care where they're seeing how people complement each other. You know. I think I learned very early on doing this work that you know a well-timed

136

00:34:55.110 --> 00:35:12.259

Jurgen Unutzer: 5 min phone conversation at the right time for the patient or even a text message can be a lot more impactful than having another 50 min hours. That's scheduled where the patient has to take a half a day off from work and come into the office and sit with me, and maybe it's not the right time for them.

137

00:35:12.260 --> 00:35:30.129

Jurgen Unutzer: and so if we are a little bit more flexible about how we use our time, our skills if we start using technologies. And early on it was simple technologies. A phone call a text message. Now, we have more sophisticated technologies. I think if we're willing to say.

138

00:35:30.130 --> 00:35:56.349

Jurgen Unutzer: how do we practice a little bit differently? How do we teach people how to practice a little bit more flexibly, and then you might start saying, Oh, my God, you know what if we don't? What if we do now things that don't work terribly. Well, that's why I think it's important. Whatever it is we do we still have to say. Is it actually engaging the patient. And most importantly, is the patient getting better. And again I go back to my analogy in cancer care at the bottom line is, is the cancer going away

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00:35:56.680 --> 00:36:08.769

Jurgen Unutzer: is the patient surviving? We need to do the same thing in behavioral health. We need to know, how do we know if this is working or not, and if it's not working, let's not beat ourselves up. Let's just say we need something else. Someone else.

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00:36:09.020 --> 00:36:11.510

Virna Little: We need a consultation as a team.

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00:36:11.700 --> 00:36:17.990

Jurgen Unutzer: And I think those are all the kinds of things that we don't really teach yet very much when we teach behavioral health professionals.

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00:36:18.280 --> 00:36:44.859

Virna Little: And I think we teach one way, so that you know that 50 min hour. But many behavioral health interventions are like 6 to 8 min. And so how do we think about doses of that treatment? How do I work with you on an intervention? How do I reinforce it? You know, work on an intervention and reinforce it, so that, you know, behavioral health treatment is actually better delivered in those doses and then reinforced.

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00:36:44.860 --> 00:37:09.790

Virna Little: And I think we're not teaching people that model of delivery. And I think what it does for the people that we care for is that it's very restrictive. I always call it the therapy bus, which is not a great like people get on the therapy bus. They don't know when they're going. They don't know when it's going to stop. And they're like, Oh, the 1st chance I get. I'm off right because we're kind of just limiting what their choices are. And so I love the ability to really give people

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00:37:09.790 --> 00:37:23.400

Virna Little: options, and for clinicians to be trained to deliver those options and sort of what really works best, and what works. Best oftentimes are these, you know, doses and reinforcements.

145

00:37:26.230 --> 00:37:49.529

Garrett Moran: One of the questions that the audience submitted, I think, is hitting another key issue, and that is performance measurement. I mean, you know, the old Saul that what you measure is what you get, and I tell people about visiting my primary care, Doc, not long ago, and and ask about how they deal with behavioral health issues, and he says, Well, you know, I give him a pill, or

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00:37:49.820 --> 00:37:55.969

Garrett Moran: it it it but I do. I do what it takes to meet their performance measures. So

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00:37:56.360 --> 00:38:06.080

Garrett Moran: what's the what's the gap between the the performance we're measuring and what we need to measure if we want to see the expansion of behavioral integration.

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00:38:06.680 --> 00:38:17.560

Jurgen Unutzer: Yeah, I would say that that's an area that we have come to very, very slowly in behavioral health. The idea that what we do could be measured that the care we provide

149

00:38:17.730 --> 00:38:39.960

Jurgen Unutzer: is not going to help everybody, but if it doesn't help anybody we shouldn't beat ourselves up. We should just say, let's not do a couple more of this, because that's not helping this particular client. What else can we do? How do we know? And you know, starting with the patient. How does the patient know? How do we know that they're actually getting better? So if you think about it? And again, I'm going back to a couple of medical analogies. I've

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00:38:40.210 --> 00:39:06.099

Jurgen Unutzer: I've got a problem called hypertension. I developed that in my thirties, you know I'm not in my sixties. If I hadn't treated this high blood pressure I might have died from a stroke by now, but every time I go in to see a healthcare professional, somebody puts a blood pressure cup on me and says it's good. It's not so good. People don't spend a lot of time thinking about, are they good? Are they bad? Am I good? Am I bad? If it's not the right number? We make some changes and we get it right.

151

00:39:06.240 --> 00:39:17.160

Jurgen Unutzer: You know, if you're treating somebody who's got diabetes. We're not saying to them, how do you feel? Your diabetes is going these days. We measure what their blood sugars are.

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00:39:17.350 --> 00:39:27.960

Jurgen Unutzer: but in behavioral health. For the most part, we're still saying to people, How do you feel like you're doing? And people like you? You're a nice person. They don't want to upset you so they say I'm a little bit better.

153

00:39:27.980 --> 00:39:34.840

Jurgen Unutzer: But if I said to, if somebody had said to me 25 years ago, how do you think your blood pressure is doing? I'd said I think it's doing a little bit better.

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00:39:34.860 --> 00:39:49.849

Jurgen Unutzer: I probably would be dead from a stroke by now. So I think it's really important for us, just like in every part of medicine that we say we are going to find a way to measure. If this treatment is working, and if it's not working, it's okay. We just make a change.

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00:39:49.850 --> 00:40:07.629

Jurgen Unutzer: And I think that's something that behavioral health professionals have had a slow time coming to. I think that's getting better. But we tend to take that a lot more personal than my colleagues in primary care. If someone's blood pressure isn't doing well. They're not sort of fretting about, you know. Is it my fault? Is it his fault?

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00:40:07.630 --> 00:40:21.549

Jurgen Unutzer: They're just saying, I think we need to make a change in your treatment, but in in, I think, in mental health care and behavioral health care. We often take that a little bit personal. We sort of think. Oh, you know I'm not getting them all that much better. What's wrong with me? What's wrong with them?

157

00:40:21.650 --> 00:40:43.419

Jurgen Unutzer: I feel like we should just say, how do we know if we're treating anxiety? Is the anxiety less? If we're treating depression is the depression less? If we're treating some other thing that's not working. If we're treating an addiction problem is the person using less. Those are all things that can be measured. There's nothing wrong with that. And I think it's really important that we all get comfortable and stay comfortable with that concept.

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00:40:44.320 --> 00:40:48.309

Virna Little: I think we need to think about the training again, because

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00:40:48.340 --> 00:40:54.590

Virna Little: I wasn't really trained to use tools in practice. And I spent a lot of time teaching behavioral health providers.

