Innovating Towards the Ideal

Solome Tibebu:

Good morning, everyone. I'm Solome Tibebu founder Of Going Digital: Behavioral Health Tech. Thank you so much for being here. As mental health needs continue to accelerate in the United States, it's critical for us to ensure that innovative treatments and access continue to expand. That's why I'm so excited for our panel today. I'd like to just jump right in. How about, as I ask each of you this first question, if you could just introduce yourself and a little bit about the work you're doing. Why don't we go ahead and start with Tarek first. Why is innovation important in the mental health space in the first place?

Tarek Rabah:

Thank you so much for the invitation and for the first question. My name is Tarek Rabah. I'm the CEO of Otsuka Pharmaceutical North America. We are a pharmaceutical company, obviously, that is based in Tokyo, Japan. Our US headquarters is actually in Rockville and Princeton. We are really very proud because we are one of the very few pharmaceutical companies that still invest heavily in mental health. That's something we think is really, really important.

Specifically on the innovation side, I can think about maybe three reasons that are really important for us to continue to innovate. One is the lack of parity between mental health treatment in general and other chronic physical diseases. I come in from a long history in metabolic diseases, such as diabetes, cardiovascular diseases. I can see that there was there is still a lot for us to do in this field, but we have made a lot of progress. As I come in into mental health, I can see that we have to do much, much more. Most importantly, considering mental health as a chronic disease, rather than an acute, episodic disease, which is more or less the status at this moment.

The second important thing is this growing shortage, if you want, of a specialized psychiatrists and the absolute need for us to prepare the primary care setting, in general, to really be able to handle and treat mental healthcare patients. We know that 50% of patients are coming into primary care settings. I think this is really important for us to enable them to do that. I think technology, we've heard a little bit right now on the importance of telehealth and telemedicine and other important digital connections that can train physicians to actually do that in a primary care setting or healthcare providers, in general, but also increase this engagement with their patients, for them to be able to see their healthcare professionals more frequently. The last important thing is we still have a significant lack of access to proper healthcare treatment and services, especially in under privileged communities, underserved communities, in general. I think what perpetuates all of that is, again, he mental health stigma that we all need to work to make it better.

Solome Tibebu:

Excellent. Adam, how about you?

Adam Myers:

Yes. Thank you so much. Well, I'm Adam Myers. I am the chief clinical transformation officer for Blue Cross Blue Shield. I love it that we're starting with 'why'. It's great to have the opportunity to frame the conversation in that way. I'll take you back just a bit about my personal 'why' for this. Before I went to medical school, I tried a variety of different career pursuits, everything from being a disc jockey to variety of different things. And it was really after I helped open and operate a transitional shelter for homeless men, in one of the poorest areas of Louisiana, that it became very real to me about this crisis.

That was back before I went to medical school. I became clear that the access to, or the lack of equitable access to, healthcare support specifically in many times, mental health support was either a reason for so many men being on the streets or a rate limiting step in them securing some modicum of independence.

That's what actually motivated me to go into medicine. Then I went on and became a family physician. Then as a family physician, I took care of families. One of the children that I took care of was an eight year old boy who, somewhere along the line, began to develop obsessive compulsive disorder and a germ phobia that was pretty intense. There's the washing of the hands, which can be very interfering for people in their lives. However, this young man actually got to the point to where he saw somebody at one point in his home clean out a pot from a plant with dirt in it, in the kitchen sink and from that point on, subsequently, he was unwilling to, and I would say unable to, eat any food that was prepared in that kitchen because he felt like it was unclean. That's the degree of problem that he encountered. He began to lose weight because he was literally starving himself, secondary to concern over consuming something from there.

At the time I was practicing in Oklahoma and I could not find anyone in the state who had capacity to see him on Medicaid rapidly enough in order to take care of him and avert disaster. He didn't quite meet criteria for admission yet, but I was able to call a children's hospital in another state and secure an appointment for him and then secure transportation for him to get there. We were able to avert disaster.

