John Marchica:

Welcome to Health Care Rounds. I'm your host, John Marchica, CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Here we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery. Our goal is to promote ideas that advance the quadruple aim, including improving the patient experience, improving the health of populations, lowering the cost of care, and attaining joy in work. Please send your questions, comments, or ideas for Healthcare Rounds to podcast@darwinresearch.com. And if you like what you hear, please don't forget to rate and review us wherever you get your podcasts. Let's get started.

Kim Asciutto:

Today on Healthcare Rounds, John speaks with Spencer Hutchins, CEO and co-founder of Concert Health, America's leading behavioral health medical group with a turnkey solution designed for primary care and women's health physicians. Concert Health's exceptional team of clinicians deliver collaborative care management, an evidence-based model proven to treat anxiety, depression, and other behavioral health conditions.

Prior to Concert Health, Spencer co-founded Reflection Health, where he served as CEO for three years. Spencer also previously served as senior director at West Health, where he helped source and support investments in innovate companies, such as Humedica, Change Healthcare and goBalto. Spencer has also served as a member of the founding healthcare team at the Federal Communications Commission during the Obama administration. Spencer received an MBA from Yale School of Management and a BA from Colby College.

John Marchica:

So Spencer, thanks for taking some time today to speak with me. I appreciate it, and I'm sure our audience will appreciate learning more about behavioral health and also about your organization by the magic of podcast recording. By now, whoever's listening will have heard a stilted bio about you, so tell me ... Let's do it in your words. Before we get to Concert Health, tell me about your bio and some of the things that you were working on in your past.

Spencer Hutchins:

Sure. Well, thanks so much for having me. Excited to have this conversation. I've been living and working at the intersection of healthcare and technology for a little bit better than 15 years, trained in business school, and then started my career on the East Coast doing advisory work, both for big companies as a management consultant and then taking periodic breaks to do public service work. So it was in the first term of the Obama administration, helping start a healthcare team at the Federal Communications Commission, and then found my way to San Diego a little better than a decade ago, and a family office that was invested in early stage companies and a medical research organization helping to do innovation around lowering the total cost of care. And that got my juices flowing and loved the early stage innovation world, and so for the last 10 years have been founding and running companies, and Concert Health is the second one that I founded as the CEO.

John Marchica:

So I'm always interested in, and we talked a little bit about this in our earlier conversation, but I'm always interested in entrepreneur origin stories, and we all have them. I have mine, although sometimes I think people don't view us as being a market research company as an entrepreneurial effort, but it is. So what led to the creation of Concert Health? What inspired you? Give me, as I said, the origin story.

Spencer Hutchins:

Yeah. I think it's a couple of veins coming together. The first one was my first company, Reflection Health, was trying to disrupt the world of physical therapy, using a software application that utilized a camera that underlies Microsoft Connect Camera to build an immersive at-home physical therapy experience for folks that were preparing for or recovering from joint replacements, and when we started, and had a lot of success with that, got FDA clearance, got some really marquee customers, ended up having a nice exit, but from the beginning, always we pre-conceptualized that as it had to be a software company. That was what we were building. That was what it needed. That's what investors wanted to do. That's what you did when you moved to California, create a software company.

And we always hit into this, "Well, the software is amazing," but it was really how it interacted with great clinicians that created the value, right? And it's how orthopedic surgeons, physical therapists and their team can re-conceptualize what a joint replacement was or what a knee injury was using this immersive at-home experience for patients as an important part of care. We're always going back and forth with, "Oh, software is supposed to be scalable," but then you had to get into, "How are physical therapists compensated?" Sometimes if their department compensates that by visit, and you're saying, "Hey, good news is I can get rid of 70% of the visits," you actually have to help them on the way they're compensating their team and the way they're conceptualizing their own KPIs, and we're running into that.

