Transcript / The Mental and Behavioral Health Challenge with Kyle Lavin

[00:00:00] **Melody King:** Welcome to TCN Talks. The goal of our podcast is to provide concise and relevant information for busy Hospice and Palliative Care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now, here's our host, Chris Comeaux.

[00:00:24] **Chris Comeaux:** Hello and welcome to TCN Talks. I'm excited.

Our guest today is Kyle Lavin. Kyle's a doctor and MPH assistant professor of psychiatry at UNC Chapel Hill, and he's the chief clinical officer of Cerula Care. Welcome, Kyle. So good to have you.

[00:00:39] **Kyle Lavin:** Excited to be here.

[00:00:41] **Chris Comeaux:** So Kyle, first off, what do you want our audience to know about you?

[00:00:44] **Kyle Lavin:** Yeah, uh, happy to share a little bit of my, my story, both on a, on a personal side and also on a professional side.

I think like A lot of us in Palliative Care have gotten into this work through some tough, uh, personal experiences [00:01:00] that have led me to be in here. And, um, so on the personal side, um, unfortunately, I had a mom who had really bad scoliosis, um, had a family history of alcohol use disorder, and, um, unfortunately, had back surgery in hindsight, probably developed.

Severe opioid use disorder. And so my teenage years, uh, was struggle with, with that. And I was, uh, what I told this joke, it's not really a joke on Wednesday when we were chatting, uh, that, you know, I was a pretty good kid. I didn't rebel much, but my dad was a psychiatrist and I always said I was never going to be a psychiatrist.

Um, other thing I was going to do is that I was always going to cheer for the Tar Heels, even though I did all this training like Duke, so I'm still a Tar Heel, but obviously, uh, I didn't hold the other rebellion because I ended up going into

psychiatry and, uh, The reason for that is that I was a business major in undergrad, trying to fight that, uh, following in my dad's footsteps.

And then, uh, my mom ended up getting seriously ill and passing away between my junior and senior year. And so, you know, the, the vulnerabilities [00:02:00] that come with that and being the oldest son making decisions, my dad very supportive, but we separated, I just still clearly remember it. And clinician who Embodied with the Palliative Care principles of being there, holding the space, allowing me to grieve, not making it about the decision, but making it about the process.

And then other experiences that felt much more traumatic in nature all really all sort of made it a real tough experience. And so I hesitate to describe that as a crossroads, right? But that's where I decided I wanted to have that opportunity to help people that were going through that experience that that I went through.

And so. Went back to medical school, uh, did my psychiatry residency, had the opportunity to do my master's in public health on the timing of end of life discussions for terminal cancer patients. Uh, got my friend and mentor, Don Rosenstein, who introduced me to the world of Palliative Care via psychiatry.

So, did my psychiatry training at Vanderbilt on sort of reflecting on my business background [00:03:00] and my own personal experiences. So, I'm looking at the landscape at Vanderbilt. Well, this is a problem. The mental health system is broken across the country, but a special serious illness where we know that the prevalence of these disorders gets much higher access is even more difficult as patients experience service fatigue.

And so I started thinking about how to address it from on population health level. So we got really excited about the cloud and care model ways to integrate behavioral health in serious illness care. I was lucky enough to go out to the University of Washington for my. I did care fellowship and pick the brains of the people that founded the collaborative care model app.

They will get a little bit of research on the impact of behavioral health diagnoses on acute care utilization at the end of life. Started thinking about how to apply it into the collaborative care model into the serious illness population came back to you and see, well, almost over 8 years ago. I'm feeling feeling old.

I've got some more gray hair and 3 girls. Now, um, you know, I've been thinking about [00:04:00] ways to implement this. And within the health system, it's been challenging because there are not very high margins building

supportive care programs internally becomes really challenging. And so I had the idea to try and bring these collaborative care services.

Uh, in a cost neutral to a slightly revenue generated way for, uh, seriously ill patients and started oncology and things are going really well. So I'll, uh, that's that's a lot of talking for me. So I'll.

[00:04:26] **Chris Comeaux:** One thing that just occurred to me, and maybe I missed it, and Kyle just alluded to the fact that the week that he and I were taping this, we had the amazing privilege of bringing him to our whole teleass, we call it our visioneering meeting where we have a lot of the CEOs and the senior leaders and a lot of our TCN members.

And I missed that one little quip about the Palliative Care person. In your mom's care. And just what hits me, Kyle, is I'm all about cause and purpose. And that one person impacting you in such a way that you kind of foreswore off was, [00:05:00] where was that? Was that in North Carolina where you experienced the, the public care provider that in some respects, right.

Affected the trajectory of your life.