Then a little bit into my personal 'why', and then I'll round it out to 'why' for the Blues. Personally, this is something that's important to me. I have six kids, last night we admitted one of them to an inpatient facility at three o'clock in the morning for psychiatric care. Last night. So it's very real to me. Certainly, access was not the issue for me that it is for many, societally. I get that and I'm grateful for that, but we have a lot of struggle going on right now in the United States. I thought to myself last night and this morning, "Where should I be? There's not much I can do there, present in that situation. So what I can do is come here, participate in this and give voice to some of these things."

I guess the 'why' at the end of the day, ultimately, is what we're doing isn't working. It's not this. This conference, this summit is about change. Part of it is about delineating and seeking to understand all of the opportunities for improvement that exist. I am grateful for the opportunity to do that. The Blues are grateful for the opportunity to be here and be represented. My role, I'm the senior clinician for the Blue system, which is a federated system of 34 independent Blues plans that serve 115 million Americans in the US. That's one in three Americans. We have seen the stories like what I've described with my own personal family, with my own personal practice ... Historically, we have seen those play out over and over again in the lives of those that we serve, as members and in the lives of those even beyond that, as we look at the data. These problems are real and we are excited about the opportunity to be here. That's our 'why' and why change is necessary, why innovation is necessary, simply put because what we're doing right now is not sufficient.

Solome Tibebu:

Excellent. Thanks so much for sharing that, Adam. I can relate. I know that as a teen myself, I struggled with severe OCD and panic attacks. What was there was not meeting the need and brought me into this space as well. Next, Tony, I'll turn it over to you please. Why is innovation needed right now in mental health?

Tony Barrueta:

Thanks. Thank you for that. Thank you for the question. My best wishes to your child.

Adam Myers:

Thank you.

Tony Barrueta:

I hope you everything turns out well. I'm Tony Barrueta. I'm senior VP for government relations for Kaiser Permanente. Kaiser Permanente is an organization I think many of you know. We serve 12.6 million people across eight states in the district of Columbia and that's the full range of care. Frankly, what we have seen over the past several years is a vast expansion in the need for access to mental health services. Trying to provide those services at scale is extraordinarily challenging right now. We put enormous effort into this. We have a history of innovation, as an organization, in many respects. I think we're just at the front of a time at which there will be a lot of change. We're already seeing a lot of change in behavioral health and there's a need for a lot more.

Yeah. I was reading an article last evening on innovation. It was kind of an opinion piece. It made the point that behavioral health is culturally a very conservative field. That was an observation that spoke to me a lot, as somebody who works in a policy space, who's been a patient for mental health services. I've suffered from depression over the years and I've talked to groups about that over time. What it strikes me is that the tradition of psychology and psychiatry is, in many ... I went to a Jesuit university, so I get to study things like this as well. The history of how society understands itself and how humans understand themselves as human beings is deeply, deeply rooted into work that has gone on for over a hundred years. Much of the philosophical thinking that underpins Western society is about psychology. So the conservatism is a good thing, in that those who are in the field are in it for the right reasons and they're very rooted in traditions and the ideas that surround how to improve how we feel about living in the world.

It's probably fair to say that society reveres this as well. At the same time, as a policy person, I have to say that structures and institutions grow up around these traditions that cause them to get locked into place in a way that can often be intractable. I didn't get to watch most of the earlier panel, but the thing that has interested me the most as we're looking at how do we execute on the needs that society has in this space, as institutions who are responsible about that, is a fundamental mismatch between the resources that are available and the needs that exist. A lot of that has to do with politics. A lot of it has to do with policy. A lot of it has to do with regulation and how all of that is in place.

Much of the innovation I think we need to think about involves how can we bring policy innovation that will support the types of clinical innovation that my colleagues here really can talk about, much better than I can. The last thing that I want to do is, as a policy professional, is be standing in the way of optimizing the experience that these folks can bring to people more broadly. A lot of that's going to go to the types of issues around licensure. A lot of it goes to professions transforming themselves into seeing themselves as serving patients, as opposed to the profession. All of this is stuff that kind of pushes buttons. We should just be open and honest about that.

