Pediatric Grand Rounds-20241004_082939-Meeting Recording

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1h 4m 37s

◉ **Kamat, Deepak M** started transcription

Kamat, Deepak M 0:24

Good morning.

It's 730 and time to start the pediatric grand rounds. The CME code is in the chat box and will keep repeating it.

Also reminder, please complete the evaluations at the end of the presentation so we can provide feedback to the speaker.

It's my great pleasure to introduce my dear friend, Doctor Justin Feber, who is assistant professor of psychiatry and Pediatrics at University of Pittsburgh School of Medicine and also at the Western Psychiatric Institute and Clinic.

Cyber received his bachelor's degree in science from the University of California and went on to receive his master's in public health focused on health policy and administration at Boston University.

He received his Doctor of Osteopathic Medicine at Torr University College of Osteopathic Medicine and did his residency and fellowship in Pediatrics. General Psychiat adolescent psychiatry at the University of Pittsburgh.

During this time, he focused on projects addressing child healthy.

It's through outdoor activity, collaborative care with pediatricians and child psychiatrists addressing the psychiatric needs of children with chronic medical conditions and fusion Wellness. As I said earlier, Doctor Cyber is an assistant professor of psychiatry and Pediatrics at Western Psychiatry Hospital and the Children's Hospital through the Univers.

Of Pittsburgh Medical Center.

He is an associate program director for the Triple Board Residency program.

He works as a medical director for outpatient.

E-mail health services at Children's Hospital Pittsburg providing behavioral health services for children with chronic health needs.

He is the medical director and also serves as a pediatrician and child psychiatrist for the whole child Wellness Clinic. He is also medical director for the skip for PA

Integrated Behavioral Health Care and Implementation study.
He serves as a course director for the Pediatric Behavioral Health elective and Psychiatry resident community psychiatry and child advocacy courses.
Nationally.
He sells on the planning committee for the AAP National Conference, focusing on the behavior of health and integrated care.
Doctor Shahbad, thank you very much for accepting our invitation and I'm looking forward to your presentation.
The floor is yours.

SJ **Schreiber, Justin** 2:39
Thank you very much.
And again, it's an honor to be able to be here and again, having a great friend be able to introduce, as we have an opportunity to be able to work together the Planning committee and so really appreciate this opportunity, especially to talk about an issue that is really.
Very close to me, close to me, near and dear. And really, what led to me do a lot of the work that I do is around the idea of integrated mental health care.
And so today, we're going to focus a lot on.
The growth.
The what is integrated mental health care?
The evidence behind it, and then really focusing specifically on.
Some of the work that I've done to around here in Pittsburgh and happy to talk more about what that looks like in other places throughout the country as well.
I don't have any disclosures and won't be discussing the off label treatments today.
And so as I described, this is a bit of our dive through that we're going to do around looking into what integrated mental healthcare means.
So to start with a case that we're going to use throughout our this presentation, since Chris is a 13 year old who presents for Wild Child check.
He's does a PHQA again.
Seven in the waiting room to assess for depression and anxiety.
And both are a little bit elevated.
Not too high, not too concerning, for safety, but hopefully can see some concerns.
So you talked to Chris alone and he reports that over the last year he's been feeling more depressed and anxious due to some bullying at school, and he's had a drop in

his grades related to that.
He denies any current or previous suicidal thoughts.
He's never seen a therapist or been on medications. He's completely new to the idea of behavior, health, involvement, and he says he's OK with you bringing the family back in, discussing it when they come in. They acknowledge the same thing.
They've noticed that he's been seeming.
Depressed a little bit more anxious, and so they agree.
That behavioral services would be a good benefit. I'm sure this is a case that we've all seen, no matter in a Pediatrics office within a sub specialty office, you know kind of any level of care. We've seen these kids and adolescents, especially since the pandemic who started to.
Identify some increases in concerns and oppression and anxiety, and really come to us is that primary person they're talking to to say, how do I get some help?
I'm noticing some changes.
We want to make sure we're intervening to help support them.
So this kind of dives into the idea of how do we support and thinking about integrated mental health care as a way to do that.
So I want you all to just think for a little bit when you when you hear the words integrated mental health care. What do you think are about?
Or integrated care. What does that come to mind?
You know what does that look like?
What do you think about?
And so take this the 2nd to kind of think about that really quick.
So I always like to emphasize one important part that it's different than integrative care.
So as was mentioned, I work on the planning group where I work with our integrative medicine group and and that is also in many ways can be integrated but is more of a focus of talking about different kinds of treatments that are often times things such as A/C.
Massage, yoga. Other ways of providing support so different than integrated care.
So it's always important to kind of be able to distinguish those two.
But when we think of integrated care, this really devoted from the idea that start an adult. That said, we're noticing a lot of.
Adults have chronic care issues.
There's multiple providers they need to see.

They need other supports besides even just what the physicians are able to provide and how are we supporting them, making sure they're not getting lost and falling through the cracks.
And so the idea of trying to bring those services together make increase the communication, increase the supports to ensure that someone can get access is important to ensure best health care for those those adults who had these chronic care issues.
And so we started to see that the importance of doing that was was really.
Necessary in Pediatrics? Well, and especially within behavior health, we're oftentimes we see such large silos between what we do in our Pediatrics care and our behavioral healthcare.
And so how could we start to bring this together to make sure that therapy, psychiatry, other indicated collaborative care services could come together in a way that could provide the best care for a patient?
And so oftentimes this was meant to say we saw on the adult side, there was improvements in collaboration.
We saw there was an increase in communication.
Can we find ways to do that to ensure that it's, you know, I think a lot of us talk about how if you refer out to a provider may be a therapist or psychiatrist, you may never know what's going on 'cause it's hard to get a hold of.
Them there's no they don't use the same medical records.
We don't have releases for them.
It's, you know, there's you have.
We're both busy, so it's hard to find the time to call and talk with them, so trying to figure out how to be able to fit that together is important.
So this is where integrate care came out to say.
Hey, let's try to find a way to make this work.
And it's also looking at a broader range than just what we're doing and we think about as a as kind of typically with a a physician you know instead of being just assessing, diagnosing, maybe providing medication, how are we addressing the psychosocial needs as well, how are we?
Thinking about the other areas of care that this person might need, besides what's just a therapist.
A therapyer medication as well, and then as the recognition for this, he came out, we started to see the spectrum developed, which we'll talk about more about what that

