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GREG HORNE: Hello and welcome to The Health Pulse, a podcast exploring how analytics in the health and life sciences industry is growing and its repercussions in all our lives. My name is Greg Horne, and I am your host for this series. And as always, we'll be joined by my expert guest to discuss a topical subject of the day.

On this week's episode, we turn our attention to whole person care or mental health or many other ways of talking about behavioral health and health care. But before we get to that, last week we heard from Mark Lambrecht And he was talking a bit about introducing the subject of the podcast, and he got into some detail about the life sciences industry and its role to play.

We're still looking for you to send in your questions through email to TheHealthPulsePodcast@sas.com. And as we mentioned in the last episode, we're going to be putting together a future episode where we talk about those questions and get the audience participation and the audience response to the topics we've raised. So remember to drop your email to TheHealthPulsePodcast@sas.com, and we'll add those feedback questions into our discussion in that future episode.

So for now, let's turn our attention to this week's episode. And we have a really great guest with us again this week. Josh, would you like to come on and just introduce yourself and tell us a little bit about you.

JOSH MORGAN: Hey there, Greg. Great talking to you again. And hello, everyone. I'm Dr. Josh Morgan. I am a licensed psychologist by training and SAS's National Director of Behavioral Health and Whole Person Care.

GREG HORNE: Brilliant. And just tell us a little bit, Josh, about how you got into this position at SAS, a little bit about your kind of recent work history and the like.

JOSH MORGAN: Absolutely. You know, it's kind of funny because I never would have imagined being in this type of role. As I mentioned, I became a licensed psychologist because I want to help people. I was planning on just having a private practice doing clinical work.

And you know, all of my clinical training, my doctoral program, et cetera, really focused on caring for people in holistic ways and strengths-based focuses, et cetera. And then when I got out into the real world and discovered many of those things don't happen. There's systems. There's benefits packages and things that actually inhibit us from really providing true whole person care.

And that started opening up the pathway for me to really see the power of research, data, evaluation, analytics-- in our language, really-- to be an advocacy tool, to help us raise more awareness of our systems and our structures that really do need to change. And being able to provide evidence for that helps us to advocate for better whole person care.

GREG HORNE: Brilliant. Thank you very much, Josh. That's really interesting. And one of the other things we like to try and do on this podcast as well is find out a little bit about you as a person. So when you're not being a psychologist, talk to me a little bit about one of the things that really interests you out of the work environment.

JOSH MORGAN: Absolutely. You know, people who may follow me on Twitter or LinkedIn know my family and I are big nerds. I think my Twitter byline is "a data psychologist by day and Trekker by night." I probably should reverse those things because I'm more of a Star Trek fan probably than a psychologist in many ways.

But you know, I love some of those realms of sci-fi-- Star Trek being exemplary of that-- that really help us start to explore more of our moral and ethical dilemmas. In many ways, as I kind of look back, not trying to impose too much meaning on it-- I enjoy it just for the sake of enjoying it-- but it has aligned with a lot of these values and reinforced this idea of critical thinking, of keeping an open mind and staying curious to what else may be going on. What do we need to change in our system, turning the mirrors around to ourselves and having hope, having an optimistic future?

And you know, it's actually kind of funny because I was thinking about this the other day during one of my clinical practicums. I was kind of resistant actually in some ways to the quantitative world of things and assessing people. And I remember coming back to my supervisor and talking about how Star Trek actually and the character of data helped challenge my own assumptions and-- in many ways-- biases around the limitations of the quantitative realm and recognizing that, in fact, quantifying things that are hard to quantify may actually help us continue to push the boundaries and perhaps even make us more human.

GREG HORNE: That's brilliant. Thanks very much, Josh. And I was just make a quick note here that in our next episode, we're going to be addressing very strongly that idea of bias and looking for how we can make our analytics more fair for our population. So that's kind of a nice sort of lead for that. But

Let's just think a little bit about your area right now and think a bit about virtual care. So there are many barriers into health care. We know that in general. But when we think about mental or behavioral health and the like, the barriers are often even higher. So can you talk a little bit about what those barriers to health care access are and how might virtual health care in this space help out?

