Rebecca: This is Dr. Rebecca Daniel-Burke, your host for the American Counseling Association’s 2015 podcast series. Today, we are speaking with Dr. Anthony Centore about the future for private practice clinicians.

Anthony Centore, Ph.D. LMHC is founder of Thriveworks, a counseling company with 19 locations, focused on premium clinical care and customer service. A licensed mental health counselor in the Commonwealth of Massachusetts, Anthony has published research in the *Journal of Mental Health Counseling*, and has published writings on a wide variety of subjects, including the role of religion in marriage and family counseling, parenting, loving your child too much, integrity, and *The Therapist Clinical Guide to Online Counseling and Telephone Counseling*.

Anthony is author of *How to Thrive in Counseling in Private Practice: The Insider's Guide to Starting and Growing a Counseling Therapy Business*. Welcome, Dr. Anthony Centore.

Anthony: Thank you, Rebecca. It's an honor to be here.

Rebecca: Wonderful. The first question I have for you is; Thriveworks has had some success, what gave you the idea initially for Thriveworks?

Anthony: It has been quite the adventure growing and running Thriveworks here now in 10 states across the US. The way we started is, in January of 2007, I was offered a counseling position at a practice in Cambridge, Massachusetts. And I moved there. I moved from Virginia up to Cambridge, and within just a few months of picking up my life, moving to a new state, the practice that I was hired to work at went out of business, due to poor management and a number of other issues.

And so, one day, I'm in my apartment, and the practice was half a mile from Harvard University, my apartment was probably a mile from Harvard -- I didn't go to Harvard. I didn't know if I could compete with the very, very experienced and intelligent people in that area. But I went online, I went to Psychology Today, and I wanted to ask a question of a therapist, and the question was probably, "Are you hiring?" And so, I don't remember exactly what the question was.

I go to Psychology Today, and as you know, to be on Psychology Today, you pay your 30–35 dollars a month and you have solicitation for clients. You're basically saying, "Hey, I have a practice. I'm accepting clients. Please call me." Well, I called the first person on the list who was a psychologist. And I'll never forget what he said to me. He said, "You've reached my voicemail. If this is a medical emergency, please go to your nearest emergency room, or dial 9-1-1." And I thought, "Wow, that's interesting." And so I was like, "Okay", I shrugged my shoulders and I went to the next person on the list who is a woman, and I was surprised to learn that she said the same exact thing that he said.
And that day, I called 40 therapists in a row, and I got 40 voicemails in a row. And I remember at the time thinking, "This is crazy. Nobody's ever going to believe that this happened." And of course, today, at Thriveworks, we're calling providers all day long for one reason or another and we never. Seven years later, we never get them on the phone.

I didn't go to Harvard, I didn't go to MIT, but I do know how to answer the phone, and I do know how to provide good customer service, and I think I'm a good therapist too. So that was the idea, that we started in a windowless office, the proverbial, literal windowless office in Cambridge, Massachusetts. One room space with a shared waiting room, and based on the concept that we're going to provide a higher level of customer service and good clinical care to clients.

Rebecca: And that's what you started with?

Anthony: That's what we started with.

Rebecca: That is a wonderful idea, Anthony. So many people call a therapist's office, a counselor's office and they don't get a call back for a day. Well, during that 24 hours, let's say they have an angry adolescent, they're just going crazy during that first 24 hours.

Anthony: A day might be okay. I'm getting calls from people who say, "I try to call another practice and I got a callback two weeks later or 30 days later." -- or never, or not at all. I mean, if a practice is calling someone back in a day, that's still not good, but they're still beating the curve I think with a one day return.

Rebecca: So you offered something that the potential clients needed?

Anthony: That's right. That's one of the first things we invested in, was having someone answer the phone. Because it's a challenging issue, right? Therapists on session, when they're in session, there's no one there. There's just no one available. And even if they call back when they get out of session, then the client or potential client isn't available and then they got this game of phone tag going back and forth.

So one of the first things we invested in was that area of better service that we sought before.

Rebecca: That's excellent. How is running a practice today different than when you began 7 years ago? I'm assuming it's different. How is it different?
Anthony: For me, there's two ways to answer the question. One is to talk about the practice. One office in Cambridge is an 11 office suite. We have 15 providers. We're doing everything from psychotherapy to medication management, psychological testing, out of a much larger space. So of course, the scale has changed, and everything involved in it has changed. But regarding the industry, which is probably even a more relevant question, there are so many changes.