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00:40:54.590 --> 00:41:19.459

Virna Little: How do you actually do measurement based care like day to day? How do you have the discussions with people about what got better? What got worse? How do you have conversations that involve the tools and not just sort of go through a checklist? How do you use the tools to arrive at a differential, to come up with a care plan, you know. Like, as an example, you know, for the Phq. If I'm a 0 to a 1. Well, we're starting to think about

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00:41:19.460 --> 00:41:44.109

Virna Little: a go forward plan right? If I score 2 or 3, then maybe that's going to be, you know stuff we're going to pay attention to. And then I might ask some questions. And then I'm going to, you know, get some information from my psychiatric consultant, and I'm going to kind of go through and use that as a foundation for that that encounter that day which is, can be engaging and getting information and also really building in that tool

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00:41:44.110 --> 00:42:01.919

Virna Little: and that measurement based care and then sharing it with someone. Hey, you know you're here, and you want to be here, you know. And what does that look like? And let's talk about a way to get there. And I think that is a skill that we need to start early on in training and then needs to get role modeled in in practice.

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00:42:07.320 --> 00:42:20.929

Anne Roubal: Thank you for those answers. I'm going to stick with the barriers, because there's a question here about how do we use emerging technologies such as AI, you know, to advance integration of behavioral behavioral health.

164

00:42:21.280 --> 00:42:39.959

Jurgen Unutzer: Yeah. So that is definitely looking forward. And I think it's a great question. I would say, before we go to that, I want to sort of mention one other thing, and I think it's not unrelated. But one of the challenges in a busy primary care clinic is that you always have competing priorities.

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00:42:40.210 --> 00:42:59.109

Jurgen Unutzer: you know. So when you're treating something like an addiction problem or a serious depression or anxiety problem, or somebody who's struggling with post-traumatic stress disorder or bipolar disorder. These are not things you can sort of make. Go away with one or 2 or 3 touches. But what's happening in primary care is.

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00:42:59.210 --> 00:43:26.519

Jurgen Unutzer: The office is full of people who are coming in with an acute problem. They need that acute problem addressed. And so there is what I call the tyranny of the urgent. There's always going to be something that's more urgent today right now than paying attention to something that's been there for a while, and it's probably still going to be there for a while. And that's the same thing. If we and again sorry about back to my cancer analogy, if we sort of said, we want to treat cancer. We can't forget about the cancer. We got to keep on that.

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00:43:26.650 --> 00:43:51.510

Jurgen Unutzer: because if every time they come in, they say, now my right foot hurts, and now I have a cough, and now I have this. If we just chase every one of those things every time somebody comes in we're going to forget about the really big, important thing that sits in the background. So it's challenging to remember. So that's my segue to technology. Human brains are not very good at remembering who are all the people in my practice who? I started on something.

168

00:43:51.510 --> 00:44:03.159

Jurgen Unutzer: but they haven't finished it yet they're still not better, because the human brain just responds to what shows up and comes into my office and says I need some attention right now. That's where a piece of technology can be incredibly helpful.

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00:44:03.290 --> 00:44:06.290

Jurgen Unutzer: So a technology can say, Hey.

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00:44:06.450 --> 00:44:28.339

Jurgen Unutzer: you started these 25 people in the last month on a treatment, for anxiety, for depression, for whatever, and they're coming in for other things right now. But that's still going on. Can you remember to try to do something about that. So I think that's 1 way in which we can use technology to kind of scaffold what we as humans aren't all that good at. We're really good at

171

00:44:28.610 --> 00:44:37.659

Jurgen Unutzer: hopefully, we're good at, you know. Have the emotional intelligence to to respond to another human being who comes in front of us to hear what they need right now to address that.

172

00:44:37.790 --> 00:44:53.270

Jurgen Unutzer: And a piece of technology can sit in the background and say to us, Hey, don't forget about this other thing that's really, really important. So that's 1 way of using technology. I think more broadly. And I'd be interested to see what Verna thinks about this. But I think that

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00:44:53.760 --> 00:45:14.150

Jurgen Unutzer: if we think about collaborative care, it's a set of functions that somebody on a team needs to do so. There is engaging the patient making a diagnosis, making a treatment plan. Somebody starts a treatment. Somebody carries out the treatment. Somebody goes back to the patient and makes sure they're actually taking the treatment somebody checks to see is the treatment really working.

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00:45:14.470 --> 00:45:19.319

Jurgen Unutzer: Those are all functions that in the original collaborative care model we had human beings do.

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00:45:19.470 --> 00:45:34.119

Jurgen Unutzer: And we might have had a simple piece of technology, like a registry tool, to sort of sit behind that to make sure things don't fall through the cracks. But I do think that with artificial intelligence many of these functions you could have an AI co-pilot

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00:45:34.200 --> 00:45:45.849

Jurgen Unutzer: who's part of a collaborative care team who does a lot of these functions, and that would help me make sure it's robust. It doesn't fall through the cracks, and I might be able to help 5 or 6 times more people than if I'm just

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00:45:45.890 --> 00:45:53.660

Jurgen Unutzer: one human being on a collaborative care team. For example, you know, there are. Now, you know, AI

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00:45:53.680 --> 00:46:22.149

Jurgen Unutzer: tools that are good enough at engaging people and doing symptom checks, and, you know, reaching out to the patient at a time that's super convenient to them, and in a way that's super convenient to them, just to make sure you know their symptoms are getting better, and if they're not to flag it to me, if I have to schedule an appointment to bring you in and to read you a bunch of questions. That's a lot more cumbersome. I think you know an AI tool could do that very, very nicely.

179

00:46:22.150 --> 00:46:50.370

Jurgen Unutzer: There are now really nice AI tools that can do the basics of something like cognitive behavioral therapy. I might learn how to do that working with somebody with a human being in a primary care office. But if that person can say, Hey, you're getting pretty good at this. I have a tool here where you can practice that skill, that cognitive reframing skill, or that behavioral activation skill that we've been working on. You can practice that. However, times you want. Whenever you want it, you can do it in the middle of the night.

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00:46:50.390 --> 00:46:55.900

Jurgen Unutzer: and all I'm going to get from that tool is a little update that you're working with it that you're practicing.

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00:46:55.970 --> 00:47:16.039

Jurgen Unutzer: Then I have a co-pilot that could really leverage what I can do as a therapist. So I think there are lots of potential uses now of AI technology. And the way I would think about it is not replacing a human, but bringing an AI co-pilot onto the collaborative care team to help me be more effective and reach more people.

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00:47:16.220 --> 00:47:18.520

Jurgen Unutzer: I don't know what you think about this, this Verna.

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00:47:18.740 --> 00:47:35.319

Virna Little: Yeah, I've actually been some of what you've been thinking and also fascinated by the ability of AI to predict engagement. And so the 1st time I'm having that conversation. If someone could sort of real time. If there was AI that could predict engagement.

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00:47:35.320 --> 00:47:54.189

Virna Little: then that's someone that I might, you know, engage with every day or every other day, maybe someone that I could, you know, put forward for a week, or it would really be helpful. And I think you know, using AI for sort of functions like that are are pretty incredible. And so that's something recently that I've been like.