JOSH MORGAN: Absolutely. I mean, it's very true. Access to care-- and frankly, in the midst of a pandemic, we're starting to recognize that even more. People who could kind of ignore barriers to care-- legitimate barriers-- to care-- and I really want to emphasize that modifier of legitimate.

We talk about barriers to care, and really that's a core part of behavioral health, of whole person care, of general health care. But especially, in our behavioral health world, there's a lot of stigma and discrimination. Very few of us want to say, oh yes. I have a psychiatrist or a therapist or seek addiction treatment. There is incredible amounts of cultural and frankly legal barriers that inhibit people from actually seeking care. So that's just one on itself.

If we look back historically, at least in the United States, insurance coverage for mental health and substance use conditions was nonexistent or rare and would even have very low annual or lifetime limits. I mean, I remember seeing a 12-year-old in an inpatient facility, and she'd already hit her lifetime maximum. That fundamentally is going to create a barrier to care later on when she needs more treatment.

And a lot of these elements and cultural history still stay with us today. So when there are needs for care, people often don't want to seek it out and don't feel like it's acceptable to be able to seek it out.

And that's not even adding on a lot of our things that we often call social determinants of health, of not having health care coverage-- at least in the United States-- not having transportation, tying right back in then to our conversation around virtual care. If you can't get there, you're not going to seek care.

Or for people who may not have access to transportation, who may be in poverty and are also homeless-- I mean, I had people previously-- before coming to SAS, I worked for the San Bernardino County Department of Behavioral Health, where we dealt with folks primarily in the situations of living in poverty. And it was not infrequent that people had to take a two-to-four hour bus ride each way to get to treatment. And then heaven forbid that the bus may be late, and they're 20 minutes late to their appointment. And our system says, well, you're late. Sorry. Reschedule.

GREG HORNE: Yeah, absolutely. So with virtual care, I guess there's no being late in many ways. But can you talk a little bit about how virtual care might destigmatize the whole space as well?

Because we did some work a little while ago where we were looking at veterans, and we realized that there was an issue, particularly in rural communities, of your kind of distinctive pickup truck being parked outside the doctor's office, or you know, that you might be seen by one of your buddies to be going and taking this help when, you know, there's stigma around it. So talk about virtual care in that space as well.

JOSH MORGAN: Yeah. I mean, just first off exactly what you're talking about. If you don't have to physically go into a facility that may have behavioral health, mental health, psychiatry-- go down the list of names that we use-- on the front, that fundamentally can make it feel more acceptable to access. Removing that fear that somebody may see me accessing also helps.

But then broadening that out-- I mean, even for myself, as a licensed psychologist, I have sought therapy. I mean, that was a requirement of my doctoral program. But I've also said, after having done that, it's so valuable. I think all people should go in. But I experience my own stigma and discrimination.

And then there's the parts of going back to additional barriers of care. I'm busy. Especially in this job, I travel a lot, at least in non-COVID times. That is a barrier to care also, even if there was a provider I wanted to see and I felt comfortable with.

By having virtual care, I could be anywhere and be able to see somebody. If I could be in my own room, perhaps in my car-- wherever that may be-- and be able to be in my safe, comfortable space, that can increase access.

And that's a big part of behavioral health care is feeling safe and comfortable. We are often-- we should be safe and comfortable in our own homes. So that can also increase my willingness to engage.

GREG HORNE: That's really interesting as well. Because you do open up to a much wider group there. But you know, we're thinking now a little bit about analytics in this space with virtual care, too, and the whole behavioral health spectrum.

You've mentioned briefly this idea of social determinants. Can we explore that a little bit further please? Kind of think about what kind of social determinant data we might be looking at in this space and really how that might impact and make changes, particularly in the space of virtual health.