I think one of the biggest, one of the most pressing is that when we started seven years ago, people would call and they would sheepishly ask, "Do you accept my insurance?" And if they didn't, we could usually convert them. "No, we're not in network. We're out of network." There's some good things about us being on a network. You can pay cash, it's not that expensive when you think about it. You talk about a super bill and some people had out-of-network benefits, and they might be able to use them and all that stuff.

Today, when someone calls, it's a totally different story. They call and they say, "Do you take Blue Cross Blue Shield?" And we say, "No. If it's a new office, we don't take it yet." And we barely get another word out, where it's like, "Okay, thank you." Hang up. So that's one of the biggest things that I've seen in the last seven years, and probably even more so over the last decade, is that it is getting much, much more difficult to get people to pay out of pocket for services. And we're really in a managed care area now.

Rebecca: I agree. I've been seeing that change too, Anthony. It used to be that people were willing to pay out of pocket. But now, I see people running searches on therapy directory, and the search will be about who takes their insurance and is within driving distance, as opposed to who appeals to them most. Do you agree?

Anthony: That's absolutely right, yes. And we get calls because people do those searches on Good Therapy or Psychology Today, and then they call the therapist and the therapist doesn't actually take their insurance but they listed they did. But that's exactly what people are doing; they're searching not just the provider, not just the presenting issue, they're also looking at payer.

Rebecca: I take most of the private practice questions at ACA, and I've noticed that there are a few people who still have cash practices, but very few. Most are telling me they're on 10/15/20 insurance panels to make ends meet. Can one still build a cash practice?

Anthony: Yes. Some absolutely can. There are a few things to consider. One is, there are some markets that are just so affluent that it's easier. It's easier to get people in and pay cash because of the affluence in the area. And there are some markets, that there's such a shortage of therapists, that one can recruit cash pay clients. So where I am currently, I'm in Central Virginia, and we have a clinic here now. But before we were
here, if you wanted to see a therapist, there was one really reputable practice in town, and they didn't accept insurance because they didn't have to.

So you go to it and you pay out of pocket if you wanted to see a counselor. It's just what people did. But the weird thing is, even here and in Central Virginia, that changed. We've opened up, but also there are three or four other practices that have opened up that are all accepting insurance. Now, and even in that practice that was cash-only, many other providers in that practice are now accepting insurance. So we've noticed a trend here, but there's still some markets -- they're rare, they're becoming more and more rare, where there is a shortage of people willing to pick their insurance.

I see some people who have cash pay practices, but they have small caseloads. They're seeing a dozen clients a week or less, or definitely less than -- a full case load of 30 clients a week. And the reason is, is people who pay cash, they tend to terminate treatment. I found that they tend to terminate treatment a bit faster, they also tend to come in less frequently. So they find themselves, these providers who build cash practices sometimes, they can find themselves in this sticky situation where they got about 10–12 clients who are paying really good cash rates, and they don't want to take insurance because once they do, it's going to cut their weight per client for the clients they do have, because their current clients have insurance they prefer to use. So they find themselves in this Catch-22, where they can't grow their practice past about a dozen because they just can't get enough clients in the door, but they don't want to convert over to insurance because they wouldn't make quite as much money.

I think at the end of the day, there are some people that are so talented and so gifted, and sometimes so charismatic, that they will be able to build a demand for services. There are still some people out there, they're cash pay, they have a waiting list, and they're turning people away. But they have an X-factor. Sometimes, they don't even know it. There's something about them that people are willing just to, "Shut up and take my money!" They want to get in and talk to this person because they're so compelling.

But it is difficult, it's a shrinking market, and I think -- I know I'm going on about this, but I think that's what some people in the industry met. The individual providers, they're told they should be able to build a cash case load. They take a course on it, maybe they read a book about building a case load, and they're talked about how to promote themselves, and that's all really good information. But then, what happens, is they leave the course or they finish the book, they go out, they go to promote themselves, they try to recruit those cash pay clients, and then they feel like a failure when they can't do it. Then they feel like, "There's something wrong with me. I'm not doing it right." But what they need to realize is they're fighting an uphill battle, and they're going completely against all the trends in the industry, and it's just so exceedingly difficult.
Rebecca: It's very difficult. I know one person, personally, who has a big thriving out-of-network practice, but he wrote a book that was very popular, he's in San Francisco, lots of people have bought his book, seen him on local news; how unusual is that? That's very unusual. His case is very unusual. The case that I see more often was a mother calling me recently saying, "I'm a single mother. I have very little extra cash. I have to get my child some counseling, and it has to be insurance because the most I can pay is the 10 dollar co-pay a week." And I understand that. And when that person gets help, I'm so glad that someone took her insurance.

