Anne Armstrong:

Thank you for joining us today. I'm Anne Armstrong, vice President of Strategic Alliances here at GovExec, and it's my pleasure to welcome you to today's event, the Health of a Nation, Addressing Health Equity and the Road Ahead, brought to you by Optum and produced by GovExec. Providing a modern healthcare system requires acknowledging and addressing the barriers to fair care and accessible medicine between caregivers and their communities. In a country where the health needs are as diverse as the population public sector leaders are looking for guidance on how to build trust and transform treatment for their teams and the citizens they serve.

Joining me today to discuss these issues and more are two experts. Michael Askew is the Deputy Director of the Office of Recovery at the Substance Abuse and Mental Health Services Administration, and Dr. Ethan Burke, Senior Vice President and Chief Public Health Officer at Optum Serve. Thank you both for joining us today. Can we start by just giving a brief explanation of what your job is? Sometimes titles don't tell everything and a little bit about your current role. Michael, do you want to get started?

Michael Askew:

Sure. Thank you. We appreciate you, Ann, for being the moderator to this conversation. Very needed conversation and certainly appreciate the opportunity to share my thoughts on how we support a recovery ready nation. My role at the Office of Recovery at SAMHSA is as Deputy Director to lead the office to make sure that we are in conjunction with the priorities of SAMHSA with regards to the healthcare and behavioral health of our nation. We want to make sure that we are making an effort to support all communities with being able to establish a system that will support behavioral health throughout different venues. So I have the honor to really be part of an office where what we realized back when a couple years ago, President Biden announced beating an overdose epidemic as one of the key pillars of his unity agenda. And so we really worked in conjunction with Dr. Gupta, Office of National Drug Control Policy and really looking at historic funding that came because of the overdose death rates and access to treatment and expanding that access.

So we really at the Office of Recovery became initially the pillar of SAMHSA to really engage in the recovery community or the community at large conversation about how we can become more effective with being a critical inflection point of access to getting support for the opioid crisis epidemic. And so I'm excited about being on the office. I've been in the office for about four months and a lot of work has already been established prior to me coming, but in the four months I've been there, we have released the National Model Standards for Peer Certification. We're looking at doing another certification for housing, one for peer support, as well as the initial support with youth, young adults, and families. We're looking at equity in recovery as an all inclusive component of our strategy and we're certainly excited about some of the other initiatives that we're starting to lay ground with.

Anne Armstrong:

Thank you.

Michael Askew:

So for that, we really appreciate the opportunity to serve under the leadership and administration of the Biden Harris administration.

Anne Armstrong:

Thank you. Ethan, would you like to give us a little bit about your role?

Dr. Ethan Berke:

Great, thanks Anne, and thanks again, Michael. So as you noted in the introduction, I'm the Chief Public Health Officer for UnitedHealth Group and I'm part of Optum Serve, which is one of the entities inside of UnitedHealth Group that focuses on serving our government entities and stakeholders including veterans, members of the military, civil servants and others. I'm a family physician. I'm an epidemiologist. I've practiced for a number of decades in a number of settings and have experienced a lot of issues of substance abuse, mental health, access to primary care and other challenges that people face. I was part of the National Health Service Corps so I've worked in the federally qualified health system and then have had a long academic career prior to coming to UnitedHealth Group about six and a half years ago. Public health at UnitedHealth Group seems like a head scratcher for some because we are the largest health entity, non-governmental health entity in the world, but we touch about 150 million Americans' lives either through providing benefits or direct care delivery through our primary care services or our behavioral health services as well as data and analytics and technology.

So it's an imperative for us to think about all of the levers that we have at our disposal to improve the health of a population, and that includes the principles of public health and understanding the role of social determinants and health equity making data informed choices, focusing on prevention and thinking about something that I aspired to and follow as a family physician is following that biopsychosocial model approach of thinking about that whole person from their physical, mental, social, financial, spiritual needs. So at United and at Optum, we take that into account as we're creating our solutions and working with our stakeholders around the country.