JOSH MORGAN: Absolutely. You know, some of this depends on what population we're talking about, right? Different pieces of social determinants and if people aren't familiar with what social determinants are-- in my mind, it's really looking at contextual factors outside of health care. It can include race, ethnicity, other-- socioeconomic status, your geographic location, housing status, education level, et cetera.

We know all of these things make a really big difference when it comes to overall health care. One of the areas that I am most interested in, especially when it comes to data-- tying back to our prior conversation around my motivation of using data really as an advocacy tool-- is broadening out our definition of health, both for identifying needs as well as evaluating outcomes.

If we cannot evaluate these programs, good programs die-- or if we ask the wrong questions. Oftentimes, especially in my world, programs-- clinical work-- is evaluated by the reduction in pathology, the reduction of symptoms, the reduction of the bad stuff-- so you know, lower emergency department visits, lower hospitalizations, less crisis visits. Those aren't bad things, right? We don't want that to happen.
If we add in some social determinants, things that I see are decreasing criminal justice recidivism, decreasing homelessness, decreasing drop outs of school. Again, nobody is going to say that those are bad things.
But what unintentionally may that contribute to our perception of-- in my case-- behavioral health? If the only thing we talk about around behavioral health is reductions in hospitalizations, criminal justice recidivism, homelessness, then we actually may be implying that it's our behavioral health consumers who were filling up our hospitals, jails, and streets, which is actually not true when you look at the complete data.
So what happens if we could expand that data, especially thinking of that person-centered strengths-based realm? What about volunteerism? What about social connectedness? What about hope?
Right now, that's a big topic in our world, especially trying to come out of a pandemic. But if I put one word into the reason I became a psychologist, it would be hope. And that's why I like Star Trek, too. It's hopeful.
[CHUCKLES]

GREG HORNE: That's really interesting you put it like that. Because I've seen that first hand actually recently with this idea of a feeling of lack of hope. And I want to kind of dig into that a little bit more then. Because we've seen in recent times how socioeconomic factors, in particular, really do influence not only our ability to access care but also our ability to express and to advocate for ourselves as individuals.
So thinking about that and thinking about the use of data in this space, how might we encourage people like yourself-- people in that clinical role-- to think more about these social determinants and think more about how people are able to access their care? And do you think there are incentives that we can put in place that's going to help care providers come to this table?
JOSH MORGAN: I love this question and dialogue, Greg. I'm glad you framed it this way. You know, taking an optimistic, positive, hopeful view here, I think a lot of providers do recognize the benefits of hope, of optimism. If you don't have hope, why would you continue treatment?
Put that in behavioral health world or in cancer treatment. The people who no longer have hope are the ones who say, stop. Stop care. Or that's one of the best predictors of suicide, for instance. We know this clinically.
The problem is-- in my view-- it's a lot of, again, our systems, our structures, our benefits, our policies that do not actually reinforce us. What we're being paid for-- so you go back to incentives. What are we being paid for? Reducing hospitalizations.
So if that's my number one incentive payment, then that's what I measure first. So all of my outcomes are tied around re-hospitalizations or emergency department visits. Again, not bad things in and of themselves, but that's all a focus on really reducing costs, not necessarily improving outcomes.
So if that is the thing that gets measured, then what gets put in my treatment plans? Well, everything-- all of my treatment-- needs to focus on the thing that I'm getting paid for which is reducing hospitalizations.