[00:05:08] **Kyle Lavin:** Oh, a hundred percent, uh, affected the trajectory of my life. And, you know, I didn't even know about Palliative Care at that time. And so I'm not sure if they were a. Palliative Care provider. Yeah, it was here in North Carolina. It was at our regional hospital. I think it was just an intensivist who had the Palliative Care skills, but not actually sure that they had the official training.

But again, just like by being that human, by being embodying those skills and those communication principles. Um, well, yeah, it did it's again. It seems cliche, right? But it did it changed the trajectory of my life My entire life shifted in one time.

[00:05:43] **Chris Comeaux:** I don't think it's cliche at all And just we've actually had a couple circumstances on this podcast.

We're kind of catching on that moment Um, we actually had an amazing guest a lady named Judi Lund Person, And I just in a in a whim asked her that question and I had this incredible moment like she told this [00:06:00] story And she's well known in the Hospice space. And I had this moment where I'm sitting there because I've spent a lot of my career in North Carolina.

And she was telling the story. I realized her trajectory actually created the pathway for the program. I became a part of, and did not realize that till end of the podcast. So kind of that whole cause and purpose thing and how the path kind of finds you, uh, very providentially serendipity. It just, we bump into that all the time.

So

[00:06:25] **Kyle Lavin:** again, not to disclose too much personal information, but I'm not a super religious person, but it did feel like it was this, like, Higher power of things leading me to a certain place. And, uh, it's pretty special when, uh, cause and purpose all up and be all pieces of the answers that lead you to the pillow switch.

It's like you're supposed to be.

[00:06:43] **Chris Comeaux:** Yeah, absolutely. Well, let, well, let's get into the topic, which is, you know, behavioral health, mental health. And I'm so thankful that we found each other. It was probably about two years ago, two CEOs who I immensely respect kind of looked at me in a very, it felt, um, [00:07:00] weighty way, thoughtful way, weighty way.

And said the mental health challenge is huge. And of course, the work we're doing, we're in the weeds with a lot of Hospice and healthcare programs. I was seeing more suicide contracts I've ever seen before with patients, just seeing the challenges as team members are in IDGs. And, you know, everything in life is kind of a spillover.

And when you get that spillover into end of life care, Of the challenges of mental and behavioral health throughout our country. It just really hit my radar screen and I start reaching out. I've probably talked to five or six people and should make you smile that like, I really camped out on you cow, because the work that you're doing.

And, um, I really was looking for a personal, so they helped me understand the, the general point of view. Landscape the ecosystem. And so you're not going to get into all that. So let's, first off, just talk, Kyle, you did a great presentation about the challenges in this space, mental health, behavioral health challenges that we're facing in our country.

Can you share that perspective that you share with our network? [00:08:00]

[00:08:00] **Kyle Lavin:** Definitely. Yeah. I mean, I think the list of challenges is so long that it's, uh, it's hard to. To name them all out. But, um, you know, I think that the hardest thing is, is how siloed our current mental health care system is and how difficult it is for people with mental illness or a mental health diagnosis to access those services.

And we have created a system where the onus is on the patient when they're experiencing depression, anxiety, feeling paralyzed by. Whatever is going on in that personal experience for them to be the ones to proactively go out and access. And so, you know, the standard of care right now is that you have someone who is seeing an oncologist, the oncologist notices that they have depression.

They make a referral to the community to say, you should go access a psychiatrist or a mental health provider. And the patient says, well, I have no idea. I don't know. Check the back of your insurance card. See what who's in network column. See if they're [00:09:00] available. They call the practice. They call the insurance company.

They wait on hold for an hour or two. They figure out who's in network. They call the practice. The practice is full. It's a 6 month wait list. Um, so, you know, I think the fact that, uh, access to care is so challenging when we put it. The owners on the patients in this vulnerable time is a huge challenge. I think the other thing is that, um, you know, there's such a lack of providers and that we have some mental health providers, right?

But we know that even in primary care, even when people who have resources, uh, that it's difficult for them to access it. But, um, you know, things, I think that even a lot of psychiatrists are really not comfortable with. Serious illness with complex medical care. And so they get really worried about taking care of those patients.

And that that leads into the conversation about how do we integrate behavioral health into serious illness? And how do we make those decisions about when to sort of [00:10:00] prioritize mental health and safety versus quality of life and end of life? And we'll have a whole conversation about the ethics and the risks and benefits of that.

Of those, uh, sort of, sort of analyses towards as people get more seriously ill.

[00:10:14] **Chris Comeaux:** So, a couple of follow up questions that occur to me, just thinking about our listeners, you covered this beautifully in your

presentation that we had that we just alluded to, but what are the different types of providers, the different disciplines that are kind of involved in the delivery of behavioral health?