Anne Armstrong:

Well, thank you. Michael, I know you touched a little bit in your intro comments about the origins of the Office of Recovery and what it's doing, but do you want to expand on that or shall we talk a little bit about the trends that you guys are both seeing across the healthcare systems right now?

Michael Askew:

Sure, Ann, I'll just touch simply on some of the initiatives that the center has established since I've been part of the team since May. We have supported the nation with having regional meetings in different areas of the country. That has been nine conversations broadly about some of the things that ties into our agenda, our recovery agenda, which is wellness, social determinants of health, inclusion, equity and peer recovery support services. And so as we share that opportunity with the community at large throughout the country and coming to share with us about some of the things that they feel necessary to talk to us about, we are really designing our strategic plan. We've only been as an office for about since September of last year. So right now we're really identifying our strategic plan based on what the recovery community is sharing with us regarding a lot of the important issues that we want to address as it aligns with the Biden Harris administration unity agenda plan.

So one of the things that we know is exciting is being able to have these meetings and really from those meetings comes out reports that we provide to leadership at SAMHSA and begin the development of what we just released in June, the National Standard Model for Peer Certification, which we are excited about seeing a lot of the communities utilizing that already. And even in Minnesota, we have private insurance company that has really taken the lead and uses that plan, that report, that certification to share how their reimbursement is being established through supporting the people for recovery support services so that anyone in Minnesota can establish a recovery coach or a recovery support specialist or a certified recovery specialist at the hands of a individual, a private insurance company. So we're excited about that, but also there's other things that we're doing to establish our presence and that is to engage in community discussions like I shared with other federal agencies as well as other state directors to determine how we can work with those states from a state's perspective. And so we're excited about that work as well.

Anne Armstrong:

Ethan, what do you see as the important trends now in healthcare systems?

Dr. Ethan Berke:

Yeah, I mean, I think to take it up a level from what Michael was talking about with the work at SAMHSA is how you see that fitting into the broader ecosystem of ambulatory and acute care delivery. And I think there's a number of pieces that are once again rising to the top and they're not necessarily new ideas, but I think particularly after going through the pandemic, they're coming up again. And the biggest is around the move to value-based care. I mean, these are concepts that have been around since even predating or around the time of the Affordable Care Act, but how do practices really start to drive issues of cost and quality and inclusivity and access? And I think as models are being developed, we're starting to see partnerships across different types of healthcare delivery entities, whether it's primary care practices and hospitals as well as partnering with community organizations, public health systems and others to really get at what is of value from the perspective of the person or the patient and their family and community.

So I think we will start to see more creative partnerships. I think there'll be incentive programs that drive that type of collaborative effort that really focuses on outcomes across the system. And you'll see practices from primary care and specialty care in the ambulatory world partnering with others to really start to drive at these value type models that move us away from the traditional fee for service approaches.

So that's something we've talked about forever it seems like. I think it's happened in fits and spurts, but it feels like there is a great opportunity. The pandemic forced a number of changes in how we deliver care and how we think about what matters, and particularly around how we think about access for those who might be disenfranchised or don't have great access to a system. Hopefully those lessons will translate into long lasting transformation of the system and lead to some of these value targets that we've been thinking about, which is not just money. Value means lots of things to lots of people. Were they heard, were the outcomes that they are trying to achieve realized, and was it done in a cost-effective way so our healthcare dollars can be applied to more people within our population.

Anne Armstrong:

A lot of good points there. Michael, picking up on that, can you tell us a little bit more about what you're seeing when it comes to advancing healthcare equity in the underserved or under-resourced communities?

Michael Askew:

Sure, Anne and I think Ethan for really diving into that conversation about primary care and behavioral health and what that looks with costs and analysis. But certainly when we look at the underserved, under-resourced communities, especially of color, we just recognize how important it is to have access to services even in the rural communities. And also the fact that when you have those communities that don't have access to services, the social determinants of health does play a role in that. And I think one of the things that we have to recognize is the value of the recovering community and people that are able to get into a recovery process. I think one of the things is that when we look at the treatment and prevention aspect of this determent, we have to recognize how we should have more people in place that looks like those people in the community that they're serving.

