Episode 29 – Brightline: Bringing pediatric mental health into focus

[THEME MUSIC]

NAOMI ALLEN: The headline that I most would love to see in five years is, "The kids are all right. Brightline's Behavioral Care and Technology greatly reduced the youth mental health crisis for over 50 million families."

NARRATOR: Welcome to the "Cure for the Common Co." a podcast series looking at innovations in the world of employee health and wellbeing. Steve Blumenfield and other experts from Willis Towers Watson's Health and Benefits practice are talking to entrepreneurs and industry leaders who break ground to meet the needs of today's workforce and deliver benefit solutions that can separate employers from the pack.

STEVE BLUMENFIELD: Hey, Naomi.

NAOMI ALLEN: Hey, Steve.

STEVE BLUMENFIELD: Hi, everyone. And welcome to the Cure for the Common Co. podcast. This is Steve Blumenfield, Head of Strategy and Innovation for Willis Towers Watson's Health and Benefits business in North America. Today, I'm excited to talk about Brightline, the leader in virtual behavioral health care for children, teenagers, and their parents and caregivers. Welcome, CEO and co-founder Naomi Allen, to the podcast.

NAOMI ALLEN: Great to be here. Thanks for having me, Steve.

STEVE BLUMENFIELD: And thank you for being here with us. I'm also joined by one of Willis Towers Watson's physician thought leaders who's also deeply engaged in mental health, Siupo Becker. Welcome, Siupo.

SIUPO BECKER: Thank you, Steve. And wow, I'm a thought leader.

[LAUGHTER]

STEVE BLUMENFIELD: You are my thought leader, for sure.

SIUPO BECKER: (LAUGHING) Thank you.

STEVE BLUMENFIELD: Thanks so much for being here, Siupo. Naomi, to kick us off, tell our listeners a little bit about yourself and what led you to start Brightline.

NAOMI ALLEN: Thanks, Steve. I'm a serial entrepreneur. This is my fourth early-stage company. And while I was the chief growth officer at Livongo a few years ago, my oldest son had an experience with acute onset

anxiety and a number of other things. And as a family, trying to get high quality, accessible care for him was an incredibly hard journey for us. We spent months on wait lists. We were willing to cash-pay for care, but we couldn't find anyone. We didn't know where to start to navigate the care system. We weren't getting support from his school.

And I looked around, having spent 15 years of my career in digital health startups, and I realized there was literally nobody solving the pediatric behavioral health challenges that every family faces when they have a child going through things. And this is pre-COVID, Steve, so we just got really lucky in terms of touching on a massive area of need and a really broken care delivery system and, as it turns out, at a really opportune time, where families are recognizing that need more than ever.

STEVE BLUMENFIELD: Thank you for sharing that story. And I'll do a little bit of the same. I wish Brightline were around about 10 years ago, 15 years ago, because we went through a debilitating crisis that ended up with one of our children being in residential treatment for a number of years. And the time I spent fighting with health plans who were well-intentioned, local governments, school systems, especially when we moved from state to state, it just made you realize that in moments of crisis, the system isn't really built around the needs that children and families have. So maybe, Siupo, you could give us a little bit of the background and context for why we are where we are.

SIUPO BECKER: Thank you for sharing your stories, you guys. And that makes me so sad. And it just brings home that when I share these stats with you that are just generally depressing, know that moving forward, we're going to talk about solutions. So, in terms of in what bad shape we are with child and adolescent mental health and getting them the help they need, I will tell you in the U.S., nearly one in five children have a mental, emotional, or behavioral health problem in a given year. And only 20% of those children are receiving care. 50% -- half -- of all mental illness begins by age 14.

STEVE BLUMENFIELD: Yeah. Sobering.

SIUPO BECKER: I mean, these are all so scary in terms of statistics. And really, the question is -- I mean, it's gotten to the point where, with COVID and everything else, it's just brought home how severe the shortages in pediatric and child adolescent psychiatrists are, how the provider system is taxed, how children are really experiencing more and more issues. I mean, the leading cause of death in that age group -- I think it's the second leading cause of death -- is suicide. Right, Naomi?

STEVE BLUMENFIELD: It is. Yeah.

SIUPO BECKER: So I mean, I'm excited to hear about Brightline and exactly what they provide, the solutions they provide, and then how they work with this population. Because I know in my training, everyone kept bringing home to me, they kept on saying, children are not mini adults, and you cannot treat them that way. And I think the stance across the board, so love to hear more, Naomi.

NAOMI ALLEN: Thank you, Siupo. Well, I will also just say, knowing that probably quite a few listeners in the podcast are benefits executives and HR executives, I think the other piece that kind of ties together Steve's example of the challenges his family went through and your comments about the prevalence and how common this is, Siupo, is that the experience for working parents, if you have a child with either an under-supported or under-treated behavioral health condition or actively in treatment, is just it's an incredibly highly stressful and high-impact experience.

Parents and caregivers are much more prone to anxiety, depression and massive productivity losses while they're going through these types of things with their kids. So, it's incredibly important that we solve this as a country for the future of our children, but also, as employers, think about the future of their benefits offerings. We worked with Harris Poll, and we conducted an independent survey of 500 families, and one out of five working parents said they've quit their job in the past year or plan to quit their job in the coming year to better manage their kids' behavioral health needs. So, we have a--

SIUPO BECKER: Wow.