Now my number one priority is actually about reducing that kind of utilization rather than increasing the good-- increasing hope-- for instance in this example.
So what if we started changing what we measured? And maybe it's adding things that do focus on that person-centered strengths-based realm of things, like hope, optimism, social connectedness, volunteerism, et cetera.
Now you're not only getting credit for reducing hospitalizations. But especially maybe for folks who are very chronic and perhaps two to three hospitalizations a year actually represents stability-- and if that's the only thing you measure, it doesn't look like you've done anything. But maybe what you actually are doing is increasing social support, increasing hope, which we know long-term has huge financial impacts, human outcomes impacts, et cetera. We need to actually start measuring those things and tying incentives to those kinds of outcomes, in my opinion.
GREG HORNE: Hey, that's really interesting. I want to pick up on a couple of things in that. So let's unpack this a little bit. If I suffer with diabetes and high blood pressure, I can go and see my doctor. And they may have incentives to keep me out of the hospital. They may have incentives to keep me off dialysis. There may be all kinds of incentives that are in play there.
But they can keep that going by measuring. So they can say, well, my blood pressure is 120 over 80. Then it goes to 140 over 80 or 160. And they can say, wow, there's a change there.
You know, you can do that. You can measure my blood sugar. You can measure my heart rate. You can measure-- these things are very quantitive, yeah?
But hope is not a quantitative measure. So how might we use analytics to look at-- where would we pull that data source for? How do we measure hope?
JOSH MORGAN: Absolutely. You know-- and you're right. My dissertation actually was qualitative. I love my qualitative realm of things. And I don't think you can ever have a number that truly captures the essence of what hope is.
And one, with technological advances like natural language processing, like text analytics, I think we actually can start tapping into these ideas of hope through a range of data sources. At first, provider notes-- I'm going to guess, as a provider myself, hope is in there. It may be implied, but it's there. So that's one way to be able to tap into it, let alone if we were able to capture some sorts of narratives or other features from consumers themselves.
On the other hand, if I asked you today, Greg, on a scale of one to 10, how hopeful are you? 10 is incredibly hopeful. One is not hopeful at all. I mean, I'm going to assume you could give me an answer to that.
GREG HORNE: Yeah. I'm just going say, and it would be relevant to me. Because if you are asking me that over a period of time, it wouldn't matter that you can't measure me against somebody else. Because it's relative to me.
So that's what you're measuring. So in my case of blood pressure, when you say my 120 over 80 becomes 140, 160, you're measuring that relative to me as well. A similar idea-- so I guess that scale would be seen--
JOSH MORGAN: That's precise-- that's exactly right, where-- people, sometimes we dismiss the subjective. But a lot of times the subjective is the most important thing actually and especially in health care. And when we start tapping into social determinants and that person-centered strengths-based, it is all about my personal, subjective experience of my life.

So you're exactly right. And you know, that's a one to 10, really basic example. But you're right. We can track it. And that is a way to quantify it. Again, it doesn't capture the full essence of hope. But it is meaningful. It does tell a story.

And there are actually validated hope scales out there. There are other tools that are being used that do capture a realm of social determinants and strengths-based things that sometimes aren't always in the health care space. There's some used in the foster care system that do quantify some of these things that we could capture through data integration, entity resolution-- is this the same Josh Morgan in these systems-- to be able to capture a more holistic view of what people are ultimately and the impact being made.

GREG HORNE: Yeah. And we see the same kind of idea with pediatric pain scales as well, don't we, where you see the faces-- the smiley face, the angry face-- and you get the kiddie to point and say, well, where's my pain on this scale? So I can really see how that would work.

And then let's think about it a bit more then. So we see a lot of chronic disease now. And we think in the physical health area the rise of chronic disease has been huge and had pain treatments and those kinds of things. We've seen kind of an increase in behavioral health issues that kind of go along with that as well.

So you know, I want to think a little bit about this idea of whole person care. If I have a patient in chronic pain all the time, think about how that affects me from a mental point of view and that impact as well. And just talk a little bit about how we should start seeing a whole person care as our interconnectivity of those two things.

JOSH MORGAN: You know, that really is a nice, succinct definition in my mind of whole person care, Greg. Sometimes it gets focused on that behavioral health realm, which can include both mental health and substance use. But it really is about seeing people as they are. Maybe there's no behavioral health conditions.

And you're right. Pain is one of the areas that has a lot of, what we call, comorbidities of overlap with behavioral health conditions. As you said, it seems like it's increasing. I think the reality is we're actually looking at data around it. We're actually being curious and asking the questions of what else goes on.