There's an issue with trust, there's an issue with adherence to medications. There's an issue with understanding how to understand cultural competence of an individual or community. And I do know that those services need to be aligned with what people in that culture can really gain, really have connection to. So those issues of having not enough services that align with the culture is very important to have. And I think the last piece I'll share is how the systems that the underserved under-resourced communities are experiencing is prison and the reentry part of having very limited access to supports as well as people coming out of treatment systems and are not being able to continue the elevated support from medications like buprenorphine, being able to access methadone, suboxone, I mean just certain types of medical therapies that are not available.

And then when I talk about reentry, just in closing, I think what we share is a common belief that people that are criminalized are not of too much value when they come out of prison systems, but we have to put more emphasis on how we support those reentry communities that really have a valid role in coming back into the community and supporting their families as well as themselves. And with the lack of services, it's very challenging for them to really gain the access that most other people can get.

Anne Armstrong:

Ethan, would you like to follow up on that and perhaps touch on what are some of the trademarks of a successful healthcare system?

Dr. Ethan Berke:

Sure. I think those were some great comments. And I think Michael, as you were talking, it sort of reminded me at the end of the day, healthcare boils down to trust in relationships. And I think the challenge that health systems have are how do I scale that and how can I be efficient in building trust and relationships? And we always talk about populations and trying to get to these larger aggregate results, but population health happens one person at a time, and that challenge for health systems is how can I understand the people I'm serving? Is it someone coming out of prison? Is it somebody who is new to our country? Is it an executive who works for an automaker? Everybody has a story. How does the system adapt to all of those stories to provide the best care in the context of what they need and understand that context outside of the exam room, all those other factors that influence somebody's health that don't have anything to do with their physiologic medicine and the pills they're taking, but things around food and transportation and financial security, et cetera.

That's a big challenge for a health system to be able to do all of that and then do it over and over again for so many individual people that all have different stories. So I think a successful health system is one that learns the importance of those contextual factors and then figures out ways to manage and work with individuals and their families at that person level to achieve those population outcomes. And that requires a number of things. Some of them Michael talked about around building trust, having people cared for and listened to by those who get them, whether they look like them, live near them, work like them, or whatever those factors are. It could be a wide range, but then also having the data and the systems to be able to measure how well you're doing and to be able to measure some of these other factors. So this needs to be a data-driven approach. It needs to be a humanistic approach, and it needs to be one that's flexible for health systems to succeed.

Anne Armstrong:

Michael, do you want to respond to that or add a little bit more about how you all are using and building data as part of the recovery?

Michael Askew:

Yes, so thank you, Ethan. I want to just elaborate a little bit on what Ethan was sharing about data-driven approaches. And so at the Office of Recovery, we're about ready to, in September release a report, a short recovery report based on reporting from the recovering community as to what recovery was like during COVID as well as post-COVID, and certainly determining how people continue to navigate their recovery process through what strengths and weaknesses approached with them. And this report is through the advanced 2021 NSDUH, which is National Health Substance Use Disorder Report, that we want to just identify some of the things that we have recognized, the value of what the recovering community shared with us regarding how they fared with 30 days, what multiple pathways they used, what was available for them to continue their recovery after 30 days or 60 days or 90 days.

Just a lot of the impact, and once again, data-driven analysis shares with us that there's communities that strive more in urban community settings than rural only because of the services that are less available, but more importantly, like we shared when we talk about underserved and under-resourced communities, especially communities of color, that ratio diminishes based on the fact that there's not a lot of support for those individuals based on the needs that needs to be met.

Anne Armstrong:

Okay. Ethan, do you want to comment at all on that?

Dr. Ethan Berke:

No, I agree with all of that.

Anne Armstrong:

Okay, perfect.

Dr. Ethan Berke:

I think Michael got it down. Yeah.

Anne Armstrong:

Well, let's talk about what it looks like when leaders use the tools and technologies that are available to their fullest. Data is clearly one of them that we've touched on, but would you like to expand on perhaps some of the other tools that are available?