There's been incredible innovation in the digital and technical space. Then in the pandemic, it's been brought to the fore with tele psychiatry and tele psychology. How are we going to integrate that effectively, going forward, in a way that really maximizes the capacity for people to take advantage of it in the best way, and weaves it together in a way that keeps people from falling between the cracks? There's such enormous opportunity in front of us. There's such enormous need in front of us. I don't know how anything, but really thoughtful innovation is going to get us there.

Thanks for inviting us. Looking forward to this conversation.

Solome Tibebu:

Absolutely.

Neil Leibowitz:

Hi, everyone. I'm Neil Leibowitz. I'm the chief medical officer for Beacon, which is Anthem's behavioral health company, which is rebranded as Elevance. I'm still getting used to it, so I'll probably call my company by the wrong name several times. I'm also a psychiatrist, which makes me doubly dangerous. I echo a lot of the sentiments of my colleagues. A couple of thoughts come to mind. Thank you for sharing about your children. I have five children. This is the first time I've ever been on a panel with someone with more children than me, but that wasn't what I wanted to say. Really is. One, I think it's harder to be a young adult now than it was for me. Some of the need I've probably helped create, as a parent, but we've created and we haven't caught up and figured out how to meet that demand.

Innovation and technology becomes one way to do it. Why is that important? How is it important? Previously, before coming to this role, I worked in telehealth and we did asynchronous care. Why is that even relevant? People say, "Ah, that's not even treatment." It was interesting to me, because telling people how to access mental health, telling people what your care looks like ... This is how I trained, come to my office at 9:30. I'm going to do this. I'll give you medication in some cases. You'll come back in a month. Maybe you'll get blood work, therapy, 10 o'clock that's your appointment. The modal number, the most common number of sessions was one. Most people who get mental healthcare go once and never come back. That's not because their problem is solved. I assure you that. There's something going on there that we're not serving the need.

To me, it becomes about expanding choice. Innovation and technology can help us find new modalities of care. It's more important to me that someone come back. Sometimes that means on their terms, comfort of their home. A lot of people will never go into a psychiatrist's office. They're uncomfortable. Just not going in and they want care. How can we deliver it and give people options? Maybe it's not an appointment. Maybe you're texting with a therapist, maybe you're on video. Those things become important.

The second reason to me innovation is very important is how many of you have been inside a psychiatric locked facility here? Okay. About a quarter. For those of you who haven't, it looks like it looked 50 years ago. No other area of medicine looks that way. If you go on a hospital ward and you walk around, you are going to see advanced imaging, you are going to see sensors, trackers, all sorts of things. Yet, if you walk into a psychiatric facility today, it is going to look like when I trained and when my mentors trained, in most cases. We haven't caught up. Behavioral health is behind. The only way we are going to serve people, help them, improve their lives is if we figure out how to catch up and at least move into 20th century, let alone the 21st century.

Solome Tibebu:

Excellent. You each had so many great points and would love to dive into more of that. I know that each of your organizations are very innovative. You're pioneers in advancing access to mental healthcare through innovation. I'd love to dig into what kind of innovative ideas and projects and initiatives that each of you are doing. How about we go down the same way here. Tarek, do you want to start first?

Tarek Rabah:

No, thanks. I was really impressed and thank you for sharing your experience with the passion on the panel. I'm pretty sure many of you, we've all had some experiences and we know how devastating mental healthcare could be. I'm really happy, again, to be here to discuss this.

At Otsuka we are committed to holistic healthcare, in particular, mental healthcare with areas such as schizophrenia, multiple depression disorders and bipolar. We are also expanding into new areas, such as agitation of Alzheimer disease, PTSD. We are also looking at novel mechanisms of action to really figure out what other treatments can we bring and other solutions can we actually bring for patients and physicians. The other important thing that we're working on is, of course, digital and technology. We think this is going to be really critical. We're hearing a lot of examples on this and how important is it to empower, not only in communication, which I think is really important, such as telehealth or telemedicine, but also in terms of digital therapeutics, for example.