Anthony: Absolutely. I'm not saying anything bad about the person in California. It's remarkable what he has been able to do or what she has been able to do.

Rebecca: He, yes.

Anthony: It's just very hard to replicate that he probably has some type of X-factor, where he can go on TV and people are like, "That's the guy. I want to see that guy." But trying to communicate that to someone else and then replicate them, "Oh, these steps. Go on Facebook, go on Twitter, shake some hands and you're going to get a full case load." It doesn't convert, because the next person doesn't have that 'je ne sais quoi', that the first person did.

Rebecca: That's right. They don't have a 'je ne sais quoi'. But also, this mother who called me with a child who desperately needed help. There are lots of people like that. They have to choose between paying their electric bill or paying cash for counseling. Believe me, they can't do it. It's not that they don't want to, they do want to, but they can't do it. So they can't see my friend in San Francisco. They must see that person who is going to accept insurance. And thank goodness, there's a good selection of good counselors out there who take insurance. Don't you agree?

Anthony: Absolutely, of course. And those people, they're already paying their insurance premiums. It's not like they're looking for even free counseling, though there's nothing wrong with that. That example of the mother, she probably religiously pays her premium and that's one of the benefits of having insurance now, that she should. Mental Health Parity was created for a reason.

Rebecca: Exactly. Given all of this, what advice would you give to someone looking to start a practice today? There will certainly be people listening to this podcast who are looking to start a practice, and what kind of advice would you give them?

Anthony: One; it's a ton of work, which I think is obvious. One of the things that I want to say, do not do it if you want to focus on being the best therapist you can be. That might seem like an odd piece of advice, but the truth is when a therapist decides to open up a therapy business, especially now more than ever, they make a transition from being a technician — because therapy is the technical work of providing therapy — to
becoming an entrepreneur. And the transition, the diversity between those two roles — and I really can't overstate it — it's the equivalent of somebody who is really good at making pizzas, deciding to open up an Italian restaurant. As soon as they make that decision, their job is no more about creating great pizzas, it's about leasing office space or restaurant space, hiring their staff, setting schedules, promoting the shop, making sure the shop is up to healthcare code, and all the other lesser things that a business owner needs to do.

And as a business owner, their bringing back to counseling as a practice owner, your role comes from delivering great therapy 101 to creating an environment where you're creating the best possible opportunities for other staff to grow, for other clinicians to grow. So I guess the advice, to boil it down a bit, if you want to be the best therapist you can be and focus on the craft of providing psychotherapy, find a place that will empower you to do that. Find a place that will pay you well, empower you well and let you do that. That would be my advice. Other advice, you need to be a thought leader in your community, you need to promote your practice like crazy through both advertising and networking; you need to be passionate about that. If you're going to hire clinicians, the clinicians you choose to bring onto your team are probably going to make or break your practice more than any other decision you make, so you need to do that well, you need to deliver value to your clients in every single session or they won't come back.

When I started the franchising thing with Thriveworks, one of the reasons why we started it was because advice and tips and instruction just wasn't cutting it anymore for those who wanted to start practices. I couldn't just sit someone down and teach them what to do alone. We had to develop systems to make it possible, because they need to be able to answer the phone, and just that one -- I know we keep coming back to that one, there's others, but this is just really the first one, right? -- The average counseling practice is open from 8 in the morning until 9 at night. So if you're going to have someone who's answering the phone and scheduling sessions, you're looking at hiring three full-timers to fill those hours. Because you got vacations then you've got time off then you've got sick days and all that other stuff, and it's just a long day.

So you need someone to answer the phone, then you need to be able to get people scheduled in quickly -- so you need to coordinate schedules. You need to accept insurance, you need to bill that insurance, you need to get the word out about your practice, you need to recruit the right providers with the right employment contracts to protect you, and then you need to pay those providers appropriately with benefits.

Rebecca, I got to tell you, the Affordable Care Act -- actually, this isn't even about the Affordable Care Act, but it is getting more and more complex to pay your providers with benefits. We have a practice in Massachusetts, we have a practice in Philadelphia, and both states, just June of this year, released a new law that we have to do paid sick time for our clinicians. Which is fine. It's a good thing to provide, but it's not something that
we had at the time rolled into our compensation package. We did other things. We did other types of health benefits.