spectrum of integrated care looks like.
So I'm someone who does a lot of work in training around, motivational interviewing.
And so one of my big things always emphasizes we end with the positives. We start with maybe the negatives. We try to end with positives because it's lasting, you hear.
It's the last thing you remember, but it's important to be able to talk about that.
So we'll start first about why people don't do integrated care.
And again, if you know, think about the reasons you might have heard as negatives.
Why wouldn't do an integrated care service?
Why wouldn't bring everything together?
Why we wouldn't try to do this and you know, I think there's really valid reasons why people have had hesitancy about integrated care.
I think the number one is time that people talk about.
Is it gonna require more time for me to be able to have to talk with people more to have to try to connect and be able to figure out what the needs of a person are?
And so all of these different kinds of extra things that seem like they have to happen are gonna be a concern also cost how much extra is it gonna cost if we're bringing in other people, bringing therapists, care coordinators, psychiatrists, how are we gonna be able to pay?
For that.
In in different settings and is there a way to make it paid for?
And then the concern is always, you know, are we gonna bring in enough providers and we I'll be totally honest here at at Children's of Pittsburgh, we have looked for AGI psychologist for quite a while and sometimes finding people can be a little bit daunting to to.
Get someone into that system who's willing or interested in doing integrated care, is maybe they're used to a model that's not like that, haven't been trained in it.
And then the last thing I think, which really is.
A factor I think is changing quite a bit is this idea of be uncomfortable behaviour health. I think a lot of people.
Would say that you know my job as a primary care doctor is a subspecialist is not to also be a behavioral health provider. And what what I would emphasize is that everyone is now, you know, I think that if you look in most when I talk to most.
My pediatric colleagues, when I you know when I do my general Pediatrics clinic, about 20% of what we're seeing is behavioral health, if not more.
I mean, I've had some people who are saying, like, half their day or more can be

working with behaviour health, so it's no longer something we can really avoid and that.
Uncomfortable. I think more people are recognizing building comfort is important.
How do I get the training to be comfortable with that?
So we've heard the name.
We're talking about why do we do it?
Why do we wanna to talk about a great amount of health care?
Why is this important for us to do? And you know, there is some great. We'll talk about the evidence, but really some good positives to make that really make sense when we think about it. Like I said, people are already doing behavioral health. So if you're going to.
Do it.
Let's give you the resources.
Let's make sure that you have people you can directly communicate with connect with.
Let's give you the educational resources to make sure that.
More and more, you feel that comfortability to be able to manage things that.
That are coming your way, be it ADHD, anxiety, depression, so that it doesn't have to all be referred out just like we said, it's maybe hard to find behaviour health providers if we don't have to overrun the behaviour health system because more can be done in different setting.
And primary and subspecialty care due to integration. Then maybe we can say you know this is something that doesn't have to necessarily require as much time from our behavioural health providers and we can use the providers we have.
I always argue that is someone who does work in in primary the child setting.
That I feel, are pediatricians are.
And other and those who are other developmentally trained for Pediatrics are much more prepared and ready to work with pediatric mental health and even our our general psychiatrist or adult psychiatrist.
You have that developmental training within the pediatric residency, even if going on to do a fellowship, that helps you understand development in a way that sometimes our general psychiatrist don't have the same understanding and so being able to work with kids and understanding what really seems like develop.
Appropriate behaviour versus not.
Is something that.

Do I feel like we that you have that underlying skill related to and so a little bit of training to kinda understand how to work with some of the basic things seems really appropriate and able to be done. And we also are not going to be able to.
Quickly grow our child psychiatry group to be able to support the the level of need we as much as we are trying to do changes. We know that our our match rates within child psychiatry are on the lower end and so we really want to try to make.
Sure that we support the need that's out there.
Recognizing that the workforce.
The work level is not going to grow immediately that the workforce is still going to take some time to develop.
We know it also is a way to be able to increase patient care and access in the sense that if people are able to access care through their Pediatrics office through their primary care office, through their specialty office, that getting in is a lot easier than trying to.
Refer out to somewhere else.
I use the example here, always in that you know when our pediatricians and our academic office know they want to refer someone to GI they send.
To the children's officer GI, it's pretty easy.
Sent them over there.
It's easier to follow up on.
They know they're going to get there most of the time, and if they didn't, you know, they know where to send them to again.
Then behavior health. They can send them to tons of different outpatient private practices.
We're pretty lucky in Pittsburgh and in the sense that we have a bit more resources in some places and so they can send them to various specialized offices. They can send them to other.
Places that we have that are other healthcare systems that have behavioral health and so the ability to follow up and know their.
Is always a little bit harder because the family can get overwhelmed.
Where am I going to?
Which place should I see? And so we actually study this and found that about 5% of people who were given a referral to say, here's a bunch of resources go somewhere actually followed up.
And so that meant that 95% were coming back to the next visit saying I didn't follow

up anywhere.
So we identified that increasing having someone in the office actually significantly increase the amount of follow up with someone going to that first visit.
And once they've established it's a lot easier for them to continue.
It really opens up that accessibility for families and also really makes the barriers less.
It makes the stigma less saying, hey, I know this place. I know the people who are here.
I feel comfortable. My my primary care doctor sub specialist told me about this person or introduce me to them so I can see that comfortability to go and follow up, and then the communication it, which is really the most important part too, of being able to say hey.
This person's starting a medication or doing this therapy or this is getting worse or hey, I'm concerned about, you know, this.
New finding that's happened.
I'm not sure if it's an organic cause.
Vs psychosomatic and potentially AGI issue.
That's because they're anxious.
So let's communicate and collaborate instead of exit, increasing the amount of care they need.
And so it it really allows for us to be able to to grow that collaboration communication, we think of intercare and we're finding more and more ways to make it be able to be paid for 'cause. There's a recognition that this actually is a way to help with.
Saving money and insurers are open to this idea of can we find new ways to cover the costs and the work that's being done?
And there is growing evidence to this as well, and I included a lot of references to the end to hopefully you'll get a chance to look at, but really look at both the decrease in the amount of waiting time and decrease the amount or increase in the amount.
Of access increasing the adherence and I thought was also really interesting to see is not just adherence and saying all right, they're following through with their therapy, they're following through with maybe starting that SSRI and continuing it. But also they're following through with anticipate guidance from the primary.
Care office. So maybe because this communication.
When there is an anticipated guidance around dietary choices or around.
You know, being active, but the therapist can reinforce that and say this is important

for your depression too.
It's important for your anxiety, and so we're seeing that it's being enhanced on both sides.
Where the education piece has really helped for increasing our our comfort and prescribing for primary care providers. And and I would argue as someone who also does a lot of work in sub specialty where there's less evidence research we do, we do a little bit in some of.
The work we're doing here, but but the evidence we have so far showing that increased comfort within sub specialized populations as well and.
And then I think something that jumps out to me is especially in the last few years where we've seen the burnout that's occurred within within the medical world, just seeing that this opportunity to say I'm not feeling so overwhelmed with all these kids who are struggling with behav.
Health and not knowing what I can do and they just keep coming back to me.
Nothing's better.
Can we work together as a team and that really makes me feel better. 'cause. You know, we all went to this because we want to really help kids and adolescents, and this is an opportunity to really help with that more.
And then there is evidence to show it's decreasing the cost of care.
And you know, I think when you look at something like $38 per patient per month doesn't seem like a lot for that. But you think of the amount of patients, the amount of months that really adds up to quite a lot of money for a health.
System.
So why do I talk a lot about this and why it's important?
So I want to give you a little background.
We're going to go back about 20 some years and talk about what led me to doing the work that I do and why I really emphasize the importance of integrated care.
So I was a camp counselor in in 2004 and I was at a camp for kids with Chr, chronic illnesses called the pain material that was in California.
And they, you know, it was great 'cause. I didn't wanna go in Pediatrics and I got this opportunity to work with kids who had other medical conditions and see them having an amazing time at camp.
But every night we'd have camp chats and I'd always or cabin chats, and it always seemed like there was this conversation about like they felt like they weren't getting the behavioral support.