NAOMI ALLEN: -- crisis right now in terms of the children's care and what they need. But we also have, I think, a real crisis in a time of incredible employment turmoil. And we did a very simple survey a while back, and we just asked the question of working parents, if you had to pick between a mental health benefit for yourself or for your children, what would you pick? And 75% of working parents would pick a mental health benefit that was in service of their children even over their own mental health benefits. And so, I think that really speaks to just how much awareness there is that we're in a stage of unprecedented need for pediatric mental health that's largely been unserved up to this point until Brightline existed.

STEVE BLUMENFIELD: There's a massive family toll, so this is a family need. And let's talk in a minute about that. It's also a giant cost driver. I mean, pediatric dependent care for mental health is a massive cost driver and something that's, frankly, unaddressed by many solutions. So, you mentioned the impact on the family and how people obviously care about their kids. How did that factor into what you designed? And then maybe after that, we can lead a series of questions into what exactly the solution is. But what's the family component?

NAOMI ALLEN: Yeah, great. I think one of the core principles for Brightline is we worked backwards when starting by asking families what do they need. What are the key challenges that they've faced? And it's all the stuff you might expect in terms of affordability, access, but also unique to pediatric behavioral health. Families often feel lost. They don't know where to start. They don't know, does my child need a therapist? A psychiatrist? Is what they're going through really clinical, or do they need just a little bit of coaching?

And so one of the most fundamental things that we started with was this principle of creating multidisciplinary care models and having care that families can access if they need a little bit of support all the way up through quite a bit of support. And so we have a way to support families that need therapy for their kids, medication support, speech-language pathology services, but also families that just -- maybe their kid's getting school-based counseling, and families need a coach to help navigate the care-navigation side of that. So we have robust coaching programs as well.

That was all, basically, just in response to families coming to us saying, we don't know what we need, and it evolves over time with kids. Steve, I don't know what was true for your experience, but for my son, we got him pretty stable around his anxiety. And then during COVID, we obviously had spikes again and a whole bunch of different disruptive behaviors. And that's pretty common for behavioral health for kids, is you need to create a system of care that families can tap in and out of over time as their children's needs evolve and change, and they need, essentially, booster sessions for support.

So all that was just built based on what families told us. And then the accessibility and convenience, we really focused from day one on creating in-network rate structures for Brightline with insurance companies just so it would be affordable and convenient for families. And building a virtual-first platform, 75% of the counties in the U.S. don't have a single child or adolescent psychiatrist. About half the counties--

STEVE BLUMENFIELD: Let's just stop there. Say that again.

NAOMI ALLEN: (LAUGHING) I know, I know. 75% of the counties in the U.S. don't have a single child or adolescent psychiatrist.

STEVE BLUMENFIELD: Three-quarters.

SIUPO BECKER: It leads to bad care.

STEVE BLUMENFIELD: Yes.

SIUPO BECKER: And that's what's even worse, and that's what I appreciate about Naomi and Brightline. It's because what I have seen time and time again are parents don't know what to do, so they send their children away because they just don't know what to do anymore. And then the family is not part of the solution. They're totally cut off from their child. Or, you guys, I've seen these beautiful destination centers that I would love to live in. Right? Where, like for an eating disorder -- you guys, I'm not kidding. I saw this.

As a sign of the child being well enough to be discharged, if you have an eating disorder like anorexia, you had to take part in a pie-eating contest.

STEVE BLUMENFIELD: Oh my gosh.

NAOMI ALLEN: That's wild. Well I think, certainly, desperate times have called for desperate measures, and families that are seeking any type of support have had to cling on whatever they can get. In many parts of the U.S., that looks like medication for kids as young as 5 years old. And what we know to be true is without behavioral health support with that medication, kids are just on meds for many, many years. And they stop being effective, and it leads to more acute mental illness. And so we believe that scaling virtual care into these mental health deserts across the country is also just one of the only ways to really change the health care system.

So we're really excited about what that means. And I think the other piece, that was less driven specifically by families, but driven very much by what science tells us, is when you're treating kids, you have to use what's called a dyadic care model or family systems model. And so you can do a bunch of stuff directly with kids in therapy or speech or medication, but wrapping the parents and caregivers with the tools and the knowledge and the interventions that they should practice with their kids just makes care much more effective and stickier.

And I think about what I've seen in my own family. My husband and I were contributing to some of the anxiety that my son had. And when we learned the tools for how to help him with his cognitive reframing exercises, with managing his anxious moments in the moment, with reinforcing what he was learning in his own therapy, it changed the game for us. And so scaling that dyadic care model, I think, has been also a really big part of what we believe really helps deliver great care at the right level of dosage so that we can scale care across the country.

STEVE BLUMENFIELD: Well, mental wellbeing and mental illness is infectious in a family, to say nothing about the whole parent-child relationship, where you're fundamentally the source of growth and nurturing for the child. Beyond that, just the exposure. In our experiences, the ripple effect through our family, it affected every single person -- I won't get into it too much on the pod, but -- for years.

And some, in some ways, still affected. So let's just talk about how you actually scaled this. Tell us what the solution is. I think folks have a general sense of it, but what exactly the experience is like for the member who has a need. How do they start, and what happens next?

NAOMI ALLEN: Yeah, great. So we have three offerings that work as a system of care delivery. I think what folks need to know is we hire -- and we're not using a 10 and a nine kind of contract network -- we hire, we train, and we manage our entire clinical staff and our coaching staff. We have a care delivery system, an engine of Brightline-trained clinicians and coaches. And the way that those are accessed is families can come through their employer or through their health plan and create an account on Brightline.