So when I left that business, and I was addicted to starting another one, said, "Let's just solve a problem and build the organization required to solve that problem, and not be enamored with the type of organization it had to be at the beginning." And then I didn't have a deep background, professionally, in behavioral health as a space other than knowing it over a 15 year career as one of those places that gets talked about as even more broken. And as a person, had seen both how transformative great behavioral health support can be for people I really know and love and just how easy it was in this country not to get it, and so when I stumbled upon a research base around this care model called collaborative care, which is an evidence-based way of integrated behavioral health services into primary care, it not only made so much sense ....

Of course, that should all happen together. Now it seems obvious, and even back then it seemed obvious, though it was talked about a little bit less in 2016 when I was researching this, that of course, primary care and your behavioral health support needs to be integrated. Your depression doesn't exist separately from your obesity or your blood pressure or your diabetes. They often co-mingle.

John Marchica:

Sure.

Spencer Hutchins:

And you really need that team to come together. But not only did it make a lot of sense, but it had a huge amount of research behind it that showed that it could demonstrate better outcomes, lower total cost of care than primary care by itself, or even outpatient behavioral health by itself. And that's when I

got fascinated, but also knew that to do this well, we'd have to build a lot of great software, but we also actually needed to build a medical group and actually employ really, really talented behavioral health clinicians and psychiatrists.

And as I got excited, that's also when I knew that I was only half of the founding team. So I had to go find myself a real amazing clinical operator and was really lucky to find Virna Little, who became my co-founder and Concert Health's chief operating officer. And Virna's a psychologist and social worker that's been doing this for 15 years in a federally qualified health clinic. And so finding a way to bring her expertise, her operational and clinical credibility into a high-growth NewCo mindset, as we tried to change the way that behavioral health is delivered across the country.

John Marchica:

Was she willing and able, or did you have to twist her arm a few times to pull her away from what she was doing?

Spencer Hutchins:

It was funny. I learned about collaborative care and was fascinated by it. We can go into detail in the clinical model if that's interesting, but I was starting to do all the things you do when there's a great model, but no good revenue model in healthcare, which is, "Oh, maybe you pitch this to self-insured employers. Maybe the VA," whatever places that have the right economics to do this. That's when I found out that Medicare was going to make collaborative care a covered benefit. And that's when the light went off and said, "Oh, if we let every primary care team figures out on their own, it's going to take 30 years and they're going to mess it up." So we need an easy button, a peer medical group that could support them, deliver great care together, and make the revenue model work together. But to do that, I knew I needed someone. I knew how to start things, I knew how to sell things, I knew how to build technology teams, but I sure didn't know how to run medical groups. So I needed that.

I started asking everybody I'd met and said, "Who's the best clinical operator in the country?" Ivory tower research is nice, but it can't just be that. I need to doer, a builder. And so a bunch of people gave me Virna's name, and one was silly enough to give me her cell phone. And so I called her out of the blue. I still don't quite know why she picked up my cell phone call. A couple of years later, I found out she was gardening at the time, and I knew she had forgotten more about collaborative care that week than I had learned.

So I didn't tell her anything about that. I thought I had this information about this new guidance coming from Medicare, and she knew about it already. She'd been part of the advisory panel that was pushing and advocating it, but she'd had the same job for 15 years, so saw the same opportunity, but didn't know what a startup was. It's like, "Hey, how would I pay for my kid's college doing this?" So agreed. I think she was on board conceptually, but needed some coaxing. And so fortunately, she agreed to spend an afternoon with me if I flew out to New York, and so cross-country flight, preposterously priced because I think I bought it at about 48 hours notice, went out and we met-

John Marchica:

Ouch.

Spencer Hutchins:

A two-hour meeting became a seven-hour meeting, and left with her starting as an advisor, as we waited for these things to come together. And then once we had the guidance out and the model built, I spent some time selling it in the Phoenix area, where we started, and then she came on full-time as the COO once we got it going.

John Marchica:

But I want to get into the model and a little bit more about those nitty gritty details, but I want to ask a 30,000 foot question, and you alluded to this earlier, but I feel like behavioral health is a maligned industry and certainly that people's needs are just not being met, to your point earlier. And sometimes, I interview health system executives for a living, and when behavioral health comes up, it's almost like they want to change the subject. They understand that it's important. They understand the co-morbidity issue, but they're not tackling it head on. So I just wanted you to just take a step back, before we get into the collaborative care model, and give me your assessment of the industry today and how we're meeting the needs of patients, people.