They were struggling with their illness and they felt so connected there and they felt like it was their opportunity to 1st talk about the struggles that they came with having Crohn's and colitis or having sickle cell disease or various different illnesses they otherwise didn't get that chance to.
Talk about and. I really was like, well, this seems like such an important thing. I would love to figure out how we can support that in the future.
Kind of put that in the back of my mind.
Then I went to Las Vegas to Med school, and I was in my third year and sitting in a cafeteria and my OB rotation and another Doctor Who was randomly there said.
Have you heard of triple board?
It sounds like that stuff you were talking about when you were at camp. That's what they do is they do integrated care.
They work on being child psychiatrist and pediatricians. And how do we bring all these things together, which I thought was pretty amazing and so put that in the back of my mind.
I thought maybe something I'd want to do.
And I was involved in the Medical Student Association and there worked on access issues and advocacy and found that.
One of the issues for accessibility was that if things were not brought together, it was really hard for people to get appropriate services and so how could we better increase access, especially for kids and especially for mental health, which is oftentimes forgotten.
So I joined the Chipple board program in Pittsburgh.
Had an opportunity to gain training in in different levels and see and really one of the great opportunities was be able to work with Doctor Abigail Schlesinger, who is our now our chief of.
Our Chair of child psychiatry here and she was my program director when I first started.
And her? She's really well recognized nationally for the work that she's done around integrated care, growing it here and pushing it throughout the country. And so had a great opportunity to learn about the importance of integrated care and then promote it through different programs.
So we were able to develop a wrap around program which is a behavior health model that utilizes peers in different settings for supporting behavioral health and actually incorporate that into endocrinology and focusing on helping kids and

parents to address the.
Needs of diabetes through through this peer health model. Seeing that this integration of.
That model there could actually really improve and we saw decrease A1C levels around adolescent age where typically throughout the country we see that that's when A1CS are often increasing significantly.
We saw comparatively to those who are not participating, an actual drop back down to a closer range to what we were a goal Ranger looking for.
I also participated in our consultation service through our tips program, which is a an access program which many states do have that allows for that opportunity for primary care doctors to call and talk to a psychiatrist and get some support. And so we've seen the consultation model and.
The benefit of how we can provide consultation pediatricians can take on more and do more in their primary care offices.
And then had the opportunity to develop a clinic card to hold Child Wellness Clinic, which I'll talk about a little bit more about that really looks at full integration of physical and behaviour health.
And the same sense work on this at our Children's Hospital for sub specialized populations where oftentimes is the forgotten group to say that, yes, we've talked, we started to talk a lot nationally about the incorporation of integration and behavioral health into primary care offices. But can we?
Do the same thing in sub specialized offices as well.
So we talked about integrated care.
We'll break it down to the different levels and there's those that are less integrated but provide some level of integration and coordinated to those that are the most integrated.
So we start with our referrals and consultation, which kind of like fit in that kind of end where there is some support of integration but not really getting us full to oftentimes Co location where maybe we're starting to integrate more because we're in an actual space together and.
Opens up the opportunity for conversation.
To develop with integrated and what I call fully integrated, which we'll talk a little bit more for.
Example of the whole child Wellness Clinic of where we actually really bring kind of as much as possible into to not only one space, but one visit for families.

Referrals. First of all, these are kind of our typical we think of generally when we're connecting people to services and this develop, this is on a spectrum as well.
So you know, referral can be I'm handing you a sheet of paper.
And here's a bunch of therapists that you can go to which, you know, oftentimes many would say is pretty far from integrated care because maybe you know them, maybe you've worked with them some before, but you're probably not really connected to them.
There's not much communication with them. You don't have a way of finding out if they get there versus maybe this.
Service that you have within your academic institution.
And so this is someone who I know I can send you.
I know of them can send them there.
Maybe we even do have the same medical record.
And so there's a little more communication that can happen.
But again, it's, you know, it's not in my office.
It's in somewhere else there oftentimes.
They have to go through the process of getting set up with that appointment and so there is still some barriers to get there.
So we'll kind of go through each of these ones with our case, so.
In this case, again, we have Chris, who's struggling with anxiety.
Depression a little bit.
What benefit of getting to the therapist? And so you decide to give some information for therapist in the area that Chris could follow up with, you see him again in two months for follow up. And as I'm sure the story that many of you have heard the family.
'S called lots of places. None of them have opening for for months and months and months.
Maybe about four months.
So we still not seeing anyone and now it's getting worse.
Right now, we're the point of.
We're avoiding school.
We're seeing more impairment that's happened, so.
So we've done that referral and really, you know didn't go as well as we hoped.
So I'm not going to complete down referral, but there's our significant positives that come from referral process as well. We've done it for a long time. You know we've

seen that people can get services that way.
So we also know it works better with the current insurance structure, so funding is of course important. If we don't, you know, I think there's always people here, no margin, no missions of you can't pay for the services and they can't exist.
And and really a lot of our insurance structures built off of fee for service referral type of process. And so it it works that way pretty easily.
And also in many ways actually, you know, we talk about accessibility definitely exists when we have that direct connection, the communication warm hand off, but also you know there's some people accessibility is about where is it located and you know I'm sure for your center as well you.
Have people who are coming from various different parts.
We have in Western Pennsylvania, people coming from, you know, as up from New York with people coming in from Ohio, from West Virginia.
So to say, hey, let's see the service that's in our office, especially for specialized patient that might not really work for them because.
Can't keep getting there so sometimes actually referral allows for increased choice of location hours.
You know, we might not have weekend hours. We might not have evening hours, whereas other places private therapists might allow for that. So and then also who someone wants to see. There are people who say I want to see someone who, you know is a younger therapist or.
I want to see someone who maybe has a specialization in X thing and so sometimes extra referral allows for you to have a lot more choice.
And so that that's actually not the worst for some people to see.
But the communication is really difficult. So often times we don't have the same medical record.
Oftentimes we don't have an easy opportunity to be able to communicate with them, so it can lead for this loss of of communication and sometimes not knowing did they get in.
Did they see them?
What what's happening next and?
For families, they'll talk about the worry stigma. They're already on the fence.
They're concerned they're not going to go.
They don't say want to leave their office and see some random and tell their story all over again, so that might stop them from going and decrease the opportunity for