So now, it's one hour for every 40 hours of direct work in Massachusetts, and one hour of every 30 hours of direct work in Philadelphia. Starting this month, we now have to track all of our provider's work by the hour in a new way to make sure that we're providing this benefit that came out of nowhere to our providers. It's things like that that are making it progressively more difficult to run a practice. Because it's like, "Okay, now we have to develop an entire system around it." And we had to say, "Okay, well, if we're paying all this extra money, we have to figure out, can we afford to do that or do we need to cut somewhere else?"

The list goes on and on about what practices needs to do today to be financially successful.

**Rebecca:** And then there's the whole issue of billing. How has the Affordable Care Act affected building a practice from the billing standpoint?

**Anthony:** To some extent, it's been good. Massachusetts was one of the early states, or even before the Affordable Care Act, they had something very similar in place at the state level, where people needed to purchase insurance, and if they didn't they'd be penalized -- up in Massachusetts. So I was in my early 20's up in Massachusetts, I probably would have gone without insurance. But since I had to get it, I went online and I bought Blue Cross Blue Shield, and I paid out of pocket independently for it because I was a small business owner.

And so, that's good. That means that more people have insurance than ever before, and they came come in and they can use those benefits. We have noticed a trend recently, so it's also complicated. One of the complications that just happened, that we're noticing, that for people who are buying insurance from the open market, they're paying their premiums every month. If they fail to pay their premium, which is easier to do than in the past, what will happen is you'll notice that claims are being denied.

So just one example of many where billing is becoming more complex, is we get an authorization, the person has good insurance, then a month later they don't pay their premium, and then when we submit for claims to be paid, they get denied. And then if the client pays his premium or her premium within 60 days or so, those sessions will still get paid, but if they let it lapse, which some do, more sessions are being declined because of that. So we're seeing weird things happen because people are paying out of pockets, not coming out of their paycheck, it's not being paid by their employer in some instances.
So there are little nuances that are just going to take more learning, but also it seems that with every complexity it's more time and more money and resources to process daily.

**Rebecca:** Now, I do know someone who has an interesting private practice. She sees people out of a converted garage at her house, so a nice converted garage, beautiful space, and she sees people there. I asked her what insurance panel she's on, and she says, "Every one. Every insurance panel." But she also has realized that people want to come in the morning, or they want to come in the evening. And so, in the middle of her day, she has four hours off, and she's perfectly fine with that. And she does all the billing herself, and she's just realized how to deal with each insurance company and she deals with them. And now, it's kind of down. Is that an unusual kind of practice, or how typical is that today?

**Anthony:** I love that question. I hear a spectrum of answers to that from different providers. Some providers say exactly like she said. I have it down, I know what's going on now, I have a process -- and they feel like they're getting the reimbursement and they're going a good job of it. Others are having the exact opposite experience. They're saying, "I'm having to fight for claims to be paid." If one is doing their authorization upfront, that's a really important piece that not everyone does. If someone calls in for an appointment, the therapist or someone on the therapist team should be calling the insurance company and confirming that, yes they had benefits, yes they're in good standing, no there's no deductible that needs to be paid first, and so on -- then you're going to have an easier time on the back end.

But there are still plenty of complications; especially a lot of it sometimes depends on the insurance companies. They're not all created equal. Blue Cross Blue Shield is a wonderful one to work with, because they tend to be very transparent and be really good. But then, there are some others, not just the government-runs but some private ones that are just much more difficult to get reimbursed from. So some of it depends on who is the insurance company in your area that you're predominantly working with.

**Rebecca:** So there are a lot of problems with having a practice today. How are practices surviving today?

**Anthony:** Well, definitely some are doing great. Some are doing really, really well.

**Rebecca:** Some are getting their garage turned into an office, right?

**Anthony:** That's genius. I mean, talk about low overheads, she's got it working. She's working long days. She's working morning, and then doing her billing in the afternoon, and then seeing clients in the evening. You're looking at 12 hours, 14 hours at the end of the day? These are not short days for her. What I'm seeing is that, some practices, a fair amount, they're barely making it. They're scraping by. I see a lot of practices-- they
have about five therapists with the practice, one of them's the owner of the practice. And at the end of the year, the owner looked at the profit and loss, and he or she sees, "Okay, I made 100,000 dollars after all was said and done. If I had just a solo practice, I would have made the same."