Dr. Ethan Berke:

Yeah, and this might get to something that we were talking about earlier, just briefly, but I think it's important is there's data to measure at the person level and the family level and the community level. And Michael talked about a lot of factors in neighborhoods that are underserved or are underrepresented in the healthcare workforce, and how we need to understand what those gaps are.

The other tool that people quickly think of is technology. And technology clearly plays a role in healthcare from a data collection side, but also from a communication side and the system working better together to collaborate across entities, whether it's a nonprofit working with a large health system or a federally qualified health center working with a mobile dental unit, the more we're able to share information about somebody and have importantly that person have control of their information as well, so they can carry it around as they move through the health ecosystem.

That's really important from making sure that we're providing appropriate care and safe care and efficient care. There's also technology around self-care. We're seeing more and more mental health services through digital apps, telehealth services and otherwise. And that's I think, a great opportunity to continue with. A lot of things don't require a face-to-face visit, and in some cases digital technologies for some sectors of the population may be preferred and actually have better outcomes. So I think we need to keep a very open mind to the whole range of tools in that digital technology toolbox. But there's one area that often gets overlooked and we all go, "Yeah, of course we acknowledge that." But I still think it gets overlooked is the human innovation and the human workforce. This is a service industry at its heart. It's about relationships with people like we were talking about earlier in the session, and are we keeping up with innovation in what the people do in the health workforce, whether it's around mental and behavioral health or physical health or care navigation or otherwise.

And the roles that we have in healthcare like physicians or nurses or physical therapists or pharmacy technicians or whatnot have been around for a long time. And are the roles of traditional healthcare the roles that we need for the future, are we meeting people where they are in the communities where they live with people that understand them and get them? Are we employing a healthcare workforce that is representative of the population we're serving and do they have the skills to meet the needs of the value-based care approaches and the integrated health and mental health approaches that we were talking about earlier? I think that's a huge opportunity to rethink how we deliver care with human innovation as much as we do digital innovation. One of the programs that we've launched at UnitedHealth Group a couple years ago is leveraging the registered apprenticeship model through the US Department of Labor, and we've now created three roles in healthcare that are based on traditional roles, but with enhanced capabilities around certified medical assistants, community health workers and pharmacy technicians.

And our program is hiring people from the communities we want to serve. We want the people we're hiring to be the neighbors of the people we're serving, and we don't require that they have any medical training to come into the program. We hire them based on their attitude and their hunger and their desire to learn and to contribute, and through a highly intensive training program and then apprenticeship afterwards, which has been used in many other industries like electricians and plumbers in the trades and in other countries technical work as well. Through that apprenticeship model, they get the additional on-the-job training, mentorship, professional coaching to become successful members of our workforce.

And what we're finding is we are bringing in a much more representative workforce into those positions. We are giving people opportunities to enter the career of healthcare that never would've thought they had an opportunity before because they didn't have the credentials or the piece of paper that let them get the job. That gives stability to their income and to their family so there's a benefit to them in terms of health equity and give back to their community as well as solve the needs of doing a better job of delivering care to the people that we serve in our clinics or facilities or who we work with across state or local entities.

So that's just one example through registered apprenticeships of how we've been able to rethink and enhance our workforce to be much more representative of the people we're serving and give them additional skills that they otherwise wouldn't get in a traditional training program to really thrive in a value-based model, whether they're knocking on somebody's door on their doorstep and talking to them about their diabetes or picking up a prescription in a community mental health center in one of our pharmacies, or going to see their primary care physician and interacting with one of our enhanced medical assistants. So I think those are some of the areas that I think have huge opportunity for innovation across the entire healthcare ecosystem.

Anne Armstrong:

Okay, thank you. Made me think when you were talking about access to technology can be an issue, particularly in areas where people, they may not have their own computers, telehealth may be available, but they may not have access. So I know veterans administration and a number of other groups are making available access to technology. Michael, do you want to jump in here on any of the tools questions and skills questions?