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00:47:54.540 --> 00:47:57.909

Virna Little: think about how to bring that in and and figure that out.

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00:47:59.840 --> 00:48:13.020

Garrett Moran: Very, very interesting. It's exciting prospect. I see all the work underway on addressing workforce. And I think we're we're never going to get enough workforce unless we change the care models and start integrating

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00:48:13.180 --> 00:48:15.409

Garrett Moran: technologies like, that's just key.

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00:48:15.630 --> 00:48:33.859

Garrett Moran: So good audience question here, is on the per member per month. Capitation rates and and the the codes that are being used to to pay for behavioral health integration now. And they're they're saying that they they're not really adequate.

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00:48:33.970 --> 00:48:38.129

Garrett Moran: and particularly to cover the initial startup costs.

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00:48:38.788 --> 00:48:48.890

Garrett Moran: What? What do you see? That's being done to address those and make those more adequate, overcome that hump that's needed to deal with

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00:48:49.270 --> 00:48:51.080

Garrett Moran: the initial integration.

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00:48:51.230 --> 00:49:14.279

Virna Little: Yeah, I can. I can actually start off on that one. So a couple of thoughts, you know, really passing the dedicated Cpt Codes, you know, some years back, was incredibly helpful to collaborative care. I think, past that. What happened is that implementation and adoption on the Medicaid fee schedules by the States was all over the map.

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00:49:14.300 --> 00:49:37.549

Virna Little: I mean even to date. We're just recently at 35 States that have put the codes on the Medicaid fee schedule and how they've done it, at what percentage of medicare they reimburse literally goes from like half all the way up to 120%. What they've done around some of the minutes. Some States recognize minutes. Others like New York, do not

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00:49:37.600 --> 00:50:03.849

Virna Little: what they've done for their federally qualified health centers, and whether they've included them or not. And so that has actually really made it difficult for a lot of organizations based on whether your State has the codes and sort of based on what some of the other, you know guidance has been. I do want to say, though, and sort of put out. I am pretty hopeful about some of the Cms. Proposed rules

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00:50:03.850 --> 00:50:27.329

Virna Little: getting rid of the G. 0 5, 1, 2 for the Federally qualified and Rural health centers, I think, is huge, adding collaborative care codes. The advanced primary care, I think, is also another huge and the complete Care Act, I think, is going to be, you know, certainly helpful and a game changer. I do think there's some advocacy for states that have not yet passed the code, certainly.

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00:50:27.330 --> 00:50:41.739

Virna Little: but also to get everybody, so that there is a floor, so that we're going to say at least, Medicare is the floor for the State for Commercial, you know, for Medicaid, and and that's going to be sort of a standard across the board.

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00:50:42.160 --> 00:50:56.839

Virna Little: I do think, however, what I have seen, and and this may not be. An incredibly popular opinion, but that oftentimes one of the ways that we don't have successful implementations

198

00:50:56.840 --> 00:51:21.779

Virna Little: or sustainable implementations is because we're not doing the implementation well, like at the end of the day. If you don't have enough patients engaged in your collaborative care model, it's not going to be self-sustaining. It doesn't matter what the rates are, and I think we have learned so much about how to successfully launch collaborative care like, if you were going to ask me, I do it so

199

00:51:21.780 --> 00:51:42.229

Virna Little: differently now than I did even 2 years ago, and certainly how I did it 10 years ago, and so that we can really look for that sustainability sort of on the front end that we're actually doing pro formas. We're really talking about the financing and building models out so that practices can be successful, and that

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00:51:42.230 --> 00:52:06.329

Virna Little: you know some of you might have heard me. Oftentimes I'm speaking. I show a picture of the desert, and it's a place I call the Land of Perpetual Launch. It's a dry place once you're there, it's very hard to get out of it, and I think that is actually, you know part of the promise we've learned to launch a little bit better, so not that there aren't payment or reimbursement, and I do think we need to get to a place where we're not

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00:52:06.330 --> 00:52:19.089

Virna Little: getting rid of the administrative burden, you know, of some of the time tracking and some of those pieces, so I do think it's a a combination. So that was probably a pretty long explanation, or some thought.

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00:52:19.090 --> 00:52:28.979

Jurgen Unutzer: I think, super helpful. I I have a couple of other thoughts and and you're really much more in the middle of all of the payment stuff than I am, but I guess somebody mentioned the notion of

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00:52:29.110 --> 00:52:38.149

Jurgen Unutzer: per member per month. So that assumes that you know you're looking at total health care as some kind of a capitated thing. And I would say, That's another one of these things that's been

204

00:52:38.370 --> 00:52:54.170

Jurgen Unutzer: coming in my career for the last 30 years, and we still haven't probably found our way to it. So we're still living. 90 95% of us are living in a fee for service world, I think, in a capitated world this thing does make all the sense in the world. The research we did

205

00:52:54.290 --> 00:53:11.059

Jurgen Unutzer: and published, you know, 2 decades ago is that when we were doing this in organizations like the Va or a Kaiser permanente that really are capitated, they were seeing tremendous cost savings, and those organizations then have figured out. We got to do this on a pretty robust scale.

206

00:53:11.080 --> 00:53:29.440

Jurgen Unutzer: because it just makes all the sense in the world. Not only do patients like it, and providers like it, and and people get better, it's actually cost is actually saving us money. So I think that in that environment. I think there is a pretty strong argument to be made, and organizations that are fully capitated, I think. Have

207

00:53:29.610 --> 00:53:30.530

Jurgen Unutzer: you know,

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00:53:31.150 --> 00:53:39.099

Jurgen Unutzer: pretty robustly gone that way. You know the the interesting thing about the fee for service billing for this, as Verna mentioned.

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00:53:39.870 --> 00:53:58.740

Jurgen Unutzer: You know, it's interesting. It took us probably about 20 years to figure out how to do this well, to do the work well, how to build models that are not just efficacious. But they're effective. They're robust enough, so they don't break easily. It seems to be taking another 20 years to get people comfortable with figuring out how to use a set of new billing codes.

210

00:53:58.870 --> 00:54:12.169

Jurgen Unutzer: You know, our billing people have to get comfortable with it. Our providers have to get comfortable with it. The idea that a primary care provider has to get an informed consent from a patient, you know, to have these charges submitted.