I think if we can bring digital therapeutics or digital solutions that are accessible to patients, that are engaging, that will allow them to get access to them more frequently without, obviously, compromising the rigor, scientific and clinical work that we actually do for other therapeutics. I think that is really something important that we want to continue to work on.

The third one is that we recognize that innovation is not restricted to our own company, or to our own labs. It's really important for us to go out there and seek collaboration and partnership with whoever we think can actually help and have these innovative ideas to bring into patients.

The other important thing that I just mentioned is the stigma around mental healthcare. We really believe that one of the main issues that we need to do is to continue to work to reduce this stigma. One of the many initiatives that we have, but something we are really proud about is that we helped launched an online platform, which is Called The Society Of Valued Minds, under the principle that self expression can actually change minds. This platform is meant to bring creators and mental healthcare advocates in order for them to work on increasing mental health awareness and reduce the stigma around mental health.

Adam Myers:

Yeah. I think it's important to distinguish a little bit between, there's a whole continuum of what it is that we're talking to from a mental health, behavioral health perspective. It's not like a light switch where you go from being worried well with some angst to having serious mental illness that requires hospitalization. There's a continuum. It's like a dimmer switch as it might be. I think there are different needs for different places across that continuum. Certainly, the apps and digital transformation that is happening in that space can help a lot of people who are experiencing speed bumps in life, maybe emotional distancing, secondary to social distancing and things like that and struggling in that regard. Not to minimize that, but that's not quite the same thing as necessarily needing a psychiatrist face to face or that type of intervention. That can be quite fruitful.

The digital space that we described, from the standpoint of virtual behavioral health support, I mean what Neil is doing within Beacon, and I'm grateful and proud to say that Beacon is an Anthem, now Elevance company, that is one of the Blues that is part of our organization. There's a innovation that is a perfect example of innovation happening within the Blues. There are others that are taking a real point within this digital space. I think that's critical, but I want to spend a little bit of time hearkening on what you described, which is sort of the societal need for innovation and transformation.

There's a dichotomy where you have physical health on one hand and mental health on the other side, and never the twain shall meet. I don't know about you, but I don't have like a dividing line, a firewall or something along those lines inside my body where there's one side or the other and I can differentiate between those. It's just me. It's who I am. It's who my child is. It's who every one of us, who has ever encountered a struggle, we are one human being. I think we do a disservice as we sort of propagate this dichotomy that exists. I think there's an opportunity.

One of the things that we're embracing with Vigor inside the blues is a collaborative care model that I think breaks down some of that dichotomy. What do I mean by that? If you think about it, and really look at the data primary care physicians and their teams actually provide the majority of the behavioral health support in the United States. Not to minimize psychiatry, not to minimize people that have dedicated their entire career toward behavioral health support at all. However, the majority in the US lives in the primary care space. Last I checked, as a primary care physician, primary care physicians are already carrying major burdens for the health of America. We are, woefully at times, equipped with what we need from a training, expertise and, importantly, support standing in the wings so that we can phone a friend as it were, in order to provide us support and referrals, availability in the event that we get in over our head as a primary care physician, or need to send someone down the line for a higher level of care and escalate things.

The collaborative care model that I'm alluding to is where behavioral health support can be embedded in primary care offices, sometimes face to face, sometimes virtually in the form of behavioral health social workers and counselors who can then escalate quickly to psychiatrists and higher levels of care when the need be. That model, will provide additional access much faster than we can expand the training pool and pipeline for discrete behavioral health providers. It's gotten significant attention. Even in Congress there's legislation on the house side, that's been supportive of this collaborative care model. I think one of the things I like about it, in particular, is it helps break down that dichotomy that exists right now, societally, as you refer to it where there's this fine, bright line between the behavioral and the physical, that I think frankly, propagates some of the stigma that we encounter in the behavioral health space. I'll pause there.

Solome Tibebu:

Excellent.