Michael Askew:

Sure. I'll just add to Ethan, he shared a few that already is being established through the Office of Recovery, and certainly telehealth is one of those pieces that you shared about having access, especially in rural communities or communities underserved that doesn't have access to that opportunity. But we just finished a two-day summit with Digital Recovery Support and certainly an innovation that we know has really picked up with being able to really engage and build relationships with the younger population, especially through phones, with chat services or phone calls or even video conversations where recovery coaches are being able to connect in that way. And certainly it's really been a really unique opportunity because we know that this is the digital technology of the future is really about reaching people right where they're at spot on, and the phone is one of those opportunities to really engage people.

The other thing I want to share is the Minority Fellowship Program at SAMHSA, which is a program aims to reduce the health disparities and improve health outcomes for racial and ethnic populations. This is about a 50 year anniversary of the Minority Fellowship Program. And what it does, it really strengthens the behavioral health workforce like Ethan was just talking about. This is one of those places where the workforce has to become more inclined with able to work to reduce health disparities and improve behavioral health outcomes for racial and ethnic populations. But what we do see is from the recovery coaching and peer specialist position, they're able to go into communities and systems that really can help them engage that conversation for individuals that are really needing access once they're released from those systems to the communities, especially from prison. We talk about treatment settings, we talk about inpatient programming that people really need to engage in someone.

And so from the criminal justice system, we're looking at the front end of the court system where recovery coaches are being able to through some type of a drug court or some type of accountability court, being able to establish a relationship with a coach as another piece of their recovery plan. And so we are really being really knowledgeable and noticing the difference when peers and peers connect because we're able to see the connection they make, but also when it comes to the behavioral health system, there's a lot of connection within those systems that we're starting to see peers working in there in those systems to really engage in that conversation because they're more trusted and more experiencing what the walk that individual needs to make.

And so from the clinical aspect to the recovery aspect, it's like the bridge that's connecting those two systems to work side by side. And so we're excited from SAMHSA's point of view of being able to build more of a plan to really engage those systems, to understand how to work closely together so that individuals that are in those systems can really get the support they need.

Dr. Ethan Berke:

And that's a great example of that importance that we were both talking about of making sure that all of those pieces aren't acting in silos because there's a risk that a nonprofit will have their community peer support people, but it won't be tied back to that person's primary care or the rest of the specialty system. So this is where the technology and the data are important to be able to flow with the patient knowing where things are going, but to make sure that things stay coordinated and that the good work done in one place isn't ignored or overlooked in another, where it might actually be really critical.

So as systems start to develop and get more creative, we want to make sure the risk is that it becomes a bit chopped up and fragmented, which then poses safety, clarity of a care plan, et cetera. So I think that's a challenge, but also an opportunity because if we could figure it out in that setting, then that starts to get at a lot of those value stories that we were both talking about in the very beginning.

Anne Armstrong:

I know you've both mentioned collaborations, but what are the secrets to success for organizational successful collaborations? And I think you've both had experience at that, so I'll just throw it out there and if you want to add something to what's already been... We've been talking about, that would be great.

Michael Askew:

Well, I'll just say that from my career in the nonprofit sector in Connecticut, we were able to establish partnerships in a lot of things we did only because we had these different type of committees, community committees that established some priority goals and the community was willing to support those goals as a whole. It wasn't individualized goals that they felt their organization needed to do, but it was about the community. And so what I want to just share is that there was a organization that came together and established what we call the Reentry Collaborative. This was a collaborative of a lot of community-based agencies, programs, services that came to the table and just talked about how we can improve the effectiveness of getting those people that are reentering back into society a second chance. And so we actually had the mayor's office join in, and within a year, the mayor's office initiated the Mayor's Reentry Initiative Program.

And so through the mayor's office, they were able to hire a staff of three people that came as well as the reentry collaborative to share how as a local community government we can establish, what they did was establish a reentry resource center specifically gauged to those that were coming out of prison. And so here's a unique opportunity where just that discussion at tables can lead to certain aspects, and from those aspects became resources and supports for individuals and housing and the like. And I think that's one of the pieces I love to see from a local community government perspective. From the federal perspective I'm still learning, like I said since May, but I'm sure there's some opportunities that will present themselves. I just haven't heard that.