211

00:54:12.280 --> 00:54:31.030

Jurgen Unutzer: You know, there's lots of little things that can make things complicated, and I think it's sort of a slow process. You know. I see that in my own organization the only other thought I have is, and it goes back to the comment on technology. And AI, I do think that

212

00:54:31.430 --> 00:54:37.849

Jurgen Unutzer: if we can deploy AI technology more broadly, we can probably get

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00:54:38.000 --> 00:54:59.739

Jurgen Unutzer: more scale. We might be able to reduce the cost of doing this a little bit, because, you know, if I can have a co-pilot that doesn't cost very much, but is very effective. You know, the humans are the part that's very expensive about collaborative care, right? So the cost might become a little bit more attractive. The whole notion of

214

00:54:59.870 --> 00:55:10.259

Jurgen Unutzer: how do we capture the work of a team member? How do we track the minutes? I bet you there is technology solutions to that as well, that will evolve over time. So

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00:55:10.490 --> 00:55:13.520

Jurgen Unutzer: I think that. Yes, it's challenging.

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00:55:13.928 --> 00:55:23.440

Jurgen Unutzer: but I do think that that things are getting better with regards to that. And then we will probably have some technology solutions that will help us do that even better.

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00:55:24.980 --> 00:55:26.539

Anne Roubal: Fingers crossed. Thank you.

218

00:55:27.240 --> 00:55:50.340

Anne Roubal: Fingers crossed by second gear. It's notion that was like exactly what my brain was thinking. So I'm going to ask the last question we had prepared before or well that people submitted before. And then we've been sprinkling in the audience questions because they're obviously related to the questions that people submitted before. But we're going to turn completely to audience questions after this one. So again, just a reminder to put it, put them in the chat. I know we have quite a few in there, but

219

00:55:50.810 --> 00:56:06.999

Anne Roubal: pulling them out. So this is kind of a big big picture question you're brought up. But what cultural shifts or structural shifts might be needed in healthcare settings, or among providers for integrated care to become the standard of care rather than in exceptions.

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00:56:09.140 --> 00:56:10.020

Virna Little: You know.

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00:56:10.310 --> 00:56:10.890

Virna Little: Go ahead.

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00:56:10.890 --> 00:56:29.440

Virna Little: was gonna jump in. You're gonna you know, I had the opportunity to spend today. I mentioned with some behavioral health leaders, you know, from around the country in in integrated care settings, and one of the things that they continue to voice is, I am still asking for a seat at the table.

223

00:56:29.470 --> 00:56:45.599

Virna Little: and there are still organizational decisions. The organization puts out a quality plan. There is no behavioral health piece. Nobody asked me to participate in it. And so, you know, I think one of the pieces is for integrated care

224

00:56:45.600 --> 00:57:10.490

Virna Little: organizations to say, I have a behavioral health business line. I need to understand the finances of it. It needs to be built into all of the parts of my organization, to into quality, into compliance, into the board into all of those pieces. And I think for some that is a fairly large cultural shift. And I think for a lot of very large organizations and systems are like, Oh, that's behavioral.

225

00:57:10.490 --> 00:57:23.319

Virna Little: and we lose money on there. But you know, it's you know it is what it is. And I think you know, really trying to change some of that is is actually where we need to really think about it and to be intentional.

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00:57:24.150 --> 00:57:31.950

Jurgen Unutzer: Yeah. And I would say that that culture shift, you know. To some extent it can come from those of us who are behavioral health specialists

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00:57:32.270 --> 00:57:37.359

Jurgen Unutzer: continuing to make the argument that we have value to add in a busy primary care setting.

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00:57:37.560 --> 00:57:50.479

Jurgen Unutzer: But it also needs to come from inside of primary care, and I would say the best advocates in in our healthcare system, for example, we have a large academic healthcare system, 20 plus primary care practices. They all have

229

00:57:50.680 --> 00:58:03.699

Jurgen Unutzer: fully integrated behavioral health teams now they didn't 1520 years ago. And it's not so much me making the argument, for it's really our primary care doctors, especially our younger primary care doctors

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00:58:03.890 --> 00:58:28.409

Jurgen Unutzer: working in a clinic where, when somebody is really struggling in their office with a behavioral health problem, they know I got somebody down the hall who I can pull in. Who's going to help me? I'm going to get out in time today. My schedule isn't going to be totally overburdened and working together with this colleague in behavioral health is going to help me make a huge difference, and doctors will always argue for something that helps their patient get better. They know when they can help their patient.

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00:58:28.410 --> 00:58:36.450

Jurgen Unutzer: and I think the best advocates I've seen is is primary care. Providers who have experienced good collaborative care.

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00:58:36.450 --> 00:58:59.729

Jurgen Unutzer: and then all of a sudden it goes away, and they start saying, You know, if these people don't come back, and if I don't have this help, I'm going to go work in another clinic, and that gets people's attention. So I feel like, you know, we have to do more than just those of us who are behavioral health experts. Continuing to say, How can we get a seat on your table? I totally agree with you, Averna. That's probably what I spent most of my career doing. That's what I do in my day job here.

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00:58:59.730 --> 00:59:07.160

Jurgen Unutzer: you know, I convince people that behavioral health is a real thing, and it's a part of health care, and we should be everywhere else where there is health care delivered.

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00:59:07.170 --> 00:59:19.330

Jurgen Unutzer: But I think if if we can give our colleagues in primary care, in a busy primary care, setting the experience of having this making a difference for their patient, and then they become very, very strong advocates for it.

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00:59:19.400 --> 00:59:22.839

Jurgen Unutzer: I think it's also something that's super super helpful.

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00:59:25.990 --> 00:59:34.480

Garrett Moran: Following on just exactly that point. 1 1 of the other questions we wanted to ask was about, you know, we've got over a hundred people here listening to you all today.

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00:59:34.760 --> 00:59:56.628

Garrett Moran: What can what can we do? What can each of us do in the healthcare systems we face? And I was seeing this in in a large healthcare organization, that it's a strong reputation, and and that I'm involved as a patient. And they're not doing. They're not doing squat.

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00:59:57.780 --> 01:00:04.190

Garrett Moran: What? What can we do? What can these 100 people listening today do to to start to make a difference.

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01:00:05.410 --> 01:00:15.620

Jurgen Unutzer: Yeah, I would say, we, we tend to think a lot on the supply side as those of us who generate new solutions in in healthcare.

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01:00:15.790 --> 01:00:19.010

Jurgen Unutzer: If we thought a bit more on the demand side, what if

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01:00:19.330 --> 01:00:44.000

Jurgen Unutzer: patients start saying, why don't we have somebody here who can help me with this, you know, in our cancer center patients said, why do I have to go see somebody else? I'm here for my cancer care. I'm depressed. I'm anxious. I'm afraid of needles. Do I really have to go somewhere else when a clinic where they don't know anything about my cancer, I want good behavioral health care right here in the cancer center and our cancer center said, Whoa, we don't want to lose our patients.

242

01:00:44.000 --> 01:01:13.179

Jurgen Unutzer: We now have a really great psycho oncology team in our cancer center, right? So I think that every one of us is a consumer of health care. And if we start saying, Why don't I have this here people will pay attention, I think, if you take it one level up. Who's buying our health care? Most of our healthcare is employer purchased. So if the employers start saying, I'm not going to contract with a health plan that doesn't have a really robust way of addressing behavioral health needs. So that's going to make everybody who needs behavioral health care go to.