So they're putting in a lot of time and effort into it, and at the end of the day, it's sort of like, "Well, what did I want to do? Did I want to be a therapist, or did I want to run a business?" Because they're not making more for the level of risk that they're putting in. So it's really about what they want to do with their time. What I'm also seeing is, I'm seeing that practices, even medium and larger practices are struggling to do things the right way by the book. I get approached by a fair amount of counseling offices that are for sale, and they call and say, "You know, we're interested in selling." And they could be a big practice with a fair amount of revenue or a lot of revenue, and you look into it and their therapists are -- the first thing you'll see -- all their therapists might be independent contractors, not employees; which means they're not getting benefits, which means that they're at risk. They're at risk of the government coming in and saying, "It looks like these people are being treated more like employees and getting a fine." There's a risk of the clinicians going rogue and saying, "I feel like some of my work was being directed in a way that I was an employee", and their subject to a fine and penalty.

And also, when you have independent contractors, you have hired guns. You don't have team members. So what they see is--

Rebecca: Good point.

Anthony: They're not part of a team. And if by definition, you shouldn't give them a business card with your logo on it because they don't work. They're not part of your team. They're their own company. That's what it means. So you're seeing every year, 25% of their roster goes across the street and opens up a competing practice, because they have limited loyalty, because they're not brought in as team members. Other things that I'm seeing, is that places where practices are cutting corners to make it viable, is that clinical notes are being reviewed. That's the other thing I see a lot. So I'll talk to somebody and I'll say, "What's your process for auditing clinical notes?" And they say, "Well, my clinicians are independent contractors, so it's their responsibility to do their clinical notes." "But insurance is paying your practice." "Well, yes."

I'll tell you, I got to be careful here, but my therapists are really great. We hire wonderful therapists. My team, I live and die by my team, but we have an EHR, and we review everyone's clinical notes, and on a regular basis. Before they get billed, we're reviewing them on a regular basis, I have to follow up -- and not me -- but my team wants to follow up with the clinicians, "You didn't put in the length of the session on this clinical note" or "Your note is incomplete or it's just not done." "You haven't submitted your note." And clinicians get busy, they get sick, they just come up, they leave the office but it doesn't
get done. We're chasing them down. There's always somebody we're chasing about some note, and we're very, very vigilant about it.

And so, I know that if these business owners are not following up and checking these notes every week before their bills, they're just not there. But the problem is, it's not that the practice is lazy, it's that the idea of having someone review each case file and review each note to make sure it's complete -- it seems crazy, it seems like an unbelievable luxury to be able to have the resources to do that. And that's part of the pitch. That's why things were getting so challenging, because there's nothing left over to do that sort of a thing.

Another thing I'm seeing is, unlicensed providers are being billed under a license provider's ...

Rebecca: Problem.

Anthony: Problem, big problem, but I see it all too frequently. And of course, for those listening, there's some exceptions where that's okay. But in many, many cases, that's not okay. So I see some practices are surviving because they have to cut corners; they can't manage it like a real company. There's no HIPAA compliance officer. There's definitely no yearly HIPAA training. There's all of these liabilities rolled into some of these practices that are making ends meet because they just can't afford to do it the way that it's supposed to be done.

Rebecca: I talked to somebody recently, and she has an out-of-network type of practice, where she sees a client, she gives a client a super-bill which has the diagnosis and the CPT code and whatever else on there, and then it's the client's responsibility to get reimbursed -- and they pay cash, and it's the client responsibility to be reimbursed. That seems to be the practice that's in-between the guy who has no problem attracting cash clients, and the people who are on every insurance panel. What do you think about that?

Anthony: I have some strong feelings about it. I always want to be really honest with people. And if you do a Google search for counseling and super-bill, you're going to pull up a bunch of independent websites of people talking about their super-bill. And I really dislike the way that a lot of them go about it. I see, "If we use your insurance, your insurance company is going to know about your mental health disorder, and I'm going to need to diagnose you. Do you really want the insurance company to know about this?"

And I see all these really ugly things. It's like when you go to your PCP and you have some sort of a medical issue, your PCP doesn't say, "Hey, your insurance companies going to know that you have hypertension or going to know that you have this or that", but counselors do it shamelessly, and it makes me so upset. The super-bill is a real thing, and it can work, but those out of network benefits are becoming more and more
rare. The cost of healthcare has gone up, those plans with the out-of-network benefits, people are not opting for those plans much less than they were in the past. Which means you're talking to people about their out of network benefits, and so many of them don't have those benefits.