Tony Barrueta:

Well, I think that's really well stated. I think of it as there's so many different domains in which innovation is possible and places to have the opportunity to expand different points at which people can access services or be in an environment in which there are supports that exist. Certainly, the collaborative care model is an excellent one and critical. Integrated institutions like ours are implementing those as well. In the clinical side of things, I would say one of the things that I've been interested in describing as innovation has been something that ... Innovation can sometimes be not about inventing a new thing, but figuring out how to take things that have existed for a while and implement them at scale so that you can build new capacities. One of those, within Kaiser Permanente, has been the implementation of the feedback informed care model in psychotherapy, which is pretty basic. It's well established, but it essentially is measuring the patient's experience of how well they are doing inside the therapeutic relationship, which has a couple of good things.

It improves the bonding, typically. It lets you know, whether it's not working. I think it lets the therapist also test whether different approaches and models can work. The other thing is, once we are doing this at scale, and as of a couple of years ago, I know we started maintaining within our systems responses of like 50,000 responses a month to start building data that allows us to have a better sense of what is working and what isn't and how to steer activities one direction or the other. That's simply taking what's going on anyway, tweak it a little bit with the feedback model and then you have a data set that allows you to innovate from there. That's something that I think has been very interesting.

In the digital space, I think we've talked a little bit about that and I know we'll talk some more about that. We are rolling out many of the innovations that have been established by others. There's

enormous promise in that. One of the other domains is in the training space. As you know, it's very hard to develop new therapists. We have established a mental health scholars program, which is currently in Northern California. We're going to be expanding into other regions where it's essentially setting up master's programs and doctoral programs for Kaiser Permanente employees who are already in our system and are interested in moving into this field, with heavily subsidized tuition and then access to the further steps in the residency and training programs thereafter. We have about 300 people currently enrolled in these programs, which is a great start, but it's the kind of thing that really, if we're going to make a dent in the vacancies that we have and the need that exists in society, generally those need to be really expanded. I think there's opportunity for that.

Another area that I think we can point innovation to, to help solve is the problem in mental health services of disparities of access and disparities in the workforce itself. Equity is a huge problem in healthcare, generally. It's probably a much greater problem in the behavioral health space. A large portion of that, as may have been said in the earlier panel, is the fact that the workforce, in general, does not reflect the populations who we're seeking to serve. In order to do that, you've got to draw people out of those communities, into the field so that they can be available to serve in that field. What we are seeing with the Mental Health Services Academy is almost 75% of the folks who are interested in enrolling in that program are people of color. That is very promising to do this.

One of the biggest problems that exists in the field and this flips over to, I think, what I would call policy innovation, again, are training requirements. Training requirements are so onerous in the field of becoming a therapist in most states, that in many states you are required to essentially serve for periods of time with very low pay or almost no pay. Your hours are often not even recognized until you're into a program, until you're into the licensure space. That could be rationalized. Having it the way it is it makes it almost impossible for people from more disadvantaged communities to be able to come into this field. It's going to be overloaded with people who happen to have the good fortune of resources in their families to be able to spend time. We've got to find new and different ways to reach into those communities, to make requirements more rational so that for people with real economics, they can actually see this as a profession and a field that is available for them.

I could go on, on a bunch of things on that, but I'll stop there and we'll probably come around to some more.

Neil Leibowitz:

I'll talk about two things that we haven't spoken about yet. How do you know your therapist is any good? You're laughing. We have no idea. How do I know your therapist is good? We pay for care, whatever number of people. How do I know? That's a scarier question. I don't really know. That's an area where we need to do a lot more work. We provide an enormous amount of care. Yes, we have a shortage, but we still want the people delivering the care to be good, at least competent, hopefully excellent. We have no idea if anyone is any good. You as a consumer of healthcare, how do you find a therapist? Google, website, friend, primary care doctor, random occurrence. There's no way to evaluate.