Spencer Hutchins:

Yeah. We made a terrible decision a long time ago, decades ago, to think about it as a different industry than medical, as if the medical system and the behavioral system are separate. That created resistance, stigma, funding, coordination problems. I think in many ways, fortunately, a lot of those are falling away in the broader population. I think people are waking up. More and more prominent people are standing forward and admitting their own struggles, and that's causing more acceptance from people that says, "Hey, I need this help. My friends and family need this help. This is something that matters and I care about."

There is a growing awareness from large health systems, although many made that same years and years ago that, "I don't do that. That's a different industry," or some of the bigger hospital-based systems, maybe they do the acute side. They have an inpatient psychiatric facility or some high-acuity settings, but they've never done outpatient behavioral health. They don't employ a lot of therapists or outpatient psychiatrists. So I think there is a growing awareness of the needs. Their primary care physicians, their ed physicians are saying, "This is a huge need. I can't get patients in. I don't feel confident in my own ability to manage these on my own with my current resources."

I think also health systems, though, are looking at and saying, "Listen, whenever we try these things, we lose money. It's not our expertise. We've never figured out how to employ these. It's a different type of professional. We don't know how to do it." It's traditionally been a different type of billing, and so I think you see a giant need coming from them, from their boards, their newspapers, their clinicians, and themselves, the leaders, I think, want to solve this problem, but they've never thought of that as their core competence. And I think that's an issue, which is one reason why sometimes you're seeing more talk than action right now because of that. Underneath the curtains, it goes, "Man, whenever we build new service lines here, they're the ones that lose money or have high turnover, and we don't have the ability to manage them effectively."

John Marchica:

So is it a consequence ... Let me ask this a different way, because one of the things that we're seeing in our most recent research is health systems really starting to emphasize primary care, and we haven't gotten underneath the why of that. It's just on our latest quantitative survey, it popped up on the radar

as being a major strategic priority. Do the ones that are managing the risk, thinking about Intermountain, Kaiser, Geisinger, do they do a better job because they're thinking about the total cost of care?

Spencer Hutchins:

Yeah, absolutely. I think on average they do. Much of the early research for collaborative care, Kaiser was a lot of the early sites for the original randomized control studies because they were one of the few organizations that had the whole dollar and were looking at it. And I think whether or not you're talking about full risk in a Medicare advantage or ACO context and the direct contracting models or other places in which you're trying to bring that total cost of care angle, I think that all of those groups on the forefront are saying that behavioral health integration is going to be a top five lever to win and be successful there when they look at the underlying .... One problem, like dividing behavioral as if it was a different industry, is that folks that managed behavioral health risk have traditionally really managed high-acuity psychiatric settings. So they've just been trying to make sure there's not too many psych bed days. Right?

John Marchica:

Right.

Spencer Hutchins:

That's important work, but nervous grandmothers with COPD, they don't go to psychiatric hospitals, but their underlying anxiety disorder is what causes them to go to the emergency department nine times that year, because when they can't breathe well from their CFPD, it exacerbates with an uncontrolled anxiety disorder and creates panic attacks. Right? So anybody that's managing behavioral health in a silo says, "That's not me. That's a medical problem. That's COPD, ED utilization, hospital utilization." But I think anybody that's taking the full patient look and can see all of that says, "No, no, no. Part of my lever here is, yes, getting them on the right meds for COPD , but is absolutely supporting them to make sure that they have reduced anxiety symptoms, or there's no way to wherever we're going to keep this person out of the emergency department."

John Marchica:

So that was a perfect segue into understanding your model and the application of the collaborative care model. So can you go a little bit deeper into that?

Spencer Hutchins:

Sure. So the vast majority of our team members are licensed behavioral health providers or psychiatrist or psychiatric nurse practitioners, the behavioral care manager. So those are licensed behavioral health providers like clinical social workers, marriage and family therapists, professional clinical counselors. We've got better than 100 of those now. We operate across eight states. They mostly work from home and do care remotely, although some of them actually co-located into our primary care and women's health partners' offices. And basically, we operate as a real extension of that primary care team and encourage the primary care offices to make a couple of workflow changes.