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01:01:13.230 --> 01:01:21.309

Jurgen Unutzer: you know, a completely separate setting where there is a very poor access to specialist providers. If the employer starts saying, you know, if you don't have good

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01:01:21.500 --> 01:01:37.009

Jurgen Unutzer: working and reachable and effective integrated care, I'm not going to contract with you. Health plans will start thinking a little bit different, right? So I feel like we could do a lot of work. All of us could do a lot of work on the demand side, not so much just on pushing an idea on the supply side.

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01:01:38.540 --> 01:02:01.650

Virna Little: yeah, I would agree. And I would think you know also as employers you know, are we asking about the collaborative care, codes, are we asking what the reimbursement is? Are we asking sort of what's you know available and and what that looks like? And I think that would be a really important piece to be able to reinforce, and doing some of that that education, for sure.

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01:02:05.130 --> 01:02:07.821

Garrett Moran: Very good right. I'll see what I can do.

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01:02:08.070 --> 01:02:09.020

Anne Roubal: Yeah.

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01:02:09.970 --> 01:02:34.719

Virna Little: You need to educate them when you're there, Garrett, you know my primary care, you know, Provider, I told them that was. I told him. I said, I do trainings on how to do the Phq. 9. And I said, I'm gonna use what just happened as an example of what not to do. I said that was the worst. Phq. 9. Delivery. And I said, You better not, Bill, for that either, like I had a whole, and he now he blocks a little extra time for me, because I always get

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01:02:35.310 --> 01:02:40.050

Virna Little: he's like, did we get it right this time, Verna? And I'm like not yet. Not yet you were.

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01:02:40.050 --> 01:02:41.070

Virna Little: You're not. Yeah.

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01:02:41.070 --> 01:02:41.780

Garrett Moran: Right.

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01:02:42.170 --> 01:02:44.470

Virna Little: Quality improvement. Right there you go.

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01:02:44.470 --> 01:03:05.960

Anne Roubal: So one question in the chat is I'm just gonna read it because I don't want to speak on it, but it's is the collaborative care model considered better than the primary care model? And have these models been compared? Or is the choice between the 2 mostly dependent on workforce availability and the business model. So just wondering if you both might want

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01:03:05.960 --> 01:03:07.160

Anne Roubal: comment on that too modern.

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01:03:07.160 --> 01:03:09.639

Garrett Moran: Collaborative care versus primary care, behavioral health, yeah.

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01:03:09.640 --> 01:03:19.259

Virna Little: Yeah, actually think this whole idea of sort of choosing a mock. I don't actually get it to be honest, because it's, you know.

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01:03:19.390 --> 01:03:30.299

Virna Little: to me, collaborative care is incredibly effective for populations of patients where you're able to to think about measure outcomes, treat to target. But

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01:03:30.540 --> 01:03:43.840

Virna Little: it is not. Not. Every patient goes into collaborative care. And I think, for you know, when I think about a behavioral health population in an organization, you have patients that need health and behavior change.

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01:03:43.840 --> 01:04:08.099

Virna Little: You have collaborative care where you can measure. You have people that fall out. You have some, you know, folks that maybe have more serious that maybe are doing groups or some specialized care. And so to me, you want to come up with a way to care for your entire population, and also how you do that in design. That depends on the state and depends on your payer mix. So

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01:04:08.100 --> 01:04:17.519

Virna Little: how am I going to get reimbursed? So I always tell people stop talking about Pcbh and collaborative care. But actually think about what your population is.

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01:04:17.520 --> 01:04:38.800

Virna Little: what services you need to provide to meet those needs, what evidence based practices. And then who do you have on your team? And how are you, gonna bill and code and pay for it? And I think when you start to answer some of those questions, you can put a service model together that meets the needs of your organization and and your population.

262

01:04:39.910 --> 01:04:53.190

Jurgen Unutzer: Yeah, just a couple of additions to that. So my sense is that 1st of all, there aren't clean versions of Pcbh primary care, behavioral health and collaborative care that are truly distinct.

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01:04:53.360 --> 01:04:57.980

Jurgen Unutzer: I think all of these models. When you see them implemented in the real world.

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01:04:58.190 --> 01:05:17.920

Jurgen Unutzer: they have components of each other, and they're on a spectrum. You know. The spectrum is from a co-located provider who is readily available to you when you have a patient in the office, who is struggling with something to a full, fully implemented, collaborative care model where you have that provider. But you also have a registry. You can track on a chronic illness.

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01:05:18.070 --> 01:05:35.860

Jurgen Unutzer: You can pull in more expertise if needed. And I think it's a little bit like saying, Is it our treatments for cancer better than treatments for heart disease. They really are targeting different things. So you know, the Pcbh model in my experience is very good at

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01:05:36.010 --> 01:06:04.599

Jurgen Unutzer: the acute thing that shows up in the office that if I sit on it for too long it could become a chronic problem. It's a person who is struggling with a relationship problem with, you know, a problem in it's a young person who's struggling with going to school, you know, who is maybe saying, you know my tummy hurts. I can't go to school, and if you let that go on, for on and on and on and on, it becomes a really serious, you know. Was it a well entrenched, behavioral health problem, that kind of thing?

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01:06:04.710 --> 01:06:13.570

Jurgen Unutzer: A couple of, you know, really good brief interventions from a skilled mental health professional using the Pcbh model can make a huge difference.

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01:06:13.670 --> 01:06:17.359

Jurgen Unutzer: you know, that's different from somebody who's living with

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01:06:17.430 --> 01:06:43.979

Jurgen Unutzer: a chronic or recurrent mental illness like bipolar disorder or post-traumatic stress disorder or recurrent major depression. Those things are more like cancer, you know, or like diabetes, they really need ongoing care. They don't benefit from a couple of light touches. So it's a little bit like saying, I think they just have different targets, and and if I was in a primary care organization I'll need all of these things right. I'll need somebody who can make a brief.

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01:06:44.030 --> 01:06:51.049

Jurgen Unutzer: skilled intervention with one of my patients, you know, who's struggling with an acute problem with a relationship problem, with a.

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01:06:51.390 --> 01:07:01.489

Jurgen Unutzer: with an acute anxiety about a situation that could be about their health care with somebody who needs to learn how to, you know, work with their diabetes more effectively.