them to to show up.
We see low show rates.
You know the importance of show rates are pretty important behaviors because we just don't have a lot of providers.
So if you if someone doesn't show then that's another person who's waiting longer to be seen.
So that's a referral model, one that you know probably all pretty well.
And then we have a growing model, which is our consultation 1, so consultation can exist in different ways in a spectrum as well between things like telephone consultation, service that we see through our access lines, it can be through a consultation of maybe you have someone who is.
Who is in the hospital and see a consultation consultation service there.
Could be a consultation of someone who also you can refer to, maybe a one time and they see them once and then give you feedback to what you can do.
So there's various levels of consultation models that exist, but generally across the board the consultation model says you as the primary provider are responsible for X thing like you're going to be responsible for what I recommend and you would take over for that. And that could be a.
One time it can be in some cases multiple check insurance, but sometimes it's OK.
I saw them.
Here is a diagnosis.
Or here's a recommendation for what you do.
Then go for it and maybe you can come back and check with me.
Or maybe that's it.
Some consultations will also I know for our our consultation service. We do have care coordination for all of them, so we know it's hard to get people into services, so to say, hey, here's also some support you can do when you're doing that consultation to help get you.
In.
We think it've been about Chris.
Now we're kind of going to this consultation service, so it's got a long way to the and so the pediatrician says, OK, I'm going to call my state behavioral access line.
I'm going to talk to a psychiatrist and they connect with a care coordinator who's part of the line and they say we're going to get you a therapist with a month. And so great, we've got more services set up, the Care Coordinator actually was able to

connect them.
And they're going to be able to get in sooner.
There's a little bit more of a hand off 'cause that care coordinator said.
Hey, this is the place.
This is what you call.
And so hopefully that's gonna get them in. And for a lot of people that does like, that's the process.
We've seen that increases our ability to get people into services is just having that care coordination increase the hand off. That happens through consultation.
So what works well for consultation, it's more structured, so you know this idea of all right, I referred out, but maybe I don't know who they are.
Maybe I don't know how to get ahold of them.
I'm trying to e-mail a call and call their office.
When do we find a timer both busy? This is saying. All right, you consulted. This is how our consultation process works.
This is how we communicate.
This is how I get back to information.
We know how that's going to work.
We know what to expect.
We know how we can fit into our schedule.
You know, a lot of times they can because it's a consultation they're not.
They don't have patience.
They're following. They're providing that service as needed and so they can assist with a lot more patients.
So this idea of really expanding the workforce quite a bit by saying, hey, I'm here to support you.
And I can answer questions about, you know, five patients in an hour over the phone, or I can see it, you know, multiple new patients for a one time evaluation. And I don't have to worry about scheduling them for follow up. And so I can keep adding more. And more new evaluations to support back.
So that's great, 'cause. We again know we're limited with our our those who are providing payroll services and I would argue it's really focused on more basic concern.
So this is really not intended for.
Those who are, we're concerned about first brick psychosis or about mania. I think

most of the time you'll see for most of these.
Integrated care models.
It's how do we support for more of the ADHD depression, anxiety, assisting with starting assisting when they need to make a change, really starting on those things that are manageable.
But don't have the level of higher concern, risk, complexity, complexity with them.
And also this can when we have coordination, it can potentially decrease stigma, allow people to have that Horm had up that makes them feel more comfortable and so.
Increase that access in stigma. I think one of the biggest things I find of consultation is that.
It's gonna do what?
So you know, I as a consultant, I get a call.
I tell the person I think this is this sounds like pretty clear depression.
Let's go and start Lexapro at 5 milligrams.
The person is I don't feel comfortable that.
Can you start it for me then?
It's a little bit of back and forth, you know, through our service, we can't start it.
Well, I don't know if I feel very comfortable.
Lexapro. So should we do something else?
And then what are we doing? And so?
It's all good time for consultation.
It's it's really trying to figure out who's doing what and who's responsible, and that means comfort.
So a lot of the access services that really have been developed and grant funded.
Through the federal government and through state governments have incorporated a component of education to say we can't really allow, we can't really have primary care providers for some of those. That incorporates up specialized providers do this work if they're not comfortable with the things we're asking them to.
Do so we need to make sure the education's there to do that as well. 'cause. If not, what's the point of us offering that consultation if someone says I'm not going to be able to be responsible for behavioral services?
And like mentioned it you know it's not great. I've I've had. I've done the conversation service or I've had someone call about Mania and said what should I do? How do I start? Lithium and I said I you know.

I don't deal with him a ton.
I do it some, but I I don't know if you're gonna feel really comfortable with the monitoring and the side effect potential.
So let's maybe think about actually getting them into a psychiatrist at this point.
What we've also found is that most consultations, depending if it's in this the service you're in and in your institution, you might be on a continued EMR, but otherwise you might not. And that can be a problem because if, for example, the telephone one, do I remember every.
He said.
The reason why they said it when I go back to to kind of finish on my nose or when a question comes up.
So remember what I was supposed to do if X thing happened?
So not having that reference that note to go back to and you know we're busy, we don't always get our notes done immediately.
Are we gonna have everything in there that helps us to recognize and remember the reasons we're doing what we're doing can be part of the difficulty with that and then funding is difficult.
We've luckily had a lot of federal funding around this, but often typical insurance funding doesn't really fit unless you're doing more fee for service specifically.
So we've moved on.
We've had our referrals, there's consultation and some of these might happen in the spectrum.
There might be some referrals with Co exist in consultation, and then we have Co location so Co location is just a physical space integration.
We are in the same location.
It doesn't even mean that we're the same practice, the same academic institution, same EMR.
This could be a private practice therapist that happens to be in your office.
And so they're running their own practice, but they're in the same space.
I say virtual as well because you know, some practices run virtually and so maybe they have some abilities to.
Coordinate within the virtual space.
That's similar to where you're at. Oftentimes you think about this more in the physical space, so there's an opportunity to see each other more and communicate more as an important part of it.