It's hellobrightline.com. And they have access to over 200 content pieces and digital interventions just by creating that account. And what they do is they'll tell us why are you here and the age of their kids, and then we personalize an entire experience for them.

STEVE BLUMENFIELD: So let me just pause you on that to clarify. When you say they get online, so is this something they do on their phone? They have to have a computer for it? They go through the company's portal? What is that experience?

NAOMI ALLEN: Yeah. They can do either. So it's mobile-responsive web now, so they can do it on a laptop, on their phone, on a tablet, whatever is most convenient for them. And they create a Brightline account, and here's what's super interesting. The average family that comes to Brightline identifies seven things they need support for. Seven things. And I think that just speaks to how challenging these times are for families. We support kids as young as a year and a half up to age 18.

And so depending on the age of the child or children and what the family comes to us with, then we create a personalized experience for them. So for some families, they may just use some content. That product is called Brightline Connect. They may join a webinar. If I'm the parent of a child with ADHD, and I want to hear how other families are coping with that, some skill building there, they could join a groups webinar. And that may be all they need. Very light support, self-serve, some interventions, some content, a webinar here and there.

But always, families can also access on-demand one-on-one coaching or one-on-one therapy. And so we help families schedule that. We have a two- to three-day wait list, so you can get into coaching or therapy very quickly. And what's very common is families don't know what they need, and so we also use an assessment tool, which is the same thing that's used in a developmental pediatric office. It's called the PSC-17. And we can help families go through an assessment to figure out what's right for my family.

Coaching is really an interesting aspect of Brightline because we've built and delivered 20 different coaching programs that are protocolized. And so it's really great for short-duration skill building for families that may not have the need for a full clinical diagnostic pathway. Going back to your question around how we built this in response to family need, we heard last year, when we launched services, about a third of families that came to us said, I love what Brightline is doing, but I don't need six months of therapy for my kid. What we really want to do is three to four weeks of skill building around how to manage their anxiety with going back to school.

So we don't think that the child has clinical anxiety, general anxiety that would require a diagnosis and multiple months of CBT, but they need some real skill building. For many families, all they need is three to four weeks of coaching using a protocol that's built on an evidence-based behavioral health protocol. And then some families need a full course of therapy, and that's when we would do a more robust care model called Brightline Care. We would do a clinical intake session with the parents or caregivers to collect the family history, also with the child.

We would get the right of information to communicate back to their pediatrician if needed, and we would also collect all the eligibility information if we need a supportive medication protocol. And then they're on a four- to six-month care protocol that's measured and evidence-based as well. So it's really super interesting because all virtual, and families can flex in and out of what they need. And if they know what they need, they can go directly to that care level. It's not a step-care model. They can get straight into therapy if they need it. But if they don't know, then we can help them figure that out.

SIUPO BECKER: That's fantastic, Naomi, how you can take one child member, and as their disease worsens, you can move them into different modalities so that you still work with them. But I was wondering, you said that you have short turnaround times for those members who are so ill to get in to see someone virtually. What is that time frame to see a therapist or a psychiatrist?

NAOMI ALLEN: Yeah. I will say, it's a little bit different for a psychiatrist than therapy, Siupo, and I'll tell you why. But our typical target wait time is two to three days to first appointment.

SIUPO BECKER: Wow. That's really good.

NAOMI ALLEN: Yeah, thank you. And I think we staffed really high levels in order to make sure we're maintaining that. We keep a very close eye on it. What's interesting with respect to medication support, whether that's psychiatry or other prescribers, going back to the previous conversation of how common it is now for younger and younger children to only have medication, we made the decision in our care model to support medication, but for families that are already in a behavioral pathway. So we specifically -- right now, if you need medication support for your child, we do that concomitant with therapeutic support. And that's because really getting to the root cause of what's going on in the child is so critical to the long-term care and wellbeing.

STEVE BLUMENFIELD: How do you achieve that? I mean, that's, I think, the dream. But that's so hard to do in brick-and-mortar situations because there's no relationship between the therapist and prescriber. Might not even be one of each. So what do you do that makes that easy?

NAOMI ALLEN: Yeah, Steve, that's such an insightful point because we do know that's one of the bigger friction points for families, is this sort of challenge of I start with a therapist, and it turns out they want to refer me for psychiatric support, but I have to wait six more months to get into that care. And families just kind of fall apart during that problem, and so that's why we create a multidisciplinary care team. So the way it works, practically, is during that first intake appointment, we are conducting an assessment and a family history and identifying what the child needs.

And if they have a need for medication support, we use clinical screeners. So let's just pick ADHD. For a child that the family and the clinician think might have ADHD, we've digitized the standard assessment form there, which is called a Vanderbilt Type 2. It's a dual-report assessment tool. The family will complete it, and we'll have a teacher complete it, and depending on what comes back, we're determining does that child have a level of ADHD that can be managed through behavioral support, activities of daily living, working on routines, ameliorating, really working through nutrition.

Is it a relatively mild to moderate case, or does that child also need medication support? And if so, we do a medication evaluation appointment, and we layer that into the child's care plan. It's all based on clinical assessment tools and clinical acumen. But we have staffed a care model that allows us to do in-house referrals for medication support as well.

STEVE BLUMENFIELD: What if somebody has their own therapist and wants to use Brightline for psychiatry or vice versa? Is that something you can accommodate?