You're ultimately judging, if you walk into an office, is the office clean? Does the person see you on time? Are they pleasant? None of those three things actually show that anyone is competent. It shows that they run a decent practice. Now, I'm being a little bit glib because if the office is a mess, that's not a good sign and I wouldn't go there even if you told me they were competent. We would never choose a heart surgeon this way. Hopefully no one here would choose a heart surgeon that way. Even if the person is not even that kind, I want someone who's not going to screw up. They can be the nicest person. I want to look at their mortality. I want to look at their complication rate. Those are the

two most important things to me. I'd like them to be a kind person, but I'm willing to let the third one go, if they check the first two, if I have a choice between two people.

We're remarkably nascent in actually understanding this. Big data allows us to start to do that. We're starting to get very in depth into understanding how the network works. Who's good. Ultimately, payment is an ugly word that we don't want to go too far into. My goal, and our goal is if we understand this, those people we want to drive patients or members or people to, and they should be paid more, frankly. We want the harder people to go to them. People make micro decisions all the time. I have a private practice. Who would I take? Am I going to take someone who is very difficult or someone who's a little bit anxious? I get paid exactly the same for both patients. That's a problem, actually. There's no acuity. There's not a lot of incentive for me to take someone, I cover my own call, who's going to call me at three in the morning in crisis, Saturday night. I want to have a life. We have figured out no way to incentivize that.

Understanding who's good dovetails into payment reform and a different way of looking at it. No other area of medicine actually pays the way we do. If you go to a dermatologist, for a burn, they're going to use a different code than a pimple. Behavioral health, it's the same exact code for someone who's hearing voices and in crisis, as someone who has mild anxiety. They should all receive good care. We want to incentivize the best people to take the most complicated people. We haven't done that. That's one. We're working on that.

The second thing I'm going to highlight is what I would call specialty. I caught one of the earlier panels about 988. It got me thinking about suicide and this increasing problem in society. That should be a specialty. I have some training, I can treat someone with some level of suicidality, but someone who has severe suicidality, are we equipped for that level of specialty? Have we specialized the field enough? Have we created training? It's not watching two webinars. Have we really trained people, interventional psychiatry. If I'm a person who is going to do something that requires a device, there's no specialized path, there's no fellowship. I take a course, maybe it's online, maybe I have a rep, but I haven't really received that training. Focusing on the most complicated people, can we develop specialty tracks?

This is one where it's better to borrow than to create. There are companies that have come up that focus on singular problems. Telehealth and technology allow us to reach more people. If you're someone who needs a specialist for pregnant women, you can get that. I'm a New York state resident, it may not be in your town by the Canadian border, but you now have access to a whole network of people through telehealth. But more importantly, can we provide you with a group that maybe this is all they do, and they're excellent at it. Focusing on behavioral health, as a more specialized field, and focusing on the different treatments and issues people have as a way to provide excellent care is another area we're very focused on.

Solome Tibebu:

Excellent. Thank each of you for these great contributions. Tony, you brought up something that I think is critically important. I know we only have less than 10 minutes left, but I would love to ask you each about this, is this idea that it does seem that our industry is talking more about health equity, but there are still deep disparities when it comes to mental health access. Would love to hear maybe two minutes each, what are you doing, what are you thinking about when it comes to health equity?

Tarek Rabah:

Yes. First of all, I think it takes a village. I don't think any entity, again, will be able to do this absolutely alone. I think for a company like Otsuka, it really starts within our walls. We need to make sure that, again, our team is actually passionate about this, our team reflects these values and is really working

towards make sure anything that comes out of our labs, anything comes out of our commercialization activities and other activities reflects this importance of diversity and making sure that we have a wider access and wider equity.

The second important thing, since we're talking about research and development, is to make sure that the patients we are working with also reflect the society and the communities we are living in. That's something we're really, very passionate about. We are trying, of course, with our own efforts, but also working with companies such as [inaudible 00:38:48] , for example, which helps us for online and decentralized patient recruitments to have a wider access for patients, in addition to training and educating patients and underserved communities to be able to participate in these trials and be able to recruit patients from these communities.

I think it's really, really important for us to adapt our education, our communication in order for us to reflect this more diverse, multiracial, multiethnic aspects of communication. Not make it only one way. Again, I go back a little bit to the idea that we cannot do it alone. We really need to work with everyone that has a stake in mental healthcare, whether it is from insurance payer side or whether it is from policy side. We should have a very, very open approach to this.