The other part is billing is is somewhat difficult to to know for sure how that's going to be in Co location. Sometimes. Again, it's together institution, sometimes it's separated out.
We're gonna talk again about Chris.
So this point, you know, he had been we done.
The consultation service we had gotten care coordination to kind of help us, and we're gonna get you to see a therapist.
So you see him begin in two months and he still hasn't seen the therapist and he describes being nervous.
He's like, I don't really want to go to this place.
I don't want to tell my story again to some place I've never been before.
I have a feeling I'm going to be judged so he ends up not going. So you.
Say you know what, we actually just have this therapist who started.
They have kind of their own practice, but they're here.
They're using one of the offices that's in the office, and they're here three days a week, so I can actually take you up to the front desk and we can get you set up with an appointment that's going to be in three weeks. And so great we've got.
That appointment set up and now we're going to be able to have you start to see them.
So that's a great level of integration. We're now seeing that communication is increased. That hand off has happened. The accessibility, the comfort, the decrease in the stigma 'cause this is a place where he feels comfortable.
He's been before.
He knows the people there.
Maybe even you like walk them up to the therapist to say hi.
And so the therapist now has.
So he's actually seen this person and sees they're not a scary person, this therapist.
And so I can feel comfortable I can get started.
So, you know lots of positives that come with that, the fact that we are hopefully decreasing stigma because the location I have found alone, if you talk to a lot of families and what we've seen with some of the data that just being around other people like being.
In a place they know, and they have comfort where they've been going since they've been a baby.
And they trust their their primary care provider.

So much other subspecialists.
So much helps them to say, OK.
I can feel comfortable going there.
Increases our and that opportunity for warm hand off.
Hey, you're in the same office.
Look, I see them walking out of the office, or I can walk them by.
Show them where they're going to sit and talk to this person, even if they're already in a session.
I can't actually introduce them, but you know, one of our therapist here in our outpatient Pediatrics clinic will, you know, be in the whenever she doesn't have a patient, she'll be upstairs.
To where the where pediatricians are are seeing patients and.
And when someone says like, hey, have someone to walk in the room and say, hey, you're the person, I'm the person you're going to see, you know, this is my name.
This is what I'm going to be doing.
This way you can expect really help to increase that that hand off and make people feel comfortable they're going to go and I think has really shown the video, they've actually more, more likely to come.
You know, you think it also builds some collaboration communication, right?
We're in the same office.
We walk by each other.
You know, it can say, hey, that person I just saw, you know, do you remember what we talked about? What we gonna do next?
We can give you the example just yesterday, again doing work on the within children's. I walked by our the oncologist for the patient. I was going to be seeing and I just happened to see him on the walk in to work from the the parking garage and.
I was like, oh, yeah, I'm seeing this person today that your patient can remind me again what is what? Some of the things you were hoping we could address.
And then I happened to see him again in the stairwell after I'd seen the patient again.
Not all things that were collaborated and set up, but just because we're in the same space, we run into each other, there's there's an ease in some of that communication that's happening.
And sometimes this actually is.
We'll see.

There's opportunities for improving insurance opportunities through collocation.
It allows for the for reimbursement to happen potentially easier than than other structures, but it doesn't guarantee communication. I think this is what people sometimes forget in colocation and why it's not really fully integrated.
It gets. It's just putting you all in the same space. Doesn't mean you have the same EMR. Like I said, it could be a private practice therapist who's there.
We've had that exist for some of our private practices where they'll incorporate another private practice therapist who's there.
But they don't have the same EMR.
They don't have a set timer.
They all meet together and so they might not know what's happening during that time.
It's also sometimes unclear the support staff what their role is.
Are they supporting scheduling for the therapist or not?
Has that been established?
Is it someone else who does it?
What about if a family calls in and says my kid is really struggling?
What do we do then? Is that responsible for the primary care doctor? The sub specialist is the therapist who gets it referred to.
How do we set clear lines that isn't necessarily established just by?
In the same location.
So we've are moving down our spectrum of integration to now integrated care and this is where I would set the split mental physical health. We're saying we're going to bring it together. We don't have to make a choice then going one line or the other, we're going to.
Bring as much of this together into one not only just one place, but increase our communication, increase our way of facilitating that communication and really making sure that people feel like they're getting all the services together.
And so that means that we're on the same medical record.
It means that we have a set time for communication.
Maybe it's.
Meeting time.
Maybe it's a time where we do just specifically for patient conversations and you know, and so it really allows for that. What I would say is separate from what I talk more about fully integrated is it doesn't necessarily happen all together.

We're not meeting with the patient all together, but we all see this patient.
We are in the same space.
We have easy, more models of communicating about it.
We have ways that if the patient communicates to us, we know who can take the lead on certain areas and so we're all really as much on the same page as we can.
Even if we're not seeing the patient at the same time.
We'll go back to Chris.
So again, I'm all these other other services can be very good.
I don't wanna make it sound like with these problems that Chris has had that nothing is working well, but we're just showing like some of the pitfalls that could happen with each one. And so it's now been six months he'd been seeing this therapist who is Co Loc.
But you realized you couldn't see any notes.
And you know what's going on?
So Chris actually reported that the therapist was leaving the practice, but she had no idea what's happening because again, you didn't have that direct communication.
And so it had been getting better.
But now the school year is starting.
He's struggling more and you're saying? OK, great. We just actually developed an integrated model and we have a therapist here and a psychiatrist.
So I'm going to get you in for both our front desk and schedule you perfect.
So great, we've increased that access.
We know we're going to be able to communicate with them.
We're going to follow up, see what the therapist and psychiatrist.
Hopefully have meetings with them at some point, you know, be it monthly or whenever we have those set meetings to get that information about things are going with Chris.
So our communication has really increased.
Hope you know as the data shows, our show rates are increasing as well.
We see that this really increases that and really decreases the stigma feeling that people have of going to see the behavioral health provider even more and more.
Now that we know, hey, not only are they in the office, this person knows them well, they're going to be commun.
Back and forth.
So when they come back to see you as a primary care provider, you say, yeah, I saw

how you.
So the therapist you're working on this component of CBT?
How's that going for you so far?
Wonderful. Like we've got that understanding that family knows that and you know, and the patient knows.
Hey, we're we're all working on the same page.
We know what we're all doing for the patient whose, whose role is what.
Who's answering the phones?
Who's responding to questions?
We're in that space, but it's it can be hard to cover.
So this is not part of the typical insurance model.
We're. We'll talk more about payments, but this is not always an immediate thing that we think about.
It also can mean, hey, we have more collaboration time whenever we're doing more time for something else, it means less time to see patients.
So maybe we're losing some patient time and you know, I think this is something I see as a fear. But often times I find is not the case.
But if there's an integration, if there's easier access, do we not refer as much?
And I don't see that to be the case. I think people actually build more education, understand, they feel more comfortable.
So we've So what I would argue is fully integrated.
I don't.
I think that a lot of people kind of use integration as kind of this like one model and that it's a spectrum. But I kind of think of this like fully integrated one where you think about, hey, we're putting a lot of stuff together into one place think.
About the psychosocial benefits of everything in one area and and often times for these more complicated cases, are we adding more services together so that people can?
Can work together.
Identify what's going on.
Is there an organic cause?
Is it psychosomatic?
Is there high levels of need?
So we need more care, coordination and support.
Do we have walk in service?