So if they're really honest, it sounds like a really bad sales pitch, if they're really honest, because they'll say, "I don't want to bother with your insurance. You can probably get this paid for if you go elsewhere. But I'm going to give you the super-bill, and if you have benefits of which you probably don't, your insurance will pay a fraction of this, but nowhere near usually the whole session fee. I mean, it sounds terrible, but that's the truth of it. So it's their responsibility, and therapists are really right, and all providers are who do this are right. It's the client's responsibility to know what their benefits are. But at the end of the day, the client ends up with hurt feelings because they went and submitted that super-bill, that wasn't so super, and the insurance company said, "No", and they went back to the therapist and the therapist shrugs his or her shoulder and said, "I don't deal with benefits, so thank you for the 130 dollars an hour."

Rebecca: You talked a minute about how somebody said, "Well, you don't want your insurance company to know about this... blah, blah, blah" There's an interesting -- I was in Manhattan recently and I was on the subway, and I saw a big sign and it had a woman's face, and it said, "Do you need counseling? No wait. No stigma. No health insurance", and what it was was a texting service basically, where this person guaranteed you that you could get help 24 hours a day, 7 days a week, and you paid an ongoing fee of 25 dollars a week. And I thought, "Oh, no. Texting." And so, I looked it up when I got home, and I saw that there was no assessment, there's no informed consent- there's just these people who you call. So what is your thought about that?

Anthony: I think I know that website. I've been to that website.

Rebecca: There's a couple of them, yes.

Anthony: I'm sure there's a few of them. I don't think it's great. That idea... You're right. There's a lot of important parts of onboarding an appropriate client and call 9-1-1 at the bottom of the website typically doesn't cut it. I mean, no, I don't think that's good. I don't think any responsible clinician is going to think that's good. Not to say, there's lots of creative things to do with technology, and a lot of them can be really good -- but that model right there? 25 dollars a month? It's like, "Wait, what are the limits on this? How much can I talk with a counselor? How is this going to work?"

Rebecca: And no informed consent.

Anthony: No informed consent. It just doesn't add up.
Rebecca: It doesn't. But since we started down the technology road, what role will technology play in counseling in the future?

Anthony: It will have an increasing role, of course. Right off the bat, I think electronic health records, electronic medical records, are going to become standard. I think at some point, everyone is going to have to use such a system, and you won't be able to run a real medical practice, including a counseling practice, without it. So I think we're going to see a wider adoption of that in years to come. When you do say technology and counseling, everyone thinks about online therapy; online counseling. And that's the segment that's been dear to my heart. I wrote my doctoral dissertation on that topic. I created an early online clinic in 2003, which I sold and I'm no longer part of.

But here's the thing with online therapy today, is that counselors love the idea of it. They love it. They get to work from home, it just sounds wonderful. They see all the benefits that clients could get. If there's not a therapist in the client's area, if the client is agoraphobic or is immobile -- and all of those things are true. But for the most part, clients have not been as zealous about online therapy as clinicians have been. For example, we have those 19 locations, we'll often get a call from someone outside of our market. So we have a few in Virginia, I think we get a call from somebody near Virginia Beach where we have no center. We will typically offer that person. We'll say, "Hey. Look, we don't have anyone in Virginia Beach." We start with 'Hey'. It's like, "Hey!" This is why I don't answer the phone anymore.

Rebecca: Could you just say, "Hey?"

Anthony: I just say hey, yes. I say 'hey' to the client. Then they're like, "Who is this guy?" So we don't have anyone in Virginia Beach, but we do have a number of therapists in Virginia who can see you. And we can do telephone, we can do HIPAA-compliant video conference, we can get you set up. We can get your appointment today. And I want to say 9 times out of 10, but it's more like 99 times out of 100 that client says, "Oh, thank you very much. I'm going to see if I can find someone in person. I'm going to find someone here that can sit down with me."

So clients aren't seeing that benefit today. They might see it in six months from now. People change what they want. But today, the very minority group of clients who are specifically interested in doing online. So what I advise to people who want to use this technology, is I say, "You need to have something so compelling that people are willing to make the sacrifice to see you over the phone or see you over video conference."

For instance, if you are the expert on single moms raising autistic boys, something like that, well then a potential client might say, "You know what? I don't want to go to some general therapist here in town. I want to go to her" or "I want to go to him because that's the person who is renowned on this topic, that's the person who I believe can help me because they have expertise in this niche area," and they will make the sacrifice of
seeing you online. I think that's the way you have to build an online base today. That said, as insurance starts paying for these services more, and that trend is already starting to happen, there's some issues with originating sites -- so there's a number of telehealth-friendly states, some which you can do telehealth, but the originating sites still needs to be like the counseling center.