Dr. Ethan Berke:

Yeah, I think there's some great points there. And it gets to the issue of shared values and as people come together, is everyone aligning around the mission and the goals and what we're really trying to achieve, and are they able to leave maybe their individual preferences or beliefs at the door and come in with an open and curious approach to hear what others are thinking and then try to get to that collective shared goal. That makes it much easier then to do something after the conversation if you're all aligned.

The other side though is shared responsibility and perhaps shared risk and a little bit of skin in the game is important for organizations to really make that commitment and then stick with it versus being a passive partner. I've certainly seen plenty of meetings where everybody comes in well attended, but nobody is then willing to take that next step. And I think if the mission's aligned and I think the leadership is there and people realize what's at stake in terms of the outcomes for the populations we're serving and they're willing to make that commitment, a little bit of that shared risk goes a long way in keeping people at the table in the long run around that aligned mission.

Anne Armstrong:

That's a very good point. Ethan, I know you talked a little bit about the internships program and ways that your organization is helping create a workforce. How can larger organizations or large organizations create a workforce, not just with perhaps a small test, but how do they get their workforce empowered to drive equitable healthcare outcomes, getting everybody to sign on?

Dr. Ethan Berke:

Yeah. Well, and just to correct one thing you said, ours is an apprenticeship program, not an internship program. There's a little-

Anne Armstrong:

I'm sorry.

Dr. Ethan Berke:

No, it's okay. Well, we're pretty large. We're a Fortune Five company and have almost 400,000 employees around the world, and we're the largest primary care and behavioral health provider in the United States. You start small, you de-risk, you learn from your mistakes. You listen to the stakeholders that you're trying to help solve their problems, and you adjust on the fly. And we've successfully gotten the program to a national scale for our medical assistants where we're training them in cohorts in multiple places around the country. We've learned some of the challenges in doing that and have modified the educational model along the way, but always making sure that we're not doing anything to detract from the content or the cohesiveness of the group.

So thinking about more efficient ways to train as we get bigger. So I think certainly the work we've done is absolutely scalable, and I think we're proving that out. I think it requires like anything that you think about the problem you're trying to solve, not over balloon it too early and try to stay focused on that real primary goal. And then once you feel comfortable with that, move to the next step and the next step, we call it de-risking as other groups do too, to make sure that you're staying on target. And that's a great way to scale.

Anne Armstrong:

Michael, do you have the same kinds of challenges in your organization getting the workforce empowered, or are they sort of signed on at the beginning by the nature of their jobs?

Michael Askew:

So yes, and thanks, Ethan, you really brought out a couple of points. And one of them is that with the support and training is essential to make sure that it's cohesive for those that can learn. And so we have a population that we are wanting to engage in becoming part of the recovery workforce that they have a willingness to want to give back based on their lived experience and wanting to prove of themselves. And so one of those priorities is being able to, at SAMHSA, be able to strengthen the behavioral health workforce. And what that looks like is just making sure that we are in conjunction with communities that really recognize the value of the recovering community and the mental health community that really wants to support individuals that are in the process of changing their lives. And I think one of the things that happens is that we see people wanting to just become a peer specialist or a recovery coach just because they have an ability to believe that they have value in wanting to share that with someone else.

And so I was privileged to be able to be part of the Connecticut Community for Addiction Recovery, which developed a curriculum back in 2006, which is the Recovery Coach Academy, which has gone throughout the country and internationally as we have seen over 80,000 recovery coaches get trained on this curriculum as part of the workforce development in our communities. And I think like it's been shared with Ethan, we need to be understanding of those that we need to be more consistent with being able to support the different communities that we're engaging in and how that looks with different ethnics and different culture. And so we have made this Recovery Coach Academy curriculum available for English, Spanish, French, and even Vietnamese.