[00:10:29] **Kyle Lavin:** Yeah. So, uh, you know, my background in training, right, you've got a psychiatrist who are focused on the medical diagnosis, focus on the prescribing, so it can be strong to do. Uh, some of the psychotherapy as well. And then we've got, uh, psychologists who, uh, go through and have a long sense of training that are really focused on therapy.

And then you've got all sorts of different licensed medical providers within the social work domain. You've got, um, marriage counselors, marriage therapists. And so we've [00:11:00] got all of these individual, uh, permissions. That are trained in, in various ways that all belong skills and that there's just not enough of them to be able to, to get access to take care of the people need,

[00:11:12] **Chris Comeaux:** you know, I didn't tell I was going to ask you this, but I recently just really befriended this amazing woman who has an incredible program for autism and it starts at the very young age.

And goes up and I'm forgetting the discipline there. Is it behavioral therapists? Does that sound right? And that, that's a whole nother competency that I didn't know was out there. And it was just as fascinating to me of how they almost go down to building blocks that many of us take for granted. But if that's not diagnosed early on, how it eventually might be misdiagnosed as some mental health challenges, et cetera.

Does that, is it a behavioral therapist? Am I saying that right?

[00:11:49] **Kyle Lavin:** Yep. Yeah. I mean, there certainly are behavioral therapists. And again, right? Like we think about the licensed clinicians and that's one form of providers. But what I love about that collaborative [00:12:00] care model is that it takes non licensed providers.

Right? And so, you've got people who are trained in, uh, they have a bachelor's in science and some sort of health-related quality or health related field, and they become the person that's primarily interacting with the patient. So. Yep. It expands the field of people that we can hire from immensely to be able to provide those services.

And they were also using health coaches in our model, which is one of the fastest growing fields in health care, where there is a year-long certification

process. But the health coaches are really trained in meeting people where they are. Understanding what motivates them, what the barriers are, helping them set what we call smart goals, which are specific, measurable, achievable, relevant time bound goals to have them navigate and overcome the health care system.

And so I think we have to be really creative about not being set in our ways about the traditional way that we refer people to [00:13:00] clinicians. They see a one off and in these solid settings that. We need to build teams of people that allow everyone to work to the highest of their ability. And so we've got, we don't need everyone to have 10 years of training.

We need to have community support systems of people who are passionate and interested in trying to solve these problems, be able to hire them, train them to do the therapeutic interventions that they can do, and then create sort of a pyramid of supervising and other specialists who can give those recommendations.

patients and to the teams that are caring for patients.

[00:13:34] **Chris Comeaux:** And that's brilliant on so many different levels. I mean, first off, you know, we've used the term quite frequently in our podcast, the silver tsunami, which is the aging of America, which is going to crash on shore. And we're already short of the typical disciplines that you see in Hospice.

So, to hear you talk about that, the innovativeness and that approach, um, that's, that's really amazing. Cause that really does open up the pool of people, right. And, um, yeah. One thing that I wanted to go back on in [00:14:00] just a second, when I started off with the challenges of mental health right now, there's challenges have always been there, but it feels like the volume of mental health issues.

Do you think that COVID just, did it just expose what was brewing under the surface?

[00:14:14] **Kyle Lavin:** Yeah, I mean, it is really scary to reflect on while increasing all mental health challenges that we're facing as a society. I think that the COVID exacerbated things and again, sort of reflecting on my own. Personal life of having all 3 daughters that are ages down 6 and 4 and, and the child adolescent, uh, sort of epidemic of, of stress and anxiety and the way that social media and technology has exacerbated all of that.

Uh, no, I think that, um, you know, there are just so many pressures in so many ways that people are struggling along and the pandemic only sort of put that on fire and that's hard. But the good thing about that is that people are starting to wrecking walls a little bit more that. This is really [00:15:00] necessary.

We have to address this. Otherwise, it's, it's, you know, you're going to hold its back.

[00:15:04] **Chris Comeaux:** Perfect. So, um, you kind of alluded to this with the providers, but I originally asked you, um, Kyle, I'm going to use this term, the mental health care system and kind of wink, wink, and maybe it's not, I shouldn't laugh cause it's not funny at all.

It's more of a. A patch, a patch quilt, whatever word you want to use. It's not, it's not much of a system, but can you, and I love you use the slide. It's called the ecosystem. And if you think it makes sense, we may actually use that in the show notes. Um, but can you just describe the ecosystem, the mental health system, the various flavors of entities out there trying to stand in the gap of this hugely challenging work?

[00:15:41] **Kyle Lavin:** Yeah. Um, You know, I think that it's hard to describe because it is so patchwork. But again, you've got the individual clinicians who are working in private practice, who have their standalone clinics and programs that patients can access. And then [00:16:00] you've got the inpatient psychiatric facilities that oftentimes are embedded within health systems.