So the client can go to the counseling center and the therapist can work at home, which makes no sense in most cases. Once they allow the originating site to be the client's home, I think we might see a lot of growth there, because people can be really sold on the convenience. "Hey, you don't even need to show up." and I think you can build that market. I think that telehealth is going to have a big impact as more therapy practices work to incorporate medication management, because there's such a shortage -- there's no shortage of therapists, but there's a huge shortage of medication managers, psychiatrists, practitioners. So we can pipe them in with video conference. You can have one supporting five different offices for so many hours a day. So that could be a good thing.

I think we're going to see more technology get wrapped up in the years to come. I think it's going to happen. I don't know, maybe slowly maybe fast. I'm going to say it's going to happen pretty fast.

Rebecca: And I had the great honor of interviewing Irvin Yalom at his home. And I was leaving, he said he was hopping on a video conference to give counseling to somebody in Ireland. And I thought, "How wonderful that this person in Ireland who has heard about him wants to see him and is able to see him."

Anthony: Yes. You hit the nail the head there. I mean, anyone is willing to make the sacrifice. I can see Dr. Smith here in town or Irvin Yalom by video. You'd choose Irvin Yalom every time, right?

Rebecca: Yes, let's go see Irvin Yalom and let's pay in cash and whatever we need to pay him.

Anthony: But yes, whatever he wants. Right.

Rebecca: 10 years out, what does the industry look like? I know that hopefully it won't be what I saw in the subway in Manhattan; hopefully it won't be “no wait, no stigma, no insurance, and we will text you 24 hours.” I hope it won't be that. Or if it's that, I hope it's with an assessment and informed consent ahead of time. But in your opinion, 10 years out, what does the industry look like?

Anthony: Predictions are always--
Rebecca: It's predictions, yes.

Anthony: Just predictions. Here are my predictions. They're fun, they're fun but you just never know, right?

Rebecca: They're fun, and you never know, yes.

Anthony: I think what we're going to see in 10 years out, I think we're going to see more bachelor's level and post-master's pre-licensed level providers providing the first level of care. This is happening to some extent in Europe now. So if you're dealing with a general anxiety disorder, you don't immediately go — to my understanding — to the Ph.D., you go to the person who's an intern and you do four sessions with him. And then if you still need additional treatment, then you get upgraded. So I think we're going to see insurance companies start to reimburse, to provide some sort of method at a lower cost for those level of providers to be the first line of defense for people who have non-life threatening issues going on.

I think that we're going to see some things pop up that are going to feel like tech support for anxiety. I can see insurance companies creating call lines, and the person on the other end will be trained, somewhat, might be this intermediate level, and they're going to use a call script. So you call in and you say, "I'm dealing with panic disorders", and they type in 'panic disorders' into their system, and while they have some advice to give you and they have some things to talk to you about, or if you say, "I can't sleep. I have insomnia." They have a thing about insomnia and sleep. I think we're going to see more of that. And insurance companies are already starting to do some of these.

I think 10 years out, my prediction might be wrong because it might be 2016 that we start seeing some of this -- Anthem just came out with their telemedicine service. United has just released their telemedicine service, and others have too. They have these Dial a Doc services, where instead of going to your general practitioner, they say, "Just call us!" and it's vertical integration for the insurance company. So they're becoming -- you're insurer and your health provider will...

Rebecca: What does vertical integration mean?

Anthony: What they're doing is, they're getting into a new field. Their industry has been ensuring people's lives and they're paying health practices when those practices utilize the client's utilize those services. Well, the vertical integration means they are now both the insurers and the people who provide the care.

Rebecca: Okay. What about, I'm a person who goes to a Massage Envy, and if people don't know about Massage Envy, there are offices all over the United States where you go in and you pay -- in my case -- 59 dollars for a session. And you pick out your massage therapist and you find somebody who's a good massage therapist, and maybe
it's trial and error -- and meanwhile, every time I go there, I see this one person who's very good, and I look at the twelve spaces that they have -- massage spaces that they have -- and I say, "Why can't this be 12 counseling spaces, where people pay less?" It used to be, if I paid a private massage therapist, I paid her 89 dollars, maybe even more. Here, I pay 59, you might have to do some trial and error, try a few people and find out who's good for you, but you end up with a good deal in my opinion.

What about this future of that kind of model?