NAOMI ALLEN: Yeah, we can accommodate it. We do a consult with the outside clinician just to ensure there's continuity of care, because what we want to keep a close eye on is if something's happening in the therapeutic experience, the prescriber needs to know that, and vice versa. So that's absolutely part of it. Our chief psychiatric officer, Dr. David Grodberg, was the head of the Yale Child Study Center for many years.

And a lot of, frankly, the innovation around best practice multidisciplinary care delivery was really pioneered at Yale. So there's a lot of just remarkable ways that you can do these care team in-house consult models. But it takes using a really robust set of workflows and protocols internally that are tech-enabled to make that work.

SIUPO BECKER: Naomi, I was wondering, when you were talking about ADD and ADHD, and we know how often that's diagnosed now and how many members are on medications. Do you have any stats on how many children you're able to take off of meds? And I think that's great that you're actually looking at that.

NAOMI ALLEN: Thanks, Siupo. We haven't run the data yet of how many kids we can completely move off of medication because we're still pretty early in terms of the longevity and the claims history there. What we do know to be true is we can greatly reduce polypharma, which is the use of multiple medications, and we can greatly reduce the use of the wrong dosage because we're following the American Child and Adolescent Psychiatry medication protocol.

So we're using a protocolized approach to treatment duration, stepping up treatments, dosage, as well as protocolized approach to when you use one medication versus layering them on. So I think what's super important to point out is, frankly, the concept of combining behavioral and medication support is already groundbreaking, but the other piece that's sadly groundbreaking here is the fact that we don't just do the med eval, but we do the titration and the ongoing maintenance.

And so we're keeping an eye on the overall life of the child with a care plan and checking in of how is the treatment evolving, has the child's weight gone up. With some of these ADHD medications, there's variability in weight, which impacts the appropriate dosage. And so there's an entire difference in terms of you get prescribed once at a pediatrician's office, and then you don't talk to them for a year versus having a coordinated approach to medication-enabled therapy and the ongoing oversight and management of that, over the life of a child.

SIUPO BECKER: And again, they are not mini adults. (LAUGHING) So that's why it's so complicated.

NAOMI ALLEN: So complicated.

SIUPO BECKER: I was wondering too, when we talk about family dynamics and how family dynamics play into a lot of these behavioral health issues, it's a little bit more complicated in what you're offering, isn't it? Because the parents are the ones who have to give consent to work with the child. So what do you do to really work on maintaining that autonomy and respect for the actual person you're treating?

NAOMI ALLEN: Yeah, this is such an important insight. And I will say, if you talk to any early adolescent or teen, what's remarkable, and I think exciting and positive for the country, is that there's a lot less stigma for those adolescents and teens in terms of seeking out support. it's much more commonly discussed now than it was even my generation. But what's even more critical than ever is they want privacy and autonomy in how they do this.

And the mechanics of, like, how do I approach this, with whom, I want very relevant content and guidance and coaching. I want near-peer support. So it's a very different care model than what you see for adult care. And what we've had to do is a few things. And I will say, I think we're on a journey here. I think reducing health equity gaps and then really effectively supporting the next generation of youth are work that we're going to be doing for the next 10 years at Brightline. Like we're never going to be done. It's almost this never-ending need for improvement here.

But I'll tell you what we do now and what's on the horizon for us. What we do now is when we built the company and we launched last year, we actually launched with young kids up to age 10 first because we wanted to spend months getting the data architecture, the consent, and the privacy right. And so we actually launched our product for teens much later. We launched at the end of last year, and it's because you do have to have a very different data architecture. Partition that data so that they have a right to privacy, they can chat with their own coach, they can talk to their own therapist, and the family, the parents and caregivers and guardians, don't have access to the details.

So in Brightline, above the age of consent, and when somebody turns, on their birthday, they have to sign a new consent infrastructure and then actively have ongoing consent that they are getting treatment through Brightline under their parent or caregiver's health plan. So parents and caregivers are aware that their adolescent or teen is getting treatment because it's part of the plan design, but it's a private experience for that adolescent or teen. That's what we spent a lot of time on architecting.

And what we're doing right now is we've stood up a teen council that's very deeply advising us on the types of programs they want, the types of coaching they want, how they actually want the product experience to look and feel for them. Not surprisingly, teens like a lot more sort of short-form content, on-demand access, text-based messaging on their own terms, and so it's a very different product experience. And we're in the midst right now of reorganizing a lot of our product features to really map to their needs and preferences but always in the context of privacy, consent, autonomy, which is, I think, just a fundamental core pillar.

There's also, frankly, just a lot of different programming and content that teens want. So we're launching in Q1 teen-specific coaching programs for LGBTQ youth that have increased rates of anxiety. And we have another program that we're launching for BIPOC youth that have increased rates of risk of depression and suicidality. So pretty massive pushes on the type of programming that teens have asked us to build. That's all work that we're rolling out in Q1.

STEVE BLUMENFIELD: Wow. Yeah, I can see how this never ends. If you've had teens, you know that the needs change often. Let's just put it that way. Let's talk a little bit about the benefit itself because it's a really complicated and fascinating time in the world of mental health benefits. Five years ago, 10 years ago was very, very different. 10 years ago, you had your EAP, maybe your mental health carve-out network. You go to your health plan, you try to find someone on your own, and oftentimes, the need isn't met.