But, um, you know, I think that the way that the majority of people access mental health care in our country is through. Unfortunately, the emergency rings and through primary care, um, those clinicians aren't trained in order to handle mental health crises. And so what I think happens is that we, we don't address things preventatively, and we can't offset us when people, when people are struggling and all what we would call an adjusting disorder, or they're just feeling overwhelmed.

That's when we need to allow people to have. Access to the services that prevent them from getting more sick. And what we do is we've created a crisis response system, which is better than nothing, but people become acutely suicidal. They sent to the emergency room. They end up boarding there for a week or 2 at a time.

We make sure we're safe. Maybe they get a better inpatient psychiatric facility, [00:17:00] and then they're at the inpatient psychiatric facility for a couple of

weeks, and we do our best to try and care for them. There's so many patients that it's not what I would call the most therapeutic environment. So then they're discharged from those inpatient facilities, and they end up sort of circulating back and forth through the process.

And, um, you know, that that's not the way that I envision, uh, holistically addressing baby, uh, for poor people. And so. Um, you know, there's other sort of digital health companies that are all standing up in terms of trying to be able to improve access. And I think there's a lot of power to that. I think there's the employee assistant programs where employers are starting to recognize how much mental health can, you know, again, I would love it if everyone was motivated because it'd be the right thing to do and people feel better, but they're recognizing that when people do have behavioral health diagnoses, that they're much less likely Productive, they're much less likely to show up to work if they want them to be able to generate as much money.

And so I think employers are starting to [00:18:00] integrate behavioral health programs to try and get a little bit more in front of it, not just be that crisis response.

[00:18:06] **Chris Comeaux:** Yeah, that's that's very well said. Um, I think I was thinking I'll go here at the end, but I think I need to go here right now. There's there's it's really hitting me listening to earlier this week and now that you and I are doing this podcast You know, there's generally been this stigma Um around mental health, you know the greatest generation Um, it's funny one of our uh, one of the CEOs in the group We were talking in a breakout group after your presentation And she used her maiden's name.

I'll make it up. My last name is Comeaux. The Comeaux way is basically pull yourself up by your bootstraps and we don't talk about emotions. It does feel like the times are a changing and yes, there's been this stigma about mental health and which really gets me excited about this work that you're doing. Um, certainly in Hospice, it was embedded in our model from the get go on the bereavement and grief side.

And of course, having social workers. [00:19:00] But, you know, it's still limited in the level of expertise and competency. We were kind of advanced at the Hospice where I grew up. We actually had a psychiatrist on contract,

um, made amazing chief medical officer who was just brilliant. Um, I remember the time going, huh, why are we doing that?

But she was just all about patient and family needs. And so she was probably one of those early pioneers. Uh, seeing the need for that. So, can you just talk about the stigma a little bit? Do you think the times are a change in which makes your like you're arriving at the perfect place at the perfect time?

[00:19:33] **Kyle Lavin:** Yeah, you know, I, I do think that they're, they're slowly changing, uh, you know, what's interesting to me. And I, I loved how, uh, when we were talking on Wednesday, we, we sort of compared it to the, the Palliative Care experience. And there was the whole conversation about how are you introducing this to patients?

Are you mentioning that this is. Psychiatry, or this is behavioral health. That makes me think of all, you know, in Palliative Care, right? Do we call our services [00:20:00] all supportive care services, or we'll actually use the word Palliative Care and our patients going to respond to that? And, um, you know, I think in Palliative Care, we've, um.

Uh, a long ways. I think we've moved a lot faster than they have in, in, in behavioral health. And, you know, piety care has only been around for 20 years. Mental illness and psychiatry has been around for, I don't know the number, but 100 years or so. And that, um, it's taken so long for people to recognize the need.

And again, I think part of it is the American culture, right? Pull, pull yourself up by your bootstraps. The more you talk about it, it shows vulnerability, it shows weakness. Yes. Um, and I do think that, uh, hopefully we're getting to a point where people are more open to talking about those films, more open to accessing those services.

And then we can maybe bring the patchwork quotes and system to a little bit more of a cohesive, uh, integrated system.

[00:20:55] **Chris Comeaux:** Yeah, I truly do. I mean, I really have come out of this week more [00:21:00] hopeful, not that it's going to be next week, but and the analogy you just drew, uh, that we bumped into our time together of because I can remember sitting around the table in 2002 and going.

We're going to do Palliative Care. What is that? And just seeing how far the field has come and how we've struggled with what is the right lexicon, the right words. And just for our listeners, one example, when we're having this discussion with Kyle prior to the show. Is one of our members who's doing a really interesting program with LCSWs, um, partnered with their Palliative Care

program and they're doing some billing and the patient got an EOB, which is explanation of benefits.

And on there, um, Kyle, you probably have the, I think it said, uh, was it a psychiatric eval? Was that what the word was?