So the first is to screen for everybody using these basic tools, like there's a nine question, a tool called the PHQ-9, which is common. And those are really important because we know probably about

half the people that present don't bring up depression, and it's not obvious that they have it in a seven-minute encounter. Maybe it's because they don't realize it, or because they're hiding from it or think that depression happens to other people, and these basic survey tools that ask you, "Hey, in the last two weeks, how often have you had trouble sleeping or eating and have been low energy, isolating yourself, or even had thoughts that you'd be better off dead?" That could help capture a lot of those people that aren't going to bring it up, aren't going to present.

The second is providing an opportunity for that position to do a warm handoff. Imagine I'm the patient. Whether or not I present because I screen positive on that PHQ-9 and maybe an email the day before my PCP's visit or in the office, or just because I bring it up or my PCP notices it, she's now left with a new option, which is before collaborative care, she'd say, "Hey Spencer, here's a med, and I think he should go see a therapist. It would help you a lot." But she knows I'm probably not even going to follow up, and even if I do, I probably can't find one that takes my insurance. So 70, 80, maybe even 90% of the time, I never get connected to other services. And maybe I come back in to tell her how the antidepressants are making me feel, but she doesn't have the support around to really track me. Right?

John Marchica:

Right.

Spencer Hutchins:

And so we're often relying a lot on patients to say, "Come back in if you need help," and we're putting all the onus on that patient. In a collaborative care model, she's got a partner behavioral care manager, and she could tell me, "You know, Spencer, I work really closely with a woman named Danny. I'd love Danny to call you today or tomorrow, and she helps support a lot of my patients struggling with these same things, whether or not that'd be sleep issues or energy or nerves, grief. And what Danny does is check in with you, at least a couple of times a month, just see how things are going. She measures your symptom severity just like we did today because we track this to make sure we're getting better, just like we would your blood pressure or your sugars. And she's got some coping techniques. She teaches my patients. They find it really helpful, and how to overcome those symptoms when you feel them coming. And she keeps me totally in the loop on how things are going, and so we can really make sure that we support you through this."

And so instead of 80% of people not taking that, 70, 80% of the people will say, "That sounds great." This is just part of an expanded primary care team. Danny, though, is a licensed marriage and family therapist, and she reaches out. We try to always maintain the same day or next day access, and often talking to patients by video or phone, whichever they prefer, over the course of that month, several times a month, really doing a spectrum of what the patient wants and needs. Danny could do full-on traditional psychotherapy interventions, like cognitive behavioral therapy, or much lighter touch med rec symptom monitoring, if all I want or need is to take the medication and see how that works, often doing something in the middle, maybe something that I wouldn't describe as therapy. I'd say Danny's helping me exercise more or Danny's making sure I'm connecting with my parents or my family more frequently, or my friends more frequently. Help me set goals and just live healthier.

Now what she's doing is an evidence-based behavioral activation intervention, but if the patient doesn't want to call that therapy, that's fine. It's not about labels, it's about outcome. And then with each part-

John Marchica:

So Spencer-

Spencer Hutchins:

... Danny is doing ... Yep.

John Marchica:

Let me interrupt you one second.

Spencer Hutchins:

Yep.

John Marchica:

And then finish your thought, but it strikes me that the way that you described what was going on, playing doctor there, was entirely non-threatening, was not in any way stigmatizing. Do you have to coach the primary care offices and the physicians and the NPs that you work with on how to frame it? Because it seems that that makes all the difference.

Spencer Hutchins:

Absolutely. I mean, you're seeing resistance in the patient population fall. So sometimes you don't need to frame it at all. "Hey, I want a therapist." "Great. I've got one that I can get Jack into in the next day." That sounds amazing. But I think for populations that are more resistant, that's more likely to be with rural or older populations, but really, it can happen everywhere. Absolutely, that coaching is important. And really, what collaborative care is about is saying, "This isn't something else. This isn't behavioral. This is primary care," right?