Can someone access not just physical health but also behavioral health Med services if they have a concern more acutely? So how we bring these all together into one space and that's when we think about more that fully integrated. So you get so going back to Chris you get.
A call from the psychiatrist about for Chris, about a year later, you notice that you're going to do well. Check, and this characterist reports that he started to have a lot of physical health problems.
He's vague.
GI symptoms headaches. Also, these new auditory possible hallucinations.
Feels like he's being watched a lot more.
Starting to get really nervous.
So the psychiatrist thinks like maybe there's something organic going on.
He's having these physical symptoms.
Could there be something else? Or is this development perspiccosis?
So she says.
I really like to do a combined visit and guess what we do have in this fully integrated model some opportunity to do a combined visit for complicated cases where we can talk together and also social work can be there to help with any follow up that might be.
Needed.
This is a lot of communication collaboration, which is great.
We're in the same room.
We're coming up with a plan together, diagnostically.
Think about together, the patient doesn't have to tell their story more than once.
They're kind of telling you once to both of you.
So great opportunity to limit that kind of confusion, making sure we're on the same page.
You know, arguably we could see that this is an opportunity and This is why care coordination was really for the adult model was developed at first.
We're decreasing high levels of care. If we can have this conversation together, maybe we're decreasing you having to go to the hospital, maybe we're decreasing that you are going to need more expensive procedures cause hey.
This is not actually meeting what I would think about for an organic process, so I don't need to get that MRI.
Instead, we can work on therapeutic supports.

Or this does seem more like first break, so maybe we should be focusing on the work up the looks of that instead of other. Again, a workup that might not be necessary. And you know again, like I said, there is many families who said in the models that we have where we do this combined work that it's easier 'cause. They're not telling me to start over and over again.
They're not feeling like they're having to re traumatize the experience of what it was like to tell some of the difficult things they've been through.
But it is expensive.
It is hard to get covered.
You're doing things at the same time you're bringing in multiple providers of the 11 space, and sometimes insurance doesn't recognize that is something to cover. And also it can be longer.
Maybe we have to longer visit.
It means that we don't see as many patients because of that longer visit instead of a primary care visit being 15 to 20 minutes. Maybe they're in an hour long visit or two hour long visit with all the different people so they can talk about and do the.
Collaboration piece.
And so that means that if you have a no show, for example, that can be really terrible for the system 'cause you're really.
Losing a safe amount of time for multiple providers at once.
So these are our different levels that we think about and there's more ways that are continue to develop.
There's intricities within each 1, so it's a spectrum with many things that exist within.
But how do we pay for it?
So there's again thinking about like we talked about referral or a typical model, there's fee for service which still exists and can be really the way that we have to go for many different integrated models, consultation models and Co location where basically we're just spelling for the work.
That's being provided, but this comes with questions. Who's billing?
You know, especially in.
You look at academic centers, for example.
Is this coming from behavioral health?
Is it coming from physical health?
Who's receiving the bills?
Who's paying for the providers?

Are they panelled in Pennsylvania?
Can take a year for behavioral health provider to be fully paneled for insurances.
Who's paying for them in between to see patients?
Are they having to refuse patients?
Thinking of colocation, if I'm a private practice provider and I'm in Co located in your services, am I going to actually be able to start seeing patients?
Because I even panel them so I'm not going to see your Medicaid patients.
I'm not going to see your patients for X insurance.
26 months to get aneled O how do we think of those process and who's gonna be responsible for the building?
The hiring the paying for different things and making sure that these bills are going through so it it does work better oftentimes in in opportunities where there's collaboration and integration where we can see that we are kind of looking together at how to build, there's backup ways in.
Place so in case the building can't happen that someone that there's a way to cover those costs and continue to have that person there.
And and so those are important now.
The next one is incident two billing, which this one is is one that can be a little more controversial.
Definitely something I would talk to a billing department before you would move towards, but really looks at the idea of of expanding the work of the of the physician provider to say, can other people such as therapists or non therapists but who are providing therapeutic services or care.
Coordination be able to bill for some of the work that they're doing.
So this can be a therapist.
A nurse practitioner APA who is doing the work that was started by a physician and continue that on.
So for example, a person who has depression.
They're seeing a pediatrician and they are going to continue following them for therapy. And so they that therapist is going to continue to see them to what that work specifically. And so they can do that incident two billing where they're billing to specifically the the NPI of that.
Provider who?
They're working with the physician they're working with.
And you have to watch because not all peers are not insured.

Will do this if you're using it appropriately. There have been concerns about fraud around it, so having you really responsible for how we're appropriately using this and it's intended to again increase the work that's being done.
By that original provider, so you can't switch around to do different things that are not necessarily the original reason for that that visit that they saw the primary care provider, the pediatrician, or the sub specialist.
So you have to worry about not double billing and and that would happen when potentially you're seeing together or you're doing something new.
Hey, we're talking about depression now.
We're identifying ADHD and now this person's going to start prescribing different medicine for ADHD. But that was different from when they saw the primary care provider or.
The therapist is trying to work on.
Something completely different now that wasn't part of the original treatment plan.
It does help 'cause sometimes you might have a social worker who was trained in some basic therapy skills that they can provide.
They're using some very manualized treatments, but maybe they're not in lcsw they don't.
They're not licensed, so they can't bill for fee to service fee for service. And so this is a way for them to be able to bill.
It also allows for some increased level of billing for some collaboration that's done between the primary care provider, the the pediatrician, and the.
And the therapist or the nurse practitioner, PA, who might be doing the services with them.
Collaborative care is a growing opportunity and this is really came from the Ames Center in Washington that says, you know, we we need to find ways to be able to bill for this integrated work and collaborative work that we're doing. And so collaborative care billing basically says we.
Have a patient.
We have a primary care provider who's working with them.
We have a care manager and the care manager can be providing services such as therapy services, but they don't necessarily have to be.
A social LCSW or an LPC, they could be someone who.
Again, is doing a manualized treatment and supporting that or they could be providing care coordination services.

And so they're in our office.
So we see this registry. Basically they we have a register of these patients who are getting the service who are also follow the primary care provider and there's consultation from a psychiatrist. So psychiatrist isn't necessarily seeing them or seeing them often, but they're supporting the work that's happen.
And supporting with the primary care provider and the care manager is doing and having an opportunity to discuss the patients that are done.
And there are billing codes that that specifically address this you can see they're really based off amount of times per month.
So there is some limitation and how often they can be used and how much time per month, but really to help with care coordination with providing behavioral supports within the office.
And so this can be really helpful.
We've seen for many of our offices when you're using someone who's maybe working on developing and getting their their primary care or they're getting their licensing set up, it can be really helpful for someone who's doing a manualized treatment for the skip program that I talked about doing.
We actually have nurses, for example, who have learned a very manualized treatment that they can incorporate into.
Time and so they can bill for that service and provide behavioral support and also for trying to do care coordination. And it also you know it's helpful 'cause it limits the amount of time needed for psychiatry and hopefully will really increase our education for pediatricians to be able.
To take on some more cases.
R8.
So we've gone through the different levels, some levels for payment.
So what are some examples that we have that I can describe that that we've seen with some really good benefit?
So I'll talk about collaboration first in our children's Behaviour Health Centre.
So we have psychologists who are integrated into our various different divisions, which I think a lot of large academic institutions are doing of really trying to put in psychology directly, people who have a little bit more support, even therapists as well, and and they use this more model.
Where they're saying, how do we focus on the?
Specialized need for some of these patients.