[00:21:45] **Kyle Lavin:** Yeah, exactly.

[00:21:46] **Chris Comeaux:** And then older generation gentlemen just basically freaked out. Are you saying I'm crazy? And, and he saw it on the bill. So therein lies what we're poking on here about the stigma and navigating that.

And what's the, what is the [00:22:00] right words? And even if we figure out the right words on talking to them, Then the EOB comes to their home and, and torpedoes this hard work that we've done of using the right words with them. So there's all problems to be solved as we go forward.

[00:22:11] **Kyle Lavin:** And we've had that, that same experience in Cerula Care where we have, uh, you know, we're early on, we've all served just over a hundred members so far, but we had one member who was greatly benefiting from the service.

And we're improving significantly, but then we diagnosed them with an adjustment disorder and when they saw in their chart that they had been diagnosed with an adjustment disorder, their whole reaction was, I'm not crazy. How do you think? Why do you think I'm crazy? Or I have a diagnosis and it's like, you're benefiting from this and the fact that we've been labeled with a diagnosis is going to prevent you from accessing it.

The care that is making me feel better. Um, you know, so yeah, so we're making progress, but it's still there.

[00:22:55] **Chris Comeaux:** Maybe you and I could go fight the EOB because I'm sitting here thinking, I think I mentioned to you one of the [00:23:00] first times I was mentored by Stephen Covey's mentor, gentlemen, and Dr. Lee Thayer.

And when you do put those labels, right, there is something about that. And you could think maybe, could they not just blind that part of the EOB? Because it, it, that was, that's probably going to be a problem that is going to continue to haunt. So just simply just blind those codes. Why does the patient need to know the code?

They can see the dollar amounts or something. That might be a simple solution. Just blind that part.

[00:23:24] **Kyle Lavin:** Totally. Or what you, uh, you brought up on Wednesday, right? The, the term, what we're suffering allergies, sir. You mean, so it's, uh, you know, I think that's worth talking about. You can share your perspective on that, but what in my mind, right?

Like, why do we need to label it? Why can't, why do we, why do they need to see anything? But why can't it just be like, patient needs help. Patient wants this support. Patient benefiting from this role. Like we don't need to label it. I'll notice it. I'll perpetuate the stigma, but we're not there.

[00:23:48] **Chris Comeaux:** Yeah. What Kyle's alluding to is that we had a presentation from another brilliant physician a couple of weeks ago, and he used a term that just like, for all of us, it was like a brain tattoo.

And it was this whole conversation [00:24:00] was, what do you call a Palliative Care person. And then like We're sufferologists because we're here to relieve suffering. And I'm like, Oh my God, that is brilliant. And there's so many different forms of suffering. The work that you're doing, Kyle, is one form of that, what our Palliative Care team is doing.

And of course, if we transition them in Hospice. And so it really is to relieve suffering. So yeah, I love that. So, um, so let's get to innovations, which is going to be a great opportunity for you to talk about what you're doing, but what innovations are you seeing in this space?

[00:24:28] **Kyle Lavin:** Yeah. Um, you know, I think that, uh, the main innovations are coming along with, uh, technology and telehealth and being able to expand access to care.

Um, you know, one of the things that we're leaning into, I guess I'll start with, with what we're doing it, it's similar care and that, um, whether we call it innovative or, or not, I think there's a certain beauty and simplicity, but taking this evidence based model, the collaborative care model that we know as over 90 [00:25:00] randomized controlled trials that have shown that people get better up to 4 times faster.

The return on investment is much better and more from the population health level that we can. Decrease costs and provide care on a much less expensive way. It allows increased access to, um, the late limiting resource of the

psychiatrist in terms of. At the number of psychiatrists that are well, I'm 1 of fewer than 100 out of care.

Psychiatrists in the country. Also, when you think about the psychiatrists that are all trained in either. Out of care or psycho oncology, there's so few of us, right? And so what the collaborative care model does so beautifully is that it. Leverages the access to those resources, because rather than directly seeing the patients, they're supervising this interdisciplinary team run by care managers.

And in our case, I think, well, allows them rather than seeing, well, 200, 250 patients directly in that panel, they can see up [00:26:00] to 2000 And so thinking about different ways to use. Telehealth technology, integrated care to use collaboration, uh, so that it's easier to, uh, access, uh, I think is really important.

[00:26:16] **Chris Comeaux:** That's great, Kyle. So tell me about innovations that are going on in this whole space of behavioral health and maybe opportunity to talk about what you're doing.

[00:26:23] **Kyle Lavin:** Totally. Um, no, I think that there, there are a lot of neat things that are, that are happening in terms of innovations. Um, we'll start with what I'm doing.