Over the last several years, we saw a number of solutions infiltrate the market, from resilience to navigation to virtual networks. And then we saw these end-to-end solutions arise, like Lyra in spring and Ginger and all of the others, Modern, Meru. They keep coming, right? They just keep coming at us, and this is a great thing because there's absolutely massive need out there. What does it mean for an employer who's thinking about

how to navigate well, I've got an EAP, or I've got this next-gen EAP that also has virtual care in it. How does Brightline fit in?

NAOMI ALLEN: Yeah, great question. I think that what's great is that over the last decade, I think that the awareness that you can scale highly accessible, high quality virtual care to employees, that awareness -- the market's there, which is great. If we'd tried to start Brightline a decade ago, it would be a very different conversation right now. So I'm very grateful for the adult-focused behavioral health vendors that have really carved that path. I think what we hear often from employers -- and be curious to hear if you hear this as well, Steve -- is just so much fatigue from vendors. And so when we started Brightline, we spent a lot of time with employers through some great partnership work we did with EHIR.

And what we heard, almost down to the last employer we spoke to, is we don't want to manage another vendor. We love this idea of a behavioral health solution for families. We don't get that from the adult BH vendors. Even the ones who are trying to kind of enter into the teen space have not designed what Brightline's done in terms of this very bespoke dyadic model with a real focus on family systems and measurement care. We just don't want to pay directly for it. Can you please, please go to our health plans and get this running on our claims infrastructure so that health plans are the primary conduit for that relationship?

And so I think we're really fortunate in that we're tapping into a point in time where, I think, employers and benefits buyers and executives, their mindset is shifting where they recognize they need to be providing more benefits for the employee as a member of their family, whether that's a benefit for caring for an adult member of the family who's a senior that's aging, or whether it's a child care benefit for a young child. So benefits executives recognize that their employee lives in the context of their broader family, and so they realize, I think, this need for a pediatric behavioral health offering, they just don't want to add that as yet another carve out on top of their carved out EAP that they have to create budget for.

And so we've found that by really partnering closely with the health plans providing Brightline as an in-network benefit and then going to the employer to create enrollment marketing journeys and raising awareness for Brightline, that's been a really natural go-to-market for us. So they get all the value of adding Brightline into their benefit design without the work of having to manage another carved out EAP vendor. So I think our go-to-market has been part of what's made this a relatively fast-growing benefit in this space.

STEVE BLUMENFIELD: So let's break that down for a second. When I think about -- I'm going to use the term "point solution," it may not apply perfectly here -- but typical point solutions get rolled out in companies. They may be available through the health plan or PBM virtual formulary or through Castlight, where you co-founded [LAUGHS], or some other kind of hub or platform solution. And then they're making a decision, and there's a payment associated with that.

And now, you're talking about Brightline being available through the health plan and through claims, so is there a decision that the employer needs to make or a contract that they need to make? I'm envisioning the conversation, and I could see an employer saying, wow, this is great. Oh, it's in-network already? OK, so I'm not sure I'm involved. So go ahead. Go help my people when they come to you. What's the piece for the employer?

NAOMI ALLEN: Yeah, great question. It varies a little bit by health plans in terms of how they structure specialty solutions like a Brightline. We're just in-network for everybody, so there's no decision or action that an employer needs to take. In those cases with those plans, we still ask the employer to help us raise awareness for Brightline by allowing us to do enrollment marketing, which means we'd like to get email addresses or home addresses so that we can just increase awareness for Brightline.

STEVE BLUMENFIELD: So to clarify, for that situation, you're calling on the employer and/or their benefits consultant. This is a great benefit. It's actually in-network with your health plan. It's so important that we'd like to recommend you do a campaign --

NAOMI ALLEN: That's right.

STEVE BLUMENFIELD: -- to promote it. So no cost to you, but we'll do that campaign for you. So you are going to the employers, and that's the message in those cases.

NAOMI ALLEN: Exactly. It often will go to the employer with the health plan. I mean, the health plans put us in-network because the employers asked them to. I do think there's some really innovative health plans --

STEVE BLUMENFIELD: Certainly for a while, that'll be the case. Right?

NAOMI ALLEN: Yeah.

STEVE BLUMENFIELD: But at some point -- yeah, yeah.

NAOMI ALLEN: Recognize that they're -- yeah. And then some health plans are like, yes, we understand --

STEVE BLUMENFIELD: Fair point, fair point.

NAOMI ALLEN: -- the national crisis.

STEVE BLUMENFIELD: We brought them in for you. Yeah, OK.

NAOMI ALLEN: Yeah, totally.

STEVE BLUMENFIELD: I get you.

[LAUGHTER]

NAOMI ALLEN: I think in many cases, they have a large portion of employers that have heard about Brightline through colleagues or through our work, in terms of creating awareness. And those employers reach out to their health plans and say, hey, we love what Brightline does. Will you please put them in-network? Like that's kind of how that happens. And so what happens for us when we get a health plan contract signed up is, typically, we've got between five and 10 employer customers that are waiting for Brightline.

And so then, once we kind of sign the dotted line with the health plan, we go back to those customers, we craft a joint enrollment marketing plan, sometimes they will sign a data-sharing agreement with the health plan so that we get the data directly from that plan. They don't have to send us a separate employee email file with addresses and eligibility, et cetera. And then, we're off to the races. We run. We have a whole enrollment marketing team. It's backed by data science, so we know which campaigns are high performing in which targeted markets, et cetera. And so we can run that directly on the employer's behalf.