So maybe we're not just doing like typical depression treatment, but we're thinking about what's the need for the sub specialized care of these patients themselves and how do we incorporate behavioral health into that.
In our model, we also have psychiatry, which is what I do that are also integrated as well and so excuse me, there's a lot less psychiatry and a lot less psychiatry time.
And so we of course, cannot be as many psychiatrists to be directly in every single one. So like one person for cardiology, pulmonology.
But we break it up that we have one of our psychiatrists is within cardiology, pulmonology, endocrinology and.
Complex care. Another one who is primarily neurology. Just cuz she does a little bit less time.
And so that's her focus then myself, where I do kind of a lot of her other ones and we're hiring other people to kind of take on other roles as well.
And so we actually think about as we're doing this, how do we do integrated care that fits to the sub specialty itself.
So in complex care, there's a lot of complicated need. We're trying to decrease their need for coming into the hospital, which we know that they have a higher risk of happening. Often times the behavioral health and physical health components are very connected to that.
What's going on?
These are kids that need a lot of substantial services. Often times non verbal. Often times they are limited verbal skills.
And so we do an integrated combined visit for those ones with the psychiatrist sees them along with the complex care provider, to be able to still provide that service.
And hematologist and oncology, we do an in and out where so we see them when they're in for, for example, a bone marrow transplant, they're going to be here for a while or someone who's going through chemotherapies. Our psychologist will try to see and check in even if.
There's not an acute behavioral health need just to kind of check in with the expected need of the stress related to that.
We do a little bit more traditional endocrine referral in endocrine, but they actually have our high fidelity wrap around program where they have more peer integration. They also do.
A more traditional more of a look at kind of specifically addressing potential risk for depression for eating disorders.

And so know that they can connect with psychologists for those, and then in pain we incorporate more group therapy as well.
So we figure out how to incorporate that into the work that's happening within the initial model or the initial visit and then follow up visits.
And we do different payment types for each.
I won't go full in detail, but just the the idea that we can show that we can kind of adapt and change this integrated model to the needs of such specialist providers cause oftentimes this is what's different than what we would need in primary care model.
And so it's nice 'cause, it's Co located.
We're on the Children's Hospital.
They oftentimes are in the same wings of the hospital that they're being seen for other services, such as an oncology unit or hematology unit. We are on the same medical records, so we can communicate very easily through there. Our psychologist go to the division meeting.
And we'll talk through needs and supports, provide extra kinds of needs that might come up and be able to discuss patients through there.
We mostly do fee for service just because within these models it's hard to do some of the other ones that exist, but we have started to actually find ways to incorporate collaborative care as well.
Then our fully integrated model is our Hotel balance clinic.
So we're all pediatricians, child psychiatrists, and so we are triple board trained.
We can provide physical health, we can do well, checks for them, we do.
Immunizations, we do.
Blood draws all the things you would expect there. Cube visits for physical and behavioral health, and they can all happen in the same visit. These are for more complicated behavioral health kids, and often times younger ages who are harder to identify what's going on. And the families that.
Help to fund this and start off with foundation money was really identifying that people didn't want.
Many times.
So how can we help to make sure that we bring in therapy, psychiatry, pediatric care all into one visit and then we incorporated family partners, which I would highly emphasize is an important part of integration as well as peers who have an understanding of family, peers who underst.

A bit of what's going on and can talk through that. And so we are able to find ways to do that.
We're still working on the billing component of this, which we've been lucky again to have foundation money, but we have found that we can do.
We've done a combination of.
Fee for service incident to collaborative care billing all ways to find the funding for our various different providers that we have. We also have a space that's really set up to be able to do this where there's one way mirrors.
So people can sit behind the glass and participate without necessarily have to make families feel overwhelmed. With six people in the room with them.
But we have seen some really great data from this.
So we actually have a really significant improve show rate.
So we talked about the low show rates for those people referred even for those who are integrated.
So we have.
Behavioral health provider for primary care providers.
Those ones you know, they have about a 60 to 70% share rate, which is again better than 5%.
And but for us, we've had generally around 90 to 100% share rate. So really great show rates because people have increased comfort.
They know they're getting a lot together at one point, and our family peers really helped to coordinate getting them in and then we have had surveys that showed increase the benefit they see and also we are finding that people feel like they get a lot done at once.
And so it actually increases immunization rates.
Follow up to the sub specialized in and then. Also we're still looking at this, but we do feel like there's a decrease in what we've seen for 80 visits. For example, we have a kid that comes in for their ADHD follow up and they're having a they're having.
An asthma exacerbation because we're also listening to their lungs at every visit.
And so we've had people who had been going constantly to the ER for asthma exacerbations who had not gone for multiple years because we're doing kind of both at the same visit.
So wanna finish up by giving you some resources?
This is this is to the American Academy of Childless Psychiatry, one of the previous presidents, focus was on integrated care and so developed this integrated

careforkids.org, which tries to be a kind of hub of a lot of different integrated services around different projects that.
Are happening different educational sites, so definitely something I would encourage checking out.
And then we also have some podcasts that exists through the American Academy Child of Psychiatry that focus on integrated care.
There's a doctor session who I mentioned our chair for child psychiatry here. Does some work around.
Has published some of the big work around collaborative mental health, and so there's a site there. And then for looking at the codes and integration, these are some other sites for it too.
Alright.

Kamat, Deepak M 54:50
Thank you, Rachel.
I will try that wonderful presentation on integrated pediatric integrated mental health care.
There's always a there already a question in the chat box. Our mental health problems in children becoming more prevalent.
If so, why?
What can be done as societal level?