I'll think that there's a certain. Sort of beauty in the simplicity of, of using the collaborative care model. And again, when we think about access to care, the licensed professionals, I can get as many people to be able to have access to these services as possible. You know, the collaborative care model is wonderful because you're able to have these unlicensed professionals who are able to, um, see the patients, be the direct one.

Think about, uh, uh, specially trained [00:27:00] psychiatrists that like myself, I'm. What have less than a hundred Palliative Care psychiatrists? There's so few psycho oncologists and there's so many people that need help. And so if you're able to take a typical psychiatrist who sees 200, 250 patients and increase the access and RPNC 2000 to 3000 patients, then I think that makes a huge difference.

And then, you know, one of the things that I think is really scary to us, and I'd love to hear your thought, but I think is a huge opportunity is the use of artificial intelligence, huge. Buzzword on, but I think that we need to be really thoughtful about how we use the, if we've got limited access to certain people, can we use large language models and machine learning to be able to recognize patterns

that we say, you know, that this person has his experience and has these characteristics and that these, you know, 100 Palliative Care psychiatrists will analyze the data that meet these recommendations.

Can we create sort of prompts to be able to [00:28:00] have, whether it's a nurse practitioner or someone that doesn't have the same level of experience, be able to give that expertise or give those recommendations to patients? You know, we're, we're exploring opportunities for that and thinking about with our health coaches, right, that we've got all of these tools and all of these things that, you know, can be helpful.

We want every patient member interaction to be. Organic to be driven by the therapeutic alliance. And at the same time, if we can give AI informed nudges to be able to give prompts so that we know that the most therapeutic intervention is being delivered, then that, um, you know, there's two opportunities where we can improve scale and access when we can improve the efficacy of the interventions we build.

So, um, you know, in terms of what we're doing, that's what I'm excited about. Uh, and, you know, just using telehealth and digital technology and, uh, you know, Improving access to care, um, you need to make sure that people do have access to, uh, you know, the internet and the technology to be able to use [00:29:00] telehealth.

What are your thoughts on artificial intelligence?

[00:29:06] **Chris Comeaux:** I love that you asked that. And what, um, have you ever bumped into LYRA, L Y R A

[00:29:11] **Kyle Lavin:** yeah.

[00:29:13] **Chris Comeaux:** So, um, so you probably know where I'm going with this. And so I, I'm guessing just by watching, cause we actually got a demo. I can't remember what. How we bumped into them, but for some folks, just, it's kind of like Google's employee assistance program.

But what I kind of think is there's two things. Number one, they have this incredible credentialing process and they have this, um, plethora of different types of therapists that you could bring to the table, even different modalities. And then on the front end, the patient does via their kind of access to the EAP portal, kind of what's going on and they basically connect them.

So I got to imagine there's some artificial intelligence with that intake process is creating like a little bit of a matchmaking service. And so. And we've got a demo and I was pretty impressed by what I [00:30:00] saw actually. So I do think, and you know, artificial intelligence is moving quickly. I have two minds about the whole thing.

I've grown up in Hospice. It's very high touch. It's very sacred work, but I know this I'm an accountant by trade. We have a math problem. There's going to not be enough people compared to patients. So we're going to have to figure out how do you blend technology to get the staff at the right care, at the right place, at the right time, it strikes me that That's exactly what you're working on.

Um, just, just in a different whole different area. And it's interesting, Kyle had an experience just in the last week and I can't remember exactly. What made me do it, but I was on a call with an attorney and a pretty complicated conversation. So I opened up chat GPT and I started asking it and it was basically saying what the attorney was saying, but what it helped me do is ask the attorney, a much more complicated question, like getting beyond the deterministic, what the law is to here's the real problem I'm trying to solve.

I just sat there amazed at that whole conversation. And I'm like, yeah, I'm becoming much more [00:31:00] of a believer of how you use AI to do your job much more effectively. Yeah.

[00:31:04] **Kyle Lavin:** Yeah, I mean, again, I think we're on the same page and we haven't talked about this before, but I do, I have very mixed feelings, like it feels in some ways against the whole ethos of going into medicine and the Hospice with very high touch and the whole Hippocratic oath of do no harm and we're here to serve our patients and like, To think about it being done by technology and not that we're talking about robots doing it not interacting with people at all But uh, that's scary, but you all think it's I think it's coming Old me do it in a way that is um, like therapeutic and beneficial for people Patients and, uh, lovely to be a part of it.

[00:31:39] **Chris Comeaux:** Well, let's poke on maybe two things. I love the fact that you framed as an innovation. Us Hospice people are kind of smiling. Like we kind of think we invented the interdisciplinary approach, you know, because you know, Hospice goes back to 1983 and the older I get almost 30 years now in this work, it is a brilliant model.

Yeah. Now you [00:32:00] see, I mean, it's challenging, right? You bring multiple professionals and how does each person have the need to know? So

that way you deliver as much of a seamless experience as possible. And so do you feel like you guys have cracked that nut or learning every day of how you really do deliver that interdisciplinary approach?