And then we do have some health plan relationships where the employer has to consent to add Brightline as a benefit. So it still runs through the health plan network rails, but the employer has to agree to Brightline as an added benefit. So we've got kind of both, and in both cases, it's a pretty streamlined process. The employer doesn't have to manage us invoicing them, or go through a separate information security process, or handle giving extensive legal rights to us.

But in some cases, the employer has to notify their plan to add us as a benefit. So it's pretty straightforward for the employers, which I think is kind of-- [LAUGHS]. If I were to say, if there's any entrepreneurs out there listening that are thinking about building solutions and digital health selling to benefit executives, just making it dirt simple for those executives to add your benefit, I think, is one of the keys to the game here.

SIUPO BECKER: You know, Naomi, when I think about benefits and how it impacts employers, and then I started thinking about there are certain members that you'll be working with. What do you do with the children that you're working with who are starting to hit that adult age, and they're hitting that upper limit of

your program and what you offer? How do you transition them into the other behavioral health solutions of the employer?

NAOMI ALLEN: Yeah. Great question, Siupo. So with both employers and health plans, we can collect a whole bunch of data as part of our implementation around who are their preferred partners. And so that's true for kids who are aging out of Brightline but just also true for kids who may need additional specialty care. If we're seeing a teen, they've got anxiety but they really need a specialized program for an eating disorder, we can refer them based on the preferences for that plan and that employer. And then we do maintain an entire referral process for either kids who are aging out or that need specialty care.

SIUPO BECKER: Great. Thank you. There's so much that you're offering here. I assume that when you also get additional information about what the employer has available, that's also so that you can help to ensure that family members are getting directed to care too, at the same time.

NAOMI ALLEN: Siupo, this is important, and thank you for raising it because I--

SIUPO BECKER: OK, good.

NAOMI ALLEN: I haven't thought to mention this. But one of the things that I think is so true that we talked a little bit earlier -- and Steve, you made this point around contagion within a family, which I've never thought of it that way, but it's so accurate -- is that kids get better when their parents or caregivers or guardians are doing better. And so we actually measure, also, stress in the parent and caregiver intermittently. So when we do an intake for a child, we're collecting information about how the guardian and parents are doing, and then we measure that also throughout care so that we can see if there are spikes in their stress level or decreases.

And so with all of our employers, when we get ready to implement them, we're offering, do you want us to coordinate that family back to your adult BH vendor, back to your health plan care manager, if that adult needs their own behavioral health services. We don't provide those. We do child and family systems work. And I think what's super interesting is just the number of adults who themselves would really benefit from having their own behavioral health support. And so we do have the ability to track that and make recommendations for families for the adult care as well.

SIUPO BECKER: Yeah. I think that's so important because that tends to be, sometimes, what's missing in that whole dynamic, because, as Steve and you both have said, it impacts everyone in the family. Do you end up taking care of like multiple siblings in a family sometimes?

NAOMI ALLEN: Absolutely. And the other thing that we've seen that I think is so interesting is we'll have, in some cases, children who are getting therapy, but their parents or caregivers need coaching. Because a lot of our coaching programs can be for the parent or caregiver themselves in service of the child's wellbeing. And so we see lots of families where there's multiple family members that are using Brightline in different ways.

STEVE BLUMENFIELD: Yeah. I mean, you are indeed providing care to the family, even if it is under the auspices of helping the child in their therapy because you're helping the family to do their part to raise this child in the right way. It really is a beautiful model.

NAOMI ALLEN: Thank you. It means a lot. It's funny, when my husband and I were first starting to navigate my son's care journey, we were also just on really different pages. My husband grew up overseas in the Middle East. He's four different racial and ethnic backgrounds. He came from just a much different cultural context around how to think about mental health and how to talk about it. And he carried a lot more stigma around it, frankly, than I did, and it was just an incredibly hard journey.

And if we'd had a Brightline coach to help us navigate how to think about approaching, you know, how do we talk about it in front of the kids, and how do we talk about it in front of our son so that he feels supported and

not stigmatized, how do we talk about it with my in-laws. Right? It's just there's so much stuff there that families go through.

STEVE BLUMENFIELD: Oh, I know. I mean, my first experience with anybody that I would call, maybe, counseling was when a police officer showed up at our house.

SIUPO BECKER: Oh, Steve.

STEVE BLUMENFIELD: And my son was only 10. He'd been raised in an orphanage until the age of four, so couldn't blame him for his life experiences in a country without care. He'd been through hell. And he was trying to adapt, and his brain just wasn't capable of all the things that were being asked of him. And, thank god, no one got hurt, but we didn't realize because we were the proverbial frogs in the boiling pot. And the things we were doing -- the neighbors could see there was something wrong, and my wife would take it on herself.

She would say, I'll deal with him to protect the family and so we don't embarrass the family -- because she came from kind of a background where you had to do that -- where I was like, we should get help. And no one knew what to do. So to your point, the whole family, by the time they're reaching out for help with a child, most likely has experienced problems in school. They've experienced, for sure, problems at home. There may have been hospitalizations.

There may have been a number of things, but they didn't know how to start. And that's actually something I'd love to just ask you about. How do you make sure the information is out there? What does a good marketing campaign look like? And how does it affect those numbers that Siupo talked about at the outset of the podcast, the lack of people getting care?