So rather than seeing people in a silo-- this is my pain patient-- it's, this is Josh Morgan, who is in front of me. What are all of his needs and his strengths, based on his perspective of concerns? That's really what whole person care is about when we're talking about that person-centered strengths-based view.

Maybe pain does-- and I think it's a great example. Because in many ways the experience of pain is highly subjective. Pain is real. But if I've had a really stressful day and a fight with my kids, a fight with my wife, some struggle at work, the pain is going to hurt more actually.

And as providers, as the health care system, that is part of addressing whole person care as well as social determinants. Let's look at people in their entirety and what else may be going on that can mitigate this problem or make it worse or both.

GREG HORNE: Brilliant. Fantastic, Josh. This is really interesting to hear you talk about this. And I think our listeners are going to really enjoy it as well. And just a quick reminder that TheHealthPulsePodcast@sas.com is where you can drop those questions and comments on what we're talking about today.

But I just want to kind of move to our last question to you, Josh, and think about what the future might bring in this space, yeah? When we had the conversation with Mark Lambrecht on the last episode, he

talked a little bit about this idea of innovation that is causing people to get to see again-- curing blindness. And he talked about some of these areas being almost of like a biblical or miraculous piece, if you looked at it from eyes in the past kind of thing.

And it kind of got me to thinking about that as a question to ask all our guests, which is, you know, if you're think into the future, you think about the one thing that you can see coming down the line that's going to really change this space and really do something different, something that people maybe don't even think about right now, is there something that comes to mind in that space? And if so, can you just elaborate a little bit on that?

JOSH MORGAN: Yeah. You know, I love that because in many ways it goes back to our theme of hope-- something good and innovative moving us forward. You know, the thing that gives me hope and has driven my career goes back to frankly the idea of hope in and of itself.

I love that example of curing blindness. Before I wanted to become a psychologist, I was actually looking at becoming an ophthalmologist, giving people eyesight again. The power of vision is so important.

And you know, I had this vision for myself of-- imagine granting somebody vision again so they could see their kids. I mean, that's powerful. That's life-changing.

And then what I realized is, at least for me, it wasn't the medicine and the interventions itself that was what was motivating me. It was the people part of granting hope.

One of the things that I have gained insights on is as we can see and support people and ourselves more holistically-- sometimes it's not about reducing problems and reducing pathology. There will always be something new. It doesn't mean, of course, that we don't strive to continue to resolve illnesses.

But as a society, if we can stop looking at things as problems to be resolved and finding ways to be able to cope and see hope still in a holistic way, that is how we really move forward as individuals and as a society. And that's what's exciting. Because regardless of the problem that we face, we still have hope, and we have a way to be able to move forward.

GREG HORNE: Thank you very much, Josh. That's a very hopeful and insightful piece to end the podcast on. And Dr. Josh, thank you very much for coming along today and talking to our listeners. I think people are going to find that really interesting, and I'm sure we're going to get quite a lot of feedback on it.

JOSH MORGAN: Thanks, Greg.

GREG HORNE: And think just as a reminder-- thank you. Thanks, Josh. And just a reminder, you can do that through TheHealthPulsePodcast@sas.com. You know, I thought that the whole idea of hope as a subject was really interesting and kind of how you measure these things and turn it into a quantitative measurement point.

And I want to hear how our audience think about that as well and get the thoughts from the people out there listening. So we're going to be bringing these questions and comments in this featured episode in a few weeks, where we're going to pull together a lot of this feedback and look to build an episode around that.

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Thank you very much for joining me on The Health Pulse Podcast today. I've been your host, Greg Horne. We've had Dr. Josh Morgan here as our featured guest. Please like and subscribe to receive future episodes of the podcast.

And in the next episode, we're going to be looking a little bit more into this idea of bias and where bias in health care comes from. So until then, thank you very much, and we'll speak to you then. Good bye.