[00:32:16] **Kyle Lavin:** Yeah, I mean, no, I don't, I don't know if it's enough that can be correct, but again, I think that's an example where, you know, being able to do things remotely and being able to do things on zoom or teams, uh, allows people to, to all come together. And so, you know, we, we try our best to be very clear in terms of the, the roles and responsibilities in terms of understanding what people are supposed to be working on.

Reading protocols and frameworks to be able to make sure that we're, we're triaging and getting people to, to bring the, the most salient information, uh, into those interactions so that it can be done. Quickly and efficiently. But have you cracked the nut and you're hiding it from me? Is that where, uh, where this is going?

[00:32:58] **Chris Comeaux:** No, no, not. I wish I [00:33:00] would. And actually, it's interesting. Even TCN is a model is an interdisciplinary approach. We're delivering it to organizations. And so we're living it. We're also coaching it. Um, you know, even Hospices have done IDGs for That's whenever you do the interdisciplinary group, you review the care plan.

It's just so easy for human beings to fall into the task mode and lose the systemic thinking, critical thinking, Hey, this is a great opportunity for us to know what really matters most. What's the problem that we're trying to solve. And so having someone in a coaching capacity, um, because there is no perfect system, but someone thinking more critically to kind of poke People a little bit to think more critically as part of the closest I'd say to cracking the nut is just using that.

So people don't fall into screen saver mode. Um, I've sat through many an IDG in my years and that gravitational pull is there and just the human ability to sit there and pay attention. So the other, the other innovation I want to poke on Kyle was the telehealth aspect. And so. Do you [00:34:00] think that, um, first off the uptake and acceptance?

Are you a little bit better positioned for telehealth? Do you think in the behavioral health space, what are your thoughts about that?

[00:34:10] **Kyle Lavin:** Yeah, definitely. I mean, again, that was one of the, uh, we talked about many negative things that came out of COVID and how that really exacerbated so much of the mental health crisis.

But I do think what it did do is it forced the legislature and the insurance companies and all of us, these providers, that then we. Had to work remotely. We had to figure out how we can do this and all we can go for this. Um, I don't think it's, it's been, um, you know, much more accepted. I think that people seem to respond really well to it.

There have been some neat, uh, studies coming out in Palliative Care. When you look at Jennifer Temmelsberg and comparing sort of standard in person Palliative Care to tele Palliative Care and showing that, uh, it's just as effective. Um, you know, I think that it can, can really be effective in what we don't want to do is [00:35:00] again, just rely on that and leave that on that human connection and make sure that we're not, that's not the only way that we're seeing people.

But in our experience with what we're doing with some really care, that patients are still getting remarkable responses that, you know, depression is decreasing by an average of 60 percent over 4 months with just this virtual model. When we're tracking the, the fact G7 in terms of a quality of life measure and that quality of life is improving by 60 percent over three months.

And so a lot of the care that we do, I would say close to 50 percent is actually just by telephone, right? And so like that, that is not technologically advanced, but it does allow people to stay at home. And I think it's so important, right? When they've got a serious illness and they're already have this service fatigue of all these appointments that feel crummy for more.

You know, therapy or their chronic illness or their shortness of breath to try and ask them to come into a separate mental health appointment oftentimes [00:36:00] makes things worse. Right? And so we can bring the care to people where they are using technology. I think it's important.

[00:36:07] **Chris Comeaux:** Yeah, that's great. Kyle, you alluded to the collaborative model.

I think that'd be probably worth just explaining a little bit more, because the more that I get to know you and the work you're doing, man, that's really part of the special sauce that I think you're bringing to the table.

[00:36:21] **Kyle Lavin:** Totally. Yeah. The, uh, the collaborative care model, again, founded out at the University of Washington, basically takes behavioral health care models.

You're traditionally, Uh, they'll work in primary care where they're embedded either in person or virtually with the primary care physician. The behavioral health care manager becomes the primary point of contact, uh, with both the primary care physician, but also with the patient. They are screened and identified as having depression, anxiety, PTSD, substance use disorder, you know, uh, various mental health conditions that we can treat.

And then they're referred to [00:37:00] that program. And over time. Behavioral health care manager delivers what we call brief psychotherapeutic interventions, primarily focused on problem solving, right? So rather than the typical traditional psychodynamic, let's discuss the childhood experience, dig deep into what's going on.

It's more about being focused on the present. How can we address what's causing you distress in this moment? And then we've also trained our care managers to use. Uh, the types of therapy like acceptance and commitment therapy, behavioral therapy, and what they do is that they do these standard assessment tools and so PHQ 9 for depression, GAD 7 for anxiety, and they upload that in your registry.