NAOMI ALLEN: Yeah. First of all, thank you for sharing your story. And it so moves me that families are able to talk about these experiences because I think it just raises the opportunity for any family to talk about it. So thank you for that. It's deeply moving. And just what drives me literally every day is this idea that that moment, somebody is in Brightline, and just the light bulb goes off for them, and they start to see their kid get better versus like all the months or maybe years that came before it.

So Steve, on the question around what does a great awareness look like, there's kind of the air war and the ground war when it comes to raising attention for things like Brightline. So grateful to you both and for this podcast to help elevate the air war of just awareness. And I think for employers, as they think about implementing a Brightline, that they feel inspired not just to add this as a benefit, but to help us help engage their employees around it through enrollment, through awareness.

The best experiences are when an executive also speaks about their journey and why Brightline would have helped their family or tells their story. That is, I think, probably one of the biggest drivers that employers can do to really help change the game -- not just for Brightline, but for any mental health benefit -- is executive sponsorship and championship within an organization. What we do is build custom campaigns that try to really reduce stigma, try to really reflect diversity of employees.

You go to any of our marketing materials, we're trying to reflect racial diversity, ethnic diversity, diversity in family structures. Some families have two moms or one parent only, or a child's being raised by a grandparent. And so making enrollment a very positive experience, talking about support, talking about helping families in various ways. We don't talk about treatments or diagnoses, we talk about the most common family challenges so it really normalizes how frequent it is that a family has a challenge.

It doesn't have to mean that your child needs therapy with a big, scary capital T. And so we do a lot of work around that. And then just, obviously, on the back end, we do a lot of measurement of what types of enrollment journeys lead to people engaging so that we can amplify those enrollment journeys and meet families where they are. So I think the other piece that's super interesting about mental health that I learned -- when I was at Livongo, we bought a mental health company.

And one of the things that I learned that's true for any chronic condition, but especially true for mental health, is you have to be front of mind for people throughout the year. Because for a lot of families, especially with families with kids, it may just be the wrong time. It may be that we're about to start baseball season, I can't get to this. Or one of my kids is acting out, I can't deal with the other one.

And so it may just be that the timing is really tricky, but that if you do an enrollment campaign two months later, they're in a better headspace where they can carve the time out to enroll their kids, or their kids have settled down and they can start a therapeutic pathway. And so we also just really ask employers to kind of give us a chance to do campaigns throughout the year, not just like one time in open enrollment, so that we can be front of mind when families are seeking support. And that just happens at different times for different people.

SIUPO BECKER: I was wondering, you know how marketers target kids because they want to sell the product, so they go behind the parents' back, and they specifically target the child.

STEVE BLUMENFIELD: [LAUGHS]

SIUPO BECKER: So I mean, do you use social media in some of your campaigns as well, knowing that it's the exact opposite? You're not selling a good, you're trying to help explore an issue.

NAOMI ALLEN: We've used social media more targeting the parents themselves because in most of our cases, the parent is the driver for taking action. And so we do use social media. We haven't done extensive social media campaigns targeting teens, per se, although, certainly, there might be value to that. I think the main reason, honestly, Siupo, it's just practically speaking, we started with a direct-to-consumer offering, but we're increasingly an enterprise business, first and foremost, to health plans and employers to bring Brightline to their employees.

And so we just find that avenue of partnering directly with the employer is a more effective avenue than social media general marketing. That being said, and we do think a lot about how many kids out there are not covered by commercial insurance through an employer. There's massive, massive need right now in the Medicaid population.

STEVE BLUMENFIELD: Absolutely.

NAOMI ALLEN: So we are actively talking about developing school-based approaches to marketing and enrollment and support for the Medicaid population, so that's a very active thread of discussion in our company right now.

STEVE BLUMENFIELD: Well, let's go to a lighter note.

NAOMI ALLEN: Let's do it.

STEVE BLUMENFIELD: If Brightline were a mythological creature, like a Greek or Roman god or goddess, what would it be?

[LAUGHTER]

NAOMI ALLEN: I love this question. And I've literally, in, now, 15 years of digital health discussions and interviews, never been asked it. So this wasn't really --

STEVE BLUMENFIELD: [LAUGHS]

NAOMI ALLEN: -- keeping it real and keeping it fun. So we think that the mythological creature that kind of most embodies Brightline is the Iris, or I think it may be pronounced "E-ris." And so Iris was a goddess that was the communication and messenger for the gods and is the symbol of the rainbow and also the symbol

of new endeavors. And was kind of the personification of the link between the heavens and the gods and the messaging to the earth.

And so just this idea of something that's really uplifting. What kid doesn't love a rainbow? I was with my kids in Hawaii, and literally every single rainbow excited them. There was like five a day, and every time, stop the --

STEVE BLUMENFIELD: Me too. Oh, come on.

NAOMI ALLEN: There's also lots of rainbows, which I love that. I think it's amazing that kids get that excited by that phenomenon. But I think it's just a commentary around we all need some hope right now in that sense of something that's awe-inspiring and magical that really, in particular, moves kids. And so just this idea of the Iris, I think, really inspired us.

SIUPO BECKER: Aw.

STEVE BLUMENFIELD: Nice. And that gives me a sense of translating this difficult, complex, adult world up here down to what it takes to help the people who aren't the little adults, but who are little, and being and working with those adults with hope. That's a nice take away.

SIUPO BECKER: And Naomi, you know, I have a question too. Are children more resilient in terms of their behavioral health the way they are in terms of their medical health as well? Like, do they bounce back better than us old people?