Adam Myers:

Yeah. At the Blues, we have a pretty comprehensive health equity strategy. We've actually spoken about it a little bit before, specifically in relation to maternal health, as I think our conversation before and mental health. But our program has several different pillars within it. One has to do with data and measurement, understanding how do we get the discrete REL data and SOGI data on those that we serve, so that we can better understand the populations that we serve. Understanding and trying to acquire the same level of data on the providers within our own networks helps to sort of navigate that match between providers and patients who work better synergistically when they're more alike. Imputed data is great from a population understanding standpoint, but it doesn't really help you navigate an individual's life. That's what we're about, in the end, is trying to help individuals get stronger and better. So data.

How do you measure the outcomes? We talked a little bit, just moments ago, about how do you really measure the outcomes. Behavioral health's a perfect example of that. There aren't a lot of standardized, quality measures for behavioral health. We are in collaborative conversations with National Quality Forum, NCQA and others, as well as HHS, about how to measure these things effectively, so that we can all be rowing in the same direction toward the same outcomes. Quality, as I said, is important. How do you, not just measure it, but how do you incentivize for it? How do you pay well for quality? We're beginning to embed equity measures into all of our different payment approaches and into our center of excellence, our Blue distinction programs, our high performing networks. We're looking to embed those and encouraging others to do that same.

We've had very strong conversations with HHS and CMS over the last year. Certainly we're only one party having those conversations with them, but you're seeing now that they're beginning to embed equity components into their different payment modalities as well. I think it's what you're hearing is that partnership is essential. In this space, in the space of equity and the space of behavioral health, I really like to view. I think we all view each other more as collaborators toward a better future, than competitors. I'm excited about what that can look like. What I try to say is that we alone can do our part, but we can't do it all. That's why partnership is essential.

Tony Barrueta:

A little bit different approach on this. One of the best ways that you can attack problems around equity, particularly in providing services that are necessary to diverse population, is to focus on the schools. There's a tremendous opportunity to apply mental health and behavioral health resources through the schools. In California, the governor has included several billion dollars in the budget to fund activities that would increase access to mental health services.

One of the things that we, at Kaiser, have done in partnership with the Alliance for a Healthier Generation is establish what's called The RISE Program, it's Resilience In School Environments. What that really is designed to do, is to provide tools for teachers and staff inside the schools, to be better equipped, to deal with the behavioral health challenges that they face inside the schools. One of the things that we've always heard has been, while there are some counselors in schools, what don't exist at the kind of scale, and part of this is a payment problem, is can you get mental health resources inside schools that can provide global support for the teachers teaching them skills and all of this. We're rolling this program out. Targeting 25,000 schools is the goal, by 2023. There's currently about 3,100 schools touching 1.5 million students and 155,000 staff, at this point. It's still in the early phases, but there are pathways to bring more of these resources, much closer to the people who have not had access to them in the past.

Neil Leibowitz:

I love that. I'm going to focus for one second on codes. Wouldn't it be great. I'd love to prescribe breakfast and bill for it. Seriously. I have someone who comes in, they have no food security and I go prescribe them medication, I am not solving their problem. It goes back to payment. We should pay for breakfast. I should be able to write a prescription for breakfast. I think, actually it's not even that controversial, I don't think anyone here disagrees with that notion that we should take some of the money that we spend on healthcare ... We're not necessarily going to replace the social service framework, but we should be able to prescribe the things that someone actually needs to be well. We see a little bit of it. We see it in Medicare a little bit with food, but it's not at scale. There is no scale there. A community clinic should be able to give people food and get reimbursed as a medical expense. To me, that's how we begin to solve some of the disparity in healthcare.

Solome Tibebu:

Excellent. Thank you all for your fantastic responses. Really proud to hear about this great work. Obviously, we've got a lot of work to do, but exciting to hear these promising strides. I think now we're the only thing standing between lunch. We'll go ahead and take a lunch break. Thank you, everyone.