**Anthony:** Rebecca, our industry is on the verge of a complete change in regard to what Massage Envy has done. So what Massage Envy and Massage Heights have done with chiropractor -- with massage -- and what chiropractic has done with the joint, and what emergency medicine has done with Doctors Express and MedExpress, which just sold to Optum Health for over a billion dollars and a bunch of others. And then dental did, a number of years ago to some extent -- that is about to happen in behavioral health. So all of these industries have changed in the last 10–15 years, and behavioral health is the one that has not yet changed. And I say yet, because right now behavioral health is severely fragmented, typically run by small 'mom and pop' practices. Some are very well run, some are not so well managed. And a lot of them are dealing with those things I said earlier where they can't afford to manage them.

What we're going to see, is we're going to see insurance companies get in the game, but we're also going to see investors get interested in the space and we're going to see some large players show up. Right now, if you were to ask someone, "Give me a brand of counseling centers", they might say Thriveworks and that's really exciting for me. But many would not, and many might -- they might have a name of a local practice in the area, but most are going to say, "Oh, brand of counseling center. I can't think of any."

And that's going to change. And what's going to happen is, therapists are going to hate them at first, because you're going to see them pop up. Mark my words, this is going to happen. And the first therapists are going to say, "This is the McDonalds of counseling. This is the end of the field." And they're going to hate them for that, and then they're going to hate them because they're going to realize that they can't compete; that the small practitioners can't provide the same level of care, they can't provide the same level of service, they're not doing evidence-based treatments as well as the other practices which involves money to find efficacy of their therapist.

They won't be able to offer the wraparound services like medication management, and you're going to see these brands come in -- and this is another prediction, but I know this one's going to happen -- and you're going to see a new level of professionalism and quality and standardization in the best sense in the industry. There's going to be some brands out there. I think that's happening.
Rebecca: I know. So I'm sitting there and I'm thinking, because I'm a counselor, I'm sitting there and I'm thinking, "12 rooms, 12 counselors", and I know because I've called and asked. I've called them once, I hurt my back at an exercise class, and I called and said, "Do you have anybody who could give me a massage?" They said, "No, we're completely booked." And I understand that they're mostly completely booked -- and they say people from 8 or 9 in the morning until 10 PM at night. And they see people on Saturdays and Sundays. And I wonder, when I'm sitting there, how much money is this place making? And my hunch is a lot, right?

Anthony: I couldn't answer that. I don't know if they're making a lot or a little. I'm not sure. But they're there, and they're still in business. I think Massage Envy has 1,500 locations. They could have way more, but --

Rebecca: 1,500, oh my gosh.

Anthony: It's ubiquitous. I mean, it's huge. And that's just one brand. I mean, Massage Heights is growing like crazy as well.

Rebecca: I see. Okay, so we have talked about the good, the bad and the ugly in here. We've talked about everything. And the next question I have is an important one. Is there hope for counselors?

Anthony: Yes. These changes could be really good for therapists. You think counselors have it good today? They don't have it good today. Too many therapists are underpaid, they're overworked, they're working in clinics where the paint is peeling off the walls and the furniture was paid for in the 60's. If you are in the unfortunate circumstance to have your masters, but now need your hours to get your license. Well, good luck, because so many people are in that position and there's literally nowhere for them to go get those clinical hours that they need for licensure. I don't think counselors have it made in the shade right now. I think that they struggle, and I hate that. And I think that counselors are going to be more than okay. I think a lot of these changes, for those who want to be clinicians, I think they're going to do well. I think they're going to benefit from a lot of these changes, frankly.

Rebecca: Yes. I mean, if you had 40 counselors and you had a Massage Envy type model, then it would be cheaper to get everything for those including health insurance and all kinds of benefits would be possible, I would think.


Rebecca: Yes. Well, my last question for you, and this is really a wrap-up question is; ACA now has over 55,000 members, most of whom are clinicians, is there anything I have not asked you that you want our members to know?
Anthony: Counseling has such a bright future. We've talked a lot today about change. I'd say, do not fear the changes that might be coming. Mental health is a field that people are excited about, not just in our industry but those outside our industry. Clients are excited about it, the stigma of counseling has never been lower and it’s really, really going away. Communities are invested in mental healthcare, politicians are invested in mental health care. Investors are even interested and invested in the growth of our field. I think we are on the cusp of a very positive and exciting time for us.

Rebecca: I agree with you. Well, I want to thank you so much, Dr. Anthony Centore for joining us today to discuss the future for the private practice clinician. To view links to this program, to write to the presenter or the host, please go to http://www.counseling.org and click on the podcast page. This is Dr. Rebecca Daniel-Burke, your host for the ACA 2015 Podcast Series, signing off.