[LAUGHTER]

NAOMI ALLEN: Yeah, that's a good question. Here's what I'll say about this. There is a big distinction between mental wellbeing, mental health and mental illness. And so I in no way want to belittle what is a very meaningful national crisis around mental illness. And, at the same time, what we know to be true is kids are incredibly resilient and also, like so many other things when it comes to kids and teens, they're sponges. It's kind of remarkable.

We didn't get to talk about this much, but one of the big challenges in pediatric care is there's not many clinicians who have trained and practice evidence-based CBT measurable protocols. And so we've built a whole L&D function that helps to deliver that consistency of a care model and that measurement of the outcomes against a care model. And so that's a big innovation that we've brought to the space. But that, by and large, doesn't exist. So only 20% of clinicians, of any type of behavioral health clinician, use a measurement-based approach. And so what we know --

STEVE BLUMENFIELD: That's just terrible. I mean, it's sad. It really is sad. Right?

NAOMI ALLEN: Well, but Steve, you have to think about they're doing a lot of stuff they're not incentivized -- I mean, they're not in --

STEVE BLUMENFIELD: Oh, completely. There's no systems to do it. I don't blame them for it. It's just there's no --

NAOMI ALLEN: Yeah. I mean, there's no --

STEVE BLUMENFIELD: That's one of the things I'm most hopeful about with virtual care in general, is that we start having data, and enough physicians, therapists of all types end up having to use those protocols, and then those tools adapt and are used in everyday practice. That would be wonderful.

NAOMI ALLEN: Absolutely. One of my favorite teams at Brightline -- I mean, I love the whole company -- but the team that does our care and coaching workflows. How do you simplify the daily lives of those individuals

so that they get to go focus on the thing that matters the most, which is helping kids and families? So I do think that kids are very resilient when given the appropriate levels of care, is kind of what I'd say about that. And it's incumbent upon us as a country to make investments in the types of things that allow that to be scalable. So yes, absolutely. Now, severe mental illness is its own set of conversations around regression, recidivism and challenges there.

SIUPO BECKER: So Naomi -- again, on a lighter note -- in five years, as we see, Brightline will be incredibly successful. If there were a headline about your company, what would that headline read? What would it say?

NAOMI ALLEN: I think we've seen so many headlines in recent media that are scary, like "The kids are not all right," "National crisis," "Surgeon General Murthy indicating we have a youth mental health crisis." The headlines we're seeing are unprecedented in terms of how scary they are. And I think the headline that I most would love to see in five years is, "The kids are all right. Brightline's behavioral care and technology greatly reduced the youth mental health crisis for over 50 million families."

STEVE BLUMENFIELD: Wow. And you could use the Who song, for those old like us.

NAOMI ALLEN: (LAUGHING) I can totally see it.. We could walk around singing the headline.

[LAUGHTER]

And the place I'd like to see it, honestly, is a pretty consumer-oriented periodical, like a Fortune, because these are like everyday problems for everyday families. This is not a niche or a business topic. I mean, certainly, we believe that tremendous value will accrue to companies that make investments in pediatric mental health, but this is just like every day every people, you and me, challenge. And so I think I would like to see that show up in a more consumer type of business periodical.

STEVE BLUMENFIELD: OK. Kids love rainbows. They love ice cream. They love animals. If Brightline were an animal, what would it be?

NAOMI ALLEN: Ah-hah. This is going to sound counterintuitive, but we'd be an elephant.

STEVE BLUMENFIELD: An elephant?

NAOMI ALLEN: So here's why.

STEVE BLUMENFIELD: Yeah.

NAOMI ALLEN: You think that elephants are like slow, plodding, dumb animals, but they're intelligent, they're social, they retain lots of information, they move fast and together. So elephants are incredibly strong by themselves, but in a herd, they are powerful and they are fast. They're also often led by women. They're matriarchal leaders, which gives them a special way of staying connected over decades of their herd.

And they are highly empathetic creatures. So if any member of the herd is injured or sick, the others will literally try to lift them with their trunk and support them. And so they've got incredibly strong social bonds as well as just an incredibly strong and powerful animal.

STEVE BLUMENFIELD: What a great metaphor. Brightline the elephants. All right. That's going to stick.

[LAUGHTER]

Well, Naomi -- what's that?

NAOMI ALLEN: The rainbow elephant.

STEVE BLUMENFIELD: Right, right. Eating ice cream.

NAOMI ALLEN: Totally. Eating ice cream.

STEVE BLUMENFIELD: Naomi and Siupo, this has been so enlightening. I really believe we could go on for about two more hours, but already we have so much. This is such an important topic. Thank you for starting Brightline, and Naomi Allen, thank you so much for being our guest on the show.

NAOMI ALLEN: It's been an honor to get to talk about this with both of you. Thanks for the wonderful discussion.

STEVE BLUMENFIELD: Well, the honor, at least, is mine. Siupo, it's always so great to talk with you. You bring such sunshine to all these conversations. Thank you for being here.

SIUPO BECKER: Thank you so much. And Naomi and Steve, I mean, oh, a critical topic, but I do feel a great sense of hope from this. So thank you for sharing.

NAOMI ALLEN: Thank you.

STEVE BLUMENFIELD: Thank you both, and thanks mostly to our audience, listeners of the "Cure for the Common Co." podcast. Thanks for listening. Please remember to tell your friends if you like it, to rate the show, and subscribe. And have a great day.

[THEME MUSIC]

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