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01:07:01.900 --> 01:07:23.470

Jurgen Unutzer: But then I have patients, you know, who have developed full on chronic, recurrent mental health conditions. I'll need more. I'll probably need a collaborative care model. So I think they're not the same thing. They're not chasing the same thing. They're not trying to help the same thing. I think they all have value, but I don't think it makes a lot of sense, and as far as the evidence base is concerned, they have not been

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01:07:23.620 --> 01:07:49.859

Jurgen Unutzer: really tested robustly in a sense compared one to the other, because they're treating different things so it wouldn't make sense, really. But as far as the evidence goes, there is a ton of high quality, randomized, controlled trial evidence for collaborative care. There is not a lot of randomized control trial evidence for the Pcbh model. That's not to say that it doesn't work. It just hasn't been tested in a randomized control trial.

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01:07:53.690 --> 01:08:09.869

Garrett Moran: So there's an audience question here which interests me as a former State Mental Health Commissioner. What structural systems would a State need to ensure that integrated behavioral health had a seat at the same level that the Department of Health or the Department of Behavioral Health typically have

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01:08:09.910 --> 01:08:24.269

Garrett Moran: most Ibh falls between these types of state departments. But often there's disagreement about where it belongs, and then how to fund it and launch it across the State. Are there models, states that have done this really well.

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01:08:24.740 --> 01:08:25.180

Virna Little: No.

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01:08:25.180 --> 01:08:53.559

Jurgen Unutzer: Start, and Verna probably has a lot more specifics on this. What I would say is the big problem there is. Why do we even have a separate agency for behavioral health. It's health. It should all be health if we have all of medical health, you know, handled by one agency, and then one little slice behavioral health by a completely different group of people with a different culture, with different metrics, with different payment systems. It's never going to come together right? So you know, I would say.

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01:08:53.569 --> 01:08:54.339

Garrett Moran: Silence! Huh!

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01:08:54.340 --> 01:08:58.619

Jurgen Unutzer: Start right. I don't know what your what your thoughts are on this Berna.

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01:08:59.464 --> 01:09:23.199

Virna Little: I'm going to echo that times 10 for sure. And I would say, Yeah, and you know, in our current state where you know we're not gonna sort of have that that vision. I would say. I've seen it be owned successfully. It's just someone has to own it, you know. Like, if you take New York State, the office of Mental Health owns it. They've owned collaborative care for years.

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01:09:23.279 --> 01:09:52.690

Virna Little: They've done a really good job implementing it. I think there's certainly a national model, but I do think it wouldn't have been such a tough road had it come under the Department of Health and and sort of through some of the primary care, you know services and and that piece. But I think it's a question of ownership, and somebody actually owning it, and making sure it gets delivered and and implemented at rates that are sustainable, and with policies that

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01:09:52.770 --> 01:10:12.980

Virna Little: you know, that makes sense. We don't want attestation. We don't want some age limits. We don't want some of those pieces, you know, that that fall in. We don't have to, you know, want to recertify every 3 months, or or some of those State policies that we know just don't support implementation and adoption at a broader level.

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01:10:18.140 --> 01:10:22.984

Anne Roubal: Thank you. Yeah. I think that one's definitely a a big challenge.

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01:10:24.668 --> 01:10:45.691

Anne Roubal: we talked about this a little bit, but I think it's an interesting question here. So they're asking how we would measure success of integrated behavioral health care. So are there specific domains or measurements that would support that, and I know Garrett brought it up a little bit before. But I guess if you guys want to speak to, maybe there's like a short term and a long term measurement of success.

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01:10:46.120 --> 01:10:48.310

Anne Roubal: But curious what your thoughts are on that.

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01:10:48.540 --> 01:10:52.029

Garrett Moran: May maybe at the systems level, not just at the individual patient level.

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01:10:52.030 --> 01:10:55.069

Anne Roubal: Right? Yeah, I think that's like, scarred.

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01:10:57.460 --> 01:11:13.170

Jurgen Unutzer: I would say there's sort of a numerator. Sorry this gets a little geeky. There's a numerator component and a denominator component. So the denominator. Are all the people in your health plan, in your clinic, in your healthcare organization that have.

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01:11:13.630 --> 01:11:18.059

Jurgen Unutzer: you know, an identifiable behavioral health problem. You know, a mental illness.

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01:11:18.470 --> 01:11:44.269

Jurgen Unutzer: a diagnosable substance, use disorder. And you know, the 1st question to me is, what proportion of the people who meet that criteria have been recognized and engaged in something that looks like evidence-based care. So that's at the population level. Then the next question is of those people, and most people couldn't answer that question to be quite honest. But that's important. Think about it. If we could say

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01:11:44.390 --> 01:11:54.730

Jurgen Unutzer: we have no idea how many people in our organization have cancer, we would say, that's horrible. That's totally unacceptable. Right? If we said, we have no idea how many people in our organization have a high blood pressure.

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01:11:54.980 --> 01:12:18.389

Jurgen Unutzer: That's not okay. But we're okay with saying, we really have no idea how many people have, you know, living with a serious addiction problem. So that's the 1st thing. So what's the proportion of people who could benefit from treatment, who've been identified and have gotten engaged in some kind of meaningful treatment? That's where I would start. Then I would say of those people who started in treatment, how many of them get a good enough course

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01:12:18.560 --> 01:12:33.600

Jurgen Unutzer: of treatment that it actually looks like they should benefit from that. So that's not just we touch them once or twice. We are actually giving them a level of care that that should ideally help them. And then the big one for me is, are people getting better?

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01:12:33.680 --> 01:12:49.850

Jurgen Unutzer: And so there are a lot of ways we could do that if if I'm treating an addiction problem, I need to know is the person using, how much are they using and how much is the use interfere with their ability to do what they want to do in their life. Those are all things that can be measured.

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01:12:50.220 --> 01:13:06.479

Jurgen Unutzer: you know, if I'm treating depression, I want to see how severe is the depression. How much does it interfere with their ability to go to work, to go to school? Are they having thoughts of harming themselves. Those are all things that can be measured, and so on.

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01:13:06.590 --> 01:13:30.900

Jurgen Unutzer: just like anything else in healthcare. So I do think there is a kind of population component, and then there is for the person you know who is in care, I want to know is this getting better or not? And sometimes we might have a target. And it turns out it's not quite the right target. That's not the most important thing to the patient. We can reframe that. With them we can say, How do you and I know that if we're going to make this treatment.

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01:13:31.270 --> 01:13:40.809

Jurgen Unutzer: this treatment is really helping you. And the patient might, I might focus on a symptom. The patient might focus on something related to functioning. Those are all things that can be tracked that could be measured.

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01:13:41.520 --> 01:13:43.670

Jurgen Unutzer: So that's that's how I think about that.

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01:13:44.250 --> 01:14:10.429

Virna Little: Yeah, I would think absolutely from a you know, population thoughts. When I think about, you know, a practice or an organization thinking about provider adoption. And so what percentage of the providers are actively engaged with collaborative care, what percentage of their patients are referred and actively getting evidence-based treatment.