Schreiber, Justin 55:09
Great, that's great question.
So you know the question around prevalence, we definitely see the prevalence numbers have gone up. I think if you would ask any of us who do work in behavioral health, we'd say that yes, with a pandemic that prevents shut up. But it was actually kind of a sleep.
Giant that we were, we knew there was a lot more increased behavioral health need and kids who are probably struggling a lot more than was clear.
But it was because they didn't necessarily have the questions asked.
I compared it to, for example, ADHD naughty and people said, WOW, we had this huge expansion of ADHD and autism that happened, you know, in the like in 2000 and.
Was that because that all of a sudden there was a huge amount of new ADHD and

say I think it comes back to who's doing the evaluation, primary care subspecials, who see people often are screening more as they screen more we see more, we understand more we know.
That there's more people who are struggling.
The pandemic definitely worsened things. Kids were isolated.
It was not a good time for them to to be able to have that normal connection we'd expect.
And so we definitely saw that worsen things and then?
I think we're seeing a lot of growing evidence about the impact of.
Social media and I would argue that it's less the social media piece, but also the removal of our physical integration.
Again, the fact that kids and adolescents who who thrive on that growth and social development are losing that as they connect in a way that is not really the same thing as much as people say with social media.
Oh, you're connecting people. You're really not.
I think we all know that.
So those societal factors are definitely having an impact.
I think we have to continue to educate families about the importance of, of limitations with social media use versus.
Our outside communication and connecting with other kids doing that in school systems.
And then also I think that important work of as we've seen people feel more comfortable talking about it opening up and getting people connected to services earlier is really important. And I always think of therapy is almost like preventive medicine as well, like getting people in early to.
Therapy, even if they're not having significant symptoms, is important.

Kamat, Deepak M 57:10
Thank you.
Anybody has any other questions, comments.
So.
Heyjson how long have you been doing this?
Pediatric integrated Mental Health program at children's.

Schreiber, Justin 57:34

Yeah. So I was lucky when I started. When I finished residency in 2016, we had already developed some of this work.
We had a few psychologists who were embedded, but really in the last I would say five years. It's really exploded in terms of developing a lot more psychology in bedmin. And then our psychiatrist, we've really worked to try to develop that more direct involvement with each of the.
Integrated sub specialist more and so.
We went from, I'd say, a kind of typical referral model for all of our services.
Most of them I didn't really always know where psychologists as much, and it was mostly like, OK, we know we have someone who works with endocrine, nose, diabetes, a little better. So we can send them to this person versus the community to now the people who they really.
Know well, they're again in the different settings and really have grown how we provide these services with with a strong evidence base within each of the difference of specialty services.
So, you know, I think we're seeing that across the country.
There's more and more recognition of this is actually.
The specific talk about subspecialty integration is what I'm going to be doing.
In a little over a week in Seattle, at our Child Psychiatry meeting.
So I think there's a lot of growth around that area and interest in how do we do it.
The other thing that's interesting too is sorry.

Kamat, Deepak M 58:50
Good to ask question.

Schreiber, Justin 58:50
The only other thing I would say really quick is it's.
I always find it's interesting.
You know, I I don't.
I'm sure we have some specialists around here too as well that it's really different sub specialist to sub specialist about the comfort for these kinds of things.
So what?
I talked to a hematology, our oncologist.
They will say, you know, I I prescribe a psoriasis all the time. Like it's pretty comfortable.

And that's at least our institution.
They feel pretty comfortable, whereas I talked to some other divisions like I would never touch that. And so we've also found that to be important too is how much of that kind of pre training happen in some fellowship to make.
More comfortable as we're doing that work.

Kamat, Deepak M 59:23
Go ahead and ask your question.

Williams, Janet F (Dr.) 59:25
I I had a question about.
So this idea.
Has been floated.
And and actually practiced in Texas.
There was a groundbreaking pediatrician who went back and got her psychiatry training because of that, and and then was integrated into the same practice that she'd been serving into and tried to spread that around.
But one of our problems, which is national, actually, is the shortage of mental health.
Providers. So I would like to know what you do and have done to show the cost effectiveness your your value in terms that will convince the establishment. You know, the practice that the institution to support this, how are you monitoring this to continue to show that metric?

Schreiber, Justin 1:00:23
Yeah, that's a great question. And I think probably one of the biggest inhibiting factors for a lot of practices is how do we ensure that we're that this is this could be paid for it's cost effective.
We lucked out here early on.
Our Children's Hospital president was there.
The psychiatry hospital president, left, and his work was allotted integrated care within our within our pediatric practices.
And so he actually became president of both hospitals. And so there was a big drive to say, how do we do this?
And we're going to find ways to make it work, and it might have a cost at the beginning.

But we're gonna figure that out.
And so we lucked out because I think that allowed us to be able to try different models to find what was gonna work.
In our our outpatient practice of most of our.
Sorry, you know, I think true of many sites.
We have many outpatient practices that are now part of the hospital system and so they have incorporated therapists who are integrated with into their clinics and they do an incident 2 building model primarily, mostly because they do some of that collaboration. It increases the building level.
And and they, they are having these direct conversations with a pediatrician, so they're able to show that it fits that model. Now some of them, they tend to do a different practice to practice.
Some of them do a fee for service.
They see a lot of patients and you know you would think that would be a turn off for some therapists, but I think they like the integrated model.
So they see 35 patients a week, which in behaviour health is actually for therapists, a pretty good chunk of patients and often times what you'd see.
Maybe in a busy private practice, but not always in academics, but they are.
But that allows for them to actually.
Completely for either incident two or FIFA service models compensate for the amount of cost that they would have.
They're also starting to do collaborative care models in some very various other sites where they are doing more where they might not have the same level of services in place, but are able to still enhance with the pediatrician is doing. And so those ones were still assessing the.
Benefit, I think our health plan has been very adamant about utilizing collaborative care.
So they've been really supporting.
This push forward.
So I I think it's helpful again when you have the advocates who say we want to see this 'cause, we know it's so important for the kids we work with and we're going to figure out the funding. And once we do, we can talk about it and so.
I think those are examples in the in the Children's Hospital we we do a lot of FIFA survey 'cause we mostly have psychologists and they can generally build a little bit of a higher rate for the work they're doing, and they've also done health and behaviour

C.
One thing I forgot to mention is the hard thing in behaviour. Health is you can't really bill unless they have an actual.
Diagnosis, but not every kid you see. If you're doing, for example, preventive care in oncology is going to have adsm diagnosis. Yeah, maybe they all have adjustment, but arguably like, maybe they don't really feel bad.
And so they've been using health behaviour code.
So actually utilizing the codes for physical health but being able to utilize those indicating that this is part of the the care package as a whole and when we able to work with insurers to make that work so.
You think in behaviour health in some sense you have to be nimble and find different ways, and there's luckily some.
Really good groups through a cap and through AP that really are looking at this and and some opportunities to collaborate and talk through how to do it.

Kamat, Deepak M 1:03:52
For talking to us about the pediatric integrated mental health care, thank you all for attending this morning's grand round.
I'm going to conclude it's past 7830, so have a wonderful Friday and a wonderful weekend.
Please fill out the evaluations which Delia has already put the link in the chat box, or will send it by e-mail. Thank you.
Thank you, Doctor Schaefer.

Schreiber, Justin 1:04:19
Thanks a lot.

◉ **Kamat, Deepak M** stopped transcription