Primary care physicians, they support your weight gain. They support your pre-diabetes and early type two diabetes, they support your asthma and your COPD, and they've got to support your mood in the same way, your depression, anxiety, other conditions. And it's just this is how primary care should have always been practiced, with the right team, with the right number of resources that you're able to track this stuff and really have a team-based approach. And I think that that can make it much less threatening. You need to do some training, but a lot of times PCPs get this quickly. They understand it. They know their patients well, and they've just never had a partner on the behavioral health side that could be there that would have access that would be an extension of their team. And so it's often a revelation for them and something they get really excited about.

One thing you find, they're often an ally for us as part of the partnership, the sales conversation early, the physician voice, but always once we're there, because once they've tasted this access and partnership, it's like, man, they'd never go back because this is what they got into primary care for. It's the team-based, patient-centric care that everyone wants to provide.

John Marchica:

It must've been a big decision, getting back to the business here, it must've been a big decision to go the employment model rather than just putting together some kind of ragtag network, again, focusing more on maybe the technology rather than the implementation. At the same time, you're incurring a lot of

costs. So is that a tough choice in the very beginning, or did you know that, "Hey, this is the only way that this model is going to work is if we have an employment model"?

Spencer Hutchins:

Yeah. We talked about it a lot, but I think Virna and I both had a really conviction that the old model of network, that the legacy players like a Magellan or a Beacon had done, they just weren't cutting it, and they never were because, one, it was more optimized for paper adequacy, and second, the core to collaborative care is really getting people to change the way they practice. It's a more measurement-based approach than traditional outpatient therapy. The psychiatrists are there, not as direct prescribers. They're more there as coach for the care manager and PCP, making recommendations based on the data from the registry and weekly consultations they have. And so you really needed to create exceptional professional experiences for both talented behavioral health providers and talented psychiatrists. And we thought from the beginning, that was a level of oversight, a level of training that was critical.

And really, what you don't have in behavioral health is this generalized market failure. It's not like you have a bunch of psychiatrists and therapists with not enough work to do, and a bunch of patients that need help and you just need matchmaking. It's not a failure of just, "Oh, we're not connected well." It's that we haven't architected the outpatient behavioral health system to address the needs, and to do that, you really have to find great people and create great professional experiences for them.

So one of our core values that we wrote on a piece of paper right when we were getting going was "Service." Obviously, most importantly is service to our patients. Almost as importantly to that is the service to the primary care physicians who are allowing us to be on their team, to join this team. And to do that, it was about creating a team of exceptional clinicians, and the rest of us that aren't in frontline clinical roles, all we do is try to make the lives of our clinicians better. I forget when we started to use this phrase, but it was implicit from the beginning is that our clinicians needed to be the core of the organization, not part of the product. And I think that's really guided us from the beginning.

John Marchica:

So I'm sure you get asked this question a lot, Spencer, but what have you been able to measure in terms of outcomes? The model is evidence-based, to your point, and it should be performing better, but are you asked by payers or other folks to be able to demonstrate that you're being effective in what you do and cost-effective?

Spencer Hutchins:

Yeah, absolutely. And it's built into our DNA from the beginning, and it comes directly out of the research around this, of collaborative care. And we measure the North Star Clinical Measure. It's called the 90 day improvement rate. And so that's what percentage of patients from that warm handoff or from that positive screen have seen a 50% or 10 point reduction in their depression or anxiety symptoms as measured by those tools, the PHQ-9 and the GAD-7. And in general primary care, even at a year, it's only about 20% of people have seen really substantial improvement, so that 50% reduction in symptoms. In the collaborative care research literature, normally 50% is considered a success, and we've been fortunate to be a little above that research benchmark. So about 60, 61% of our patients, historically, have been able to see that 50% reduction in symptoms inside of 90 days.

John Marchica:

Wow.