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01:14:10.430 --> 01:14:35.369

Virna Little: And you know, sort of what does that look like? What percentage of them? And then what percentage of their patients, or how many people do they have engaged in collaborative care. And oftentimes, when you look across an organization, you see such variation in providers, you don't see variations in the populations that they care for, they're in the same practice. But you see huge variations in the

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01:14:35.370 --> 01:14:55.280

Virna Little: levels to which they refer and engage, you know, with collaborative care and sort of the evidence-based treatment. And I think when I think about success, it's really defining what you want that to look like and and really thinking about adoption and implementation across the organization I think of as like a marker of success.

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01:14:56.470 --> 01:14:57.300

Garrett Moran: Very good.

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01:14:57.590 --> 01:14:59.830

Garrett Moran: There's there's a question on school based here that.

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01:14:59.830 --> 01:15:11.379

Jurgen Unutzer: Just one more quick thought on this. So if you ask most organizations today, do you provide some version of integrated behavioral health care, you get a socially desirable answer, they're going to say, yes.

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01:15:11.810 --> 01:15:18.670

Jurgen Unutzer: But what does that really mean? So what I really want to know is, if I'm the next patient that walks in your door, and I have.

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01:15:19.060 --> 01:15:23.910

Jurgen Unutzer: You know I'm struggling with an addiction. I'm struggling with serious depression. I'm struggling with

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01:15:24.140 --> 01:15:30.300

Jurgen Unutzer: severe anxiety. That keeps me from going to work on a typical day. What's the likelihood

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01:15:30.440 --> 01:15:57.200

Jurgen Unutzer: that that the next patient who walks in the door actually gets a good course of integrated behavioral health care. That's very different from just saying, do you do it? There's a whole bunch of questionnaires out there. If you send them to the leaders in an organization and say, Do you guys have integrated behavioral health care? You will get a bunch of yeses. You get a bunch of socially desirable answers, but that's not the same as if I'm showing up here, and I'm your next patient. Would I actually get it right.

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01:15:58.700 --> 01:16:17.689

Garrett Moran: Yeah. And and there's a question on school-based care that I definitely want to get to. But but directly following on that point, Jurgen, somebody ask says, What is your best estimate of the portion of the nation's 294,000 primary care practices that have a recognizable, evidence-based, integrated care service

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01:16:18.190 --> 01:16:19.070

Garrett Moran: line.

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01:16:20.950 --> 01:16:24.753

Garrett Moran: And and you've already said, you know, they're all gonna say, yes.

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01:16:25.070 --> 01:16:34.500

Jurgen Unutzer: Well, not all. No, I would say. Maybe about a half of them would say, we got something that something is, you know, that's the that's the that's the challenge, you know.

313

01:16:34.840 --> 01:16:57.439

Jurgen Unutzer: And and you know they all don't need to have the same something. If you're a small, you need to have something that works for, who you are, where you are, who your patients are. You need to build, you know, an integrated behavioral health capacity that serves you and your patients right? And that's not going to be the same thing, you know, for 284,000, or 294,000 primary care practices.

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01:16:57.800 --> 01:17:03.740

Jurgen Unutzer: I would say about half of them. You know, I would say 30 years ago 1% of them would have said, we got this.

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01:17:03.870 --> 01:17:20.289

Jurgen Unutzer: you know, because there were even 30 years ago. They were community health clinics that were federally qualified health centers that had figured out. If we don't do some behavioral health here. You know, we're not helping anybody. That's what our patients really need. I think, Verna, you were in one of those organizations early on in your career.

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01:17:20.550 --> 01:17:32.559

Jurgen Unutzer: I think today, maybe I don't know the number. Actually, maybe half of them would say we got something. Question is, what is that? Something right. How good is it? And does it help? You know most of the patients who would walk in the door there.

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01:17:39.560 --> 01:17:42.591

Garrett Moran: Then I'll just go ahead unless Annie's jumping.

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01:17:42.930 --> 01:17:45.379

Anne Roubal: Go ahead and ask your question, Garrett. I don't want to interrupt.

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01:17:45.380 --> 01:17:54.320

Garrett Moran: Well, the other audience question is about integration of these models into school based settings. Then what's your experience and and thoughts around

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01:17:54.700 --> 01:17:56.989

Garrett Moran: how, and and how that works, and.

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01:17:57.300 --> 01:18:10.230

Virna Little: I've done so many implementations of collaborative care in school-based health centers. I ran them and did collaborative care in school-based health centers. I actually think it is fabulous

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01:18:10.230 --> 01:18:33.350

Virna Little: for lots of different reasons, one, of course, bringing in evidence-based treatment, but the ability to do those short interventions and follow up the ability to engage in some of the telephonic, you know, follow ups the ability to teach skills and then reinforce them. The flexibility that you get through the monthly case rate. I think it's actually

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01:18:33.610 --> 01:18:41.559

Virna Little: a perfect model for school based. And I've seen it be so incredibly successful. And when you think of a lot of

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01:18:41.560 --> 01:19:06.549

Virna Little: you know conditions that our adolescents are struggling with, you know, and Dbt being so helpful, and how you can teach a Dbt skill and follow it up, or anxiety. Anxiety is so prevalent, and the ability to teach box breathing or to teach some of those skills and then reinforce it. Tweak it reinforce it. I've just seen it be so incredibly helpful and flexible around their schedules and

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01:19:06.550 --> 01:19:16.400

Virna Little: hours, and the snippets of time that they might have, or that you can engage with them on, so I would be a total, a total fan.

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01:19:16.590 --> 01:19:34.109

Jurgen Unutzer: Yeah, I totally agree with all of that. I would say. You know, the 1st thing I would say is, go where the patient is so. If the patient is in primary care, go do it in primary care. Most kids aren't in primary care. They go to the primary care doctor. They go to see their pediatrician once a year, maybe for a school physical, maybe for a broken wrist, whatever.

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01:19:34.110 --> 01:19:52.779

Jurgen Unutzer: But they're not hanging out in a primary care doctor's office most of the time, so if you can help them in school, where they spend most of their time. So 1st of all, I think that's huge. The second thing I would say is, we got to go in behavioral health upstream. We are waiting way too long. I'm going to go one more time back to my cancer analogy.

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01:19:52.780 --> 01:20:08.310

Jurgen Unutzer: I think that when I was 30 years ago, when I was training in medicine, I was in the South, we were seeing a lot of people come into a regional medical center with very advanced stage cancer. You know, stage 4, colon cancer stage, late stage lung cancer.