And so I think the opportunity that really presents itself with the mission of SAMHSA to really identify strengthening the recovery workforce to make sure that we are really giving an opportunity for people with lived experience to like I shared earlier partnership with the clinical and treatment aspect of recovery so that, like Ethan said, the holistic approach is being met. We love to see evidence-based practices, but we also like to see person-centered as well. And I think that's really the constitution of what we believe in. I personally love the opportunity to see that work and not the silos, but really being able to establish that ecosystem wellness and certainly make people aware of their strengths and how they can support other people that are really challenged. Thank you.

Anne Armstrong:

I think we're coming up on time, but I did want to give you both an opportunity for one piece of advice you'd like to leave with the audience. Ethan, I go to you and then to Michael.

Dr. Ethan Berke:

Well, first thanks for the opportunity to be part of the session and thanks for guiding us through it, Anne, this was really interesting and I learned a lot from Michael as well about the efforts that they do it doing at SAMHSA. I think the opportunity to do in healthcare is always going to be there. Whether that's a good thing or a bad thing, I'm not sure. I guess that means we have a lot more to do, but it also means it's a lot of good work that we can be thinking about. I would encourage people to be holistic, think about that biopsychosocial approach, and then think about all the tools in their toolbox to get to what they define as value, not just for them, but the people that they're serving. So thinking about technology, thinking about data, thinking about issues of equity and understanding the communities that you're working in and thinking about the people that are part of your team, I think are all critical.

None of them in isolation are going to solve this. It's definitely a holistic approach. And then importantly, thinking about partnerships. Who can you be working with in your community outside your own organization? Who else should you bring in even as part of your care delivery model? And then how does information and standards and communication work across those different entities? So it's a complex system and that's what keeps us all busy and keeps us up at night. But like I said, I think the opportunity is there if we start to think about a number of those factors I just mentioned.

Anne Armstrong:

Michael, you get the last word.

Michael Askew:

Well, thank you Ethan, and thank you. It's really exciting to have an opportunity to share with you on this stage. I really thought about how valuable it was to really start this conversation about the visions of the future. We really have a unique presence when it comes to supporting the behavioral health and primary health of our nation. And what that looks like for me is being able to see the benefits of especially the recovering community and communities at large, being able to establish partnerships and collaborative efforts to initiatives that can really work in the best interests of the people that they're serving. It's all about the individual and families that we're serving. And if we stay focused to that, when we have core principles and values that we represent in our communities, I think one of the things that I do see is a commitment to get better at what we do.

And I think the indication is that data-driven, focused recovery, ethnics orientation. I think one of the things we do see is people really care about helping people. And when we at SAMHSA take a look at the overall picture and what I've seen over the last four months is how do we help engage conversation that really can help bring meaningful initiatives, choice to individuals, providing them with an opportunity to see that multiple pathways of recovery is available, no one size fits all. And then the cookie cut approach, we really want to value people for who they are and where they're at. And so we always recognize that when it comes to children, youth, and families in our communities, we want to make sure that we are really giving the best opportunities that we can provide for them so that they can be able to meet the healthy needs that they are really looking for.

In closing, I'll just like to say that the Office of Recovery has really been really excited about getting the work that we're doing out to the community. And so next month is September, which is National Recovery Month. And that month we will have on our website a number of events that's happening, that's recovery related, that will share about the impact that the recovery community is making, not only from a federal level, but from a community level. And we love for people to just come out and just be part of that celebration. This is our 34th year and being able to do that. And so we want to just let people know that recovery is real, but we are in a challenging time right now with opioid overdose, and we want make the communities understand the value of what they bring to the table as a partnership, as a collaborative effort to help fight this epidemic. This is really a challenge that I sent to our communities. If you want to be about it, do something about it.

Anne Armstrong:

Thank you. I think that's all we have time for now, but a big thanks to our speakers for being here today and to our audience, thanks for tuning in. If you missed any part of today's program or want to share it with your colleagues, the on-demand recording will be available on the website very soon. Thanks also to Optum for sponsoring this particular session. For GovExec, I'm Anne Armstrong. Have a great day.