And again, talking about using technology, you know, the collaborative care model is measurement based treatment to target. So tracking these outcomes of it all seems simple, but in behavioral health, so often. It's subjective. All of our diagnostic [00:38:00] criteria are subjective based on what people are reporting.

We say, oh, are you feeling better? Whereas, I think I'm better, but we don't actually change our treatment problems quickly enough because we don't have ways to measure it. So, all of this information is uploaded into a registry. It allows us to risk stratify patients based on if they're not getting better after three months, let's talk about it, let's change the medication, let's change the intervention.

If they get worse over a month, we can, we can change it. Um, and then, uh, they meet the disability groups virtually with our psychiatrists. And we'll, as I mentioned, with the health coach as well. Um, and the psychiatrist is able to, to give that recommendation to give, to go back to the, typically the primary care physician.

And what we're doing is embedding with an anthologist stay. I'll pause for a second. I can talk a little bit about the health coach, which I think is another novel thing that we're doing. Um, you know, the, the health coaches, um, are focused on, on the wheel of health [00:39:00] as, as we follow. So, um, there's such close interplay between behavioral health, diagnosis, and health and wellness, but in our medical system, unfortunately, the over medical is oftentimes we forget that this holistic wellness is, Just as important oftentimes as the actual medical diagnosis.

So in terms of the wheel of health, there's the practical bucket, there's the emotional bucket, there's a relational bucket, and then there's the physical bucket. And depending on what's most important to people, we may be helping them with basic things like nutrition, like exercise, like their relationship with a higher power.

How do I, there's so much social isolation now, especially after COVID and, and, and things get, especially like. How do I build my social level? And so, I'm really excited and some of the feedback we've gotten from the patients we're working with and things like, this is the first time people have asked me what brings me joy.

This is the first time people have asked me what's important to me as a [00:40:00] person. And again, I'm preaching to the choir, how I do care group. Like we're all doing well, but I'm not no shade on oncologists. You guys are great, but oftentimes they're trained in just focusing on the diagnosis role to be able to bring all Sumos, but details as well. Subliminal connection.

[00:40:17] **Chris Comeaux:** That's great. And we'll Kyle, you have the year of a lot of Hospice and Palliative Care people. Um, I could see a lot of potential partnerships on the Palliative Care side, final thoughts you'd like to share with them. And at the end, I'm going to make sure whatever you want us to include your email address, it's really is, um, email, uh, email account or, um, your website, all of that stuff's going to be in the show notes.

So folks can get connected with you.

[00:40:40] **Kyle Lavin:** I mean, I can just say in my final thoughts are, well, first of all, thank you to you for this for. Have me on here for putting together this network of people who are incredible thought leaders within the field all and I think that I'm really passionate and I truly do believe that this is a huge problem, but we can sort of disrupt the [00:41:00] status quo like this in a fragmented siloed mental health care system for a long time.

But if we get thought leaders like yourself and like others to advocate for the need for integrating behavioral health into these serious services, whether it's. Palliative Care, oncology, nephrology, you know, pulmonology. But, uh, I think that we can really revolutionize the way that we address mental healthcare in our, in our health system.

And that. Uh, not only will patients do better, but, uh, our providers like Nespronel, uh, will have more job satisfaction. So, those are my final thoughts.

[00:41:35] **Chris Comeaux:** Yeah, I'm looking, you're, you and I are going to remain friends because I'm very looking forward to watching the great work that you guys are doing. Um, again, two good friends really kind of turned me on to, Hey, are you kind of aware?

And of course I was seeing the spillover effect of this challenge, but knowing an incredible organization like yours is kind of being birthed to be great partners with us. It makes me pretty excited about the future. So thank you for what you guys are doing. [00:42:00]

[00:42:00] **Kyle Lavin:** I appreciate that.

[00:42:01] **Chris Comeaux:** Well, to our listeners, we always leave you with a quote, something that more thought provoking quote.

Um, And so this is one that Kyle and I kind of picked together. They're actually two because I couldn't get down to one. So this one's from Nido Qubein, a wonderful guy who's at, um, High Point University in North Carolina, incredible speaker. He says, your present circumstances don't determine where you go.

They merely determine where you start. And this last one, it's not the bruises of the body that hurt. It's the wounds of the heart and the scars on the mind. That's from Aisha Mirza. Thanks for listening to TCN talks.

[00:48:20] **Jeff Haffner:** Thank you to our TCNtalks sponsor, Dragonfly Health. Dragonfly Health is also the title sponsor for April and November 2024 Leadership Immersion Courses. Dragonfly Health is a leading care at home data, technology, And service platform with a 20-year history. Dragonfly Health uses advanced technology and robust analytics to manage durable medical equipment and pharmaceutical services as part of a single efficient solution for

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