Spencer Hutchins:

We're increasingly trying to align around additional measures, which are similar. Hetus has a few, ACS has a few process-based measurements of screening and response rate. There's another antidepressant medication management that we're increasingly trying to get our arms around and show that we can move the needle, and out of the research, it's shown that when you manage that intermediate metric, that 90 day improvement, not only is that an imperfect, but phenomenal to measure just a reduction in human suffering. That means that you're saying, "90 days ago you said, hey, every night I can't sleep, and now you're saying it's not a problem, or it's only a problem a couple of days out of that month," or-

John Marchica:

Right.

Spencer Hutchins:

... or "I used to have thoughts that I'd be better off dead. I don't have those thoughts anymore. I used to have energy problems. I used to isolate, and I don't anymore." That's phenomenal by itself, and we always like to cherish that as a measure, regardless of anything else, but also what the research has shown, when you have that type of impact on their depression, anxiety symptoms, you also see a reduction in total cost of care. That's the element that we haven't shown with our own data yet, just because of how new we are, but we're increasingly focused on, particularly with our systems that are already taken risk or have their own plan, which means they're both incentivized around those total cost of care measures and they have access to the claims data and the cost data that allows us to tell that story. So yeah, I think we'll be increasingly focused on that over the next few years as we continue to scale some of our biggest and most sophisticated partners.

John Marchica:

So last question, I was going to ask you about the big picture of where behavioral health is heading, but after talking to you now for half an hour or so, I'm really interested just to see where Concert Health is going in the next three to five years. What do you see the vision for your company for the future?

Spencer Hutchins:

Well, we just took care of our 10,000th patient in December.

John Marchica:

Congratulations.

Spencer Hutchins:

And we'll do several multiples of that this year. So we're just on an absolute growth tear, which is exciting, but there's not tens of thousands or hundreds of thousands, or even millions. There's tens of millions of Americans that need this kind of support and aren't getting it right now, and so there's just an enormous need to scale and to do this across more and more medical groups, more and more health

systems to help them build it, whether or not they work with us or do it themselves. We just think that's critical and there's an enormous need. And just fidelity to the existing research model is really powerful.

But underlying that research model is really bringing this engineering mindset to care and behavioral health, which means you always have to measure, because we know we have a lot of evidence-based interventions, but we know they're all imperfect. In reality, our understanding of the brain chemistry underneath depression and anxiety and other behavioral health conditions is still so preliminary. And so I think you need to take that mindset. Right now, it's mostly psychotherapy interventions or medication interventions and only increasingly, and it already is starting to be digital interventions, digital therapeutics. But you'll need that type of mindset across primary care.

So we think of collaborative care as a really way to redefine what primary care means and to be effective, and we think that'll be huge. It also creates a scaffolding and infrastructure that helps identify patients that maybe have different or more acute needs. Hopefully, you catch them earlier in the progression, and then you can rationalize the referral pathways out of primary care into that specialty setting to both be as step up and a step down care. So if we do our job, right, we'll be caring for an enormous number of patients. Hopefully, we'll be the trusted partner for the best primary care teams, best women's health teams, best pediatricians in the country. And we'll have an opportunity to really figure out a way to both catch those half the people that need care like this that aren't getting it, and also bring an outcome focus to that whole industry, which is something like 200 billion in spend across the country now.

John Marchica:

Wow. Well, Spencer Hutchins, it's been great, and I've enjoyed talking to you, and this has been very informative. I'm fairly certain we've got quite a few physician leaders who listen to Healthcare Rounds. If somebody needs to find you or reach out, what's the best way to get in touch?

Spencer Hutchins:

Sure. Our website is just concerthealth.io. A little web form there that'll get right to us, and we'll reach out promptly. They can find me, probably a little, too, online, both on LinkedIn and Twitter. @SCHutchins on Twitter, or just my name on LinkedIn, and folks can find me in any of those spots, too.

John Marchica:

Terrific. Thanks again, really enjoyed it.

Spencer Hutchins:

Thank you.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Healthcare Rounds is produced and engineered by me, Kim Asciutto, theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in-depth customer insights to health care executives. Our strategic focus is on healthcare delivery systems and the global shift toward value-based care. Find us at darwinresearch.com. See you next round.