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01:20:08.310 --> 01:20:28.380

Jurgen Unutzer: You know, late stage breast cancer. And it was really horrible. And then we basically started saying, You know, that's not going to work. You can't help these people all that much. So people started screening for cancer, people started trying to prevent cancer, people started saying, How do we catch it at stage one? So if you, if you think about what's the mental health, what's the behavioral health equivalent of that? I think

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01:20:28.390 --> 01:20:52.399

Jurgen Unutzer: by the time somebody gets admitted to our inpatient unit in their thirties or forties in a psychotic state, or, you know, in substance, withdrawal. We have missed a lot of opportunities to help somebody, and that person was in school at some point, and I feel like, you know, mental disorders are much more malleable with a young person, so a severe depression in an adolescent

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01:20:52.540 --> 01:21:14.629

Jurgen Unutzer: usually has a reason it started. You can do something, and it might look a lot better. A couple months from now. An older person who's had a stroke. Who's got severe depression. That's going to be a lot more chronic. So we should put all of our effort a lot of our effort up front upstream. You know, most of the people who are living with a mental health or addiction problem. Half of them are diagnosable by the age 14,

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01:21:14.980 --> 01:21:19.160

Jurgen Unutzer: 75% of them are diagnosable by the time they're 24 years old.

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01:21:19.490 --> 01:21:47.890

Jurgen Unutzer: That means we miss a lot of opportunity. If we don't take the chance to say, is there something we can do when we see somebody struggling in school? And I think schools, you know, they're full of teachers. Teachers are not healthcare professionals. They might recognize somebody, but they need help. So I think if you can give a school a really good collaborative care program that's adapted to the setting of the school to the population they treat. It can make a huge difference. And and I think you're right, Verna, when you do that.

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01:21:48.000 --> 01:21:51.750

Jurgen Unutzer: That's probably a great investment.

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01:21:55.560 --> 01:22:13.290

Anne Roubal: Thank you and thank you for asking that question, Garrett, to address other populations. I think I'm going to ask the last question, depending on how long your responses are. So we have a little bit of time to wrap up. But there was a question about another barrier to care so not to go back to end on a bad note.

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01:22:13.540 --> 01:22:24.729

Anne Roubal: They brought up stigma associated with behavioral health conditions. And the question is, how do you successfully navigate that stigma with care. Teams and individuals on those teams.

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01:22:30.310 --> 01:22:32.477

Virna Little: I think, having

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01:22:33.900 --> 01:23:03.359

Virna Little: you know, being all together as part of a team, that. And you know you're actually saying, you know, you're a whole person. We're caring for you. These are all of the the experience you're having on a daily on a daily basis that you're struggling with. Maybe it's your diabetes. Maybe it's your sleep. Maybe it's how anxious you're feeling and that we're going to put them all on a problem list. We're going to come up with a care plan. We're really going to work with you. And I think, having some of those conversations.

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01:23:03.708 --> 01:23:06.499

Virna Little: And I have a lot of conversations with

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01:23:06.700 --> 01:23:29.610

Virna Little: folks about putting behavioral health conditions on the problem list. And I think when we sort of have those discussions, we're actually perpetuating stigma by not actually including them, and having shared conversations and bringing them in with shared care plans. And so I think one of the best things we can do is as

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01:23:29.610 --> 01:23:40.870

Virna Little: we move forward and really develop integrated care models is that we sort of move some of those pieces forward, because I think that is incredibly helpful in sort of decreasing some of that stigma.

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01:23:41.600 --> 01:24:08.870

Jurgen Unutzer: Yeah, just to echo that I think the most important thing we can do is frankly to say it's something that we could start with in primary care. You might need specialty care. But that's the single most important thing we can do to say. You don't need to go to a weird place where only mentally ill and highly stigmatized populations get their care. You could actually get started in a school-based health center or in your primary care clinic. That's already a huge step. And then if the providers in that clinic say.

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01:24:08.960 --> 01:24:31.060

Jurgen Unutzer: Hey, depression, I know about depression. I got a team here that can help me help you with your depression. I feel good about that. That's going to send me a very different message than if the provider says, Oh, wow! Oh, you want mental health care. Well, I'm not so sure I'm so comfortable with that. I don't know if we have access to that. I don't really know much about that. That's a very, very different message. The only other thing I will say about stigma.

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01:24:31.080 --> 01:24:46.990

Jurgen Unutzer: I think one of the most important things I've seen in my career in terms of combating stigma is effective treatment. So I trained in medicine during the time when we had HIV Aids and we didn't have effective treatments. Yet

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01:24:46.990 --> 01:25:09.190

Jurgen Unutzer: it was a horribly scary thing. Everybody was afraid. People were dying. Providers were getting stung with needles. They were afraid of dying, and it was a terribly stigmatized problem, and all of a sudden medicines came along that made it possible to turn HIV into a chronic illness. You might be working in a cubicle next to somebody who's got a family who's living with HIV,

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01:25:09.240 --> 01:25:23.179

Jurgen Unutzer: and I think that all of a sudden I'm not saying there's no stigma attached to HIV, but it's a heck of a lot better than it was a long time ago, so I feel like if we can say we got treatments for this, it can be treated. You can have a good life with this.

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01:25:23.250 --> 01:25:44.449

Jurgen Unutzer: That's probably one of the single most important things we can do, and if we have good, integrated behavioral health in primary care where a doctor can say to you, Hey, that's okay. I got this. I can help you with this. This is easier for me to treat than some other things, and I have a team here that's good at this, and if the 1st thing we try isn't going to help. We got 3 or 4 other things we can try to do for this.

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01:25:44.530 --> 01:25:48.700

Jurgen Unutzer: That's gonna send me a really different message, you know in terms of

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01:25:48.840 --> 01:25:53.999

Jurgen Unutzer: how how much stigma should I be feeling? How much should I be self-conscious about this right.

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01:25:56.450 --> 01:26:17.070

Anne Roubal: Yeah, thank you guys so much. Thank you for turning my negative question into a positive answer at the end. As we end. As we wrap up here. So I want to thank both of you for joining us today and sharing your perspective. This was really fun for me to do this afternoon, and I want to thank Garrett for asking questions with me and managing those audience questions.

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01:26:17.310 --> 01:26:22.530

Anne Roubal: and then I'll just share my screen and and thank you for the audience for sticking with us.

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01:26:23.930 --> 01:26:29.610

Anne Roubal: most of you, most of you have stayed on, and I know it's an hour and a half of your day. So thank you so much for that.

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01:26:31.078 --> 01:26:34.190

Anne Roubal: So finally, here, just quickly.

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01:26:34.300 --> 01:26:45.389

Anne Roubal: we do these webinars, and we have other resources, as we mentioned before. So please feel free to visit our website again. It's integrationacademy.hrq.gov.

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01:26:45.570 --> 01:27:01.050

Anne Roubal: and then you can also sign up for our newsletters. So the same thing. But backslash newsletters, where we share our new resources as we develop them or update them, or other things that might be of interest to people interested in working in integration.

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01:27:01.050 --> 01:27:17.109

Anne Roubal: So thank you all so much for joining us today and apologies. If we didn't get to your questions, we had a lot of good ones in the chat. But this was really a great experience, and I'm so glad we got to have that and answer so many audience questions today. So thank you all.