POSTER ABSTRACT

How Primary Care Pediatricians Manage Behavioral Health Problems in Integrated and Non-Integrated Clinics

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Introduction: Pediatric primary care physicians (PPCPs) are often the first professionals families consult for management of child behavioral health (BH) problems but may vary in their level of training and experience with these issues. These factors, as well as patient access to BH providers, is likely to influence how PPCP's manage presenting BH concerns.

Method: This study assessed PPCP's perceptions on identification, treatment, and referral follow-up of patients with common BH problems (i.e., issues with anxiety, depression, feeding, sleep, toileting, behavior, and ADHD). Surveys were completed by 60 PPCPs practicing in 20 clinics within two major academic medical centers. Responses were on a 7-point Likert Scale (1= Very Uncomfortable/Unlikely to 7 = Very Comfortable/Likely).

Results: PPCP’s endorsed relative comfort with differential diagnosis of all types of BH concerns (range of 5.17 to 6.20) but indicated significantly less comfort providing treatment for all concerns (p< .001) except ADHD (p= .659). PPCPs were particularly uncomfortable treating anxiety (M= 3.78) and depression (M= 3.87).

The likelihood of using medication to treat BH problems was examined for various patient age groups (0 to 2; 3 to 5; 6 to 12; 13 and up). PPCP's only endorsed greater than neutral likelihood (M> 4.00) for ADHD ages 6 and up (M= 6.15), depression ages 13 and up (M= 4.32), sleep issues ages 13 and up (M= 4.05), and toileting problems at all ages (M= 4.41). PPCPs were significantly more likely (p< .0001) to endorse medication for children ages 6 up with anxiety, depression, sleep, behavior problems and ADHD than for those under 6.

The likelihood of patient follow-up with on-site BH services (M= 6.03) was rated significantly higher than off-site (M= 4.05), p <.001. PPCPs with on-site BH providers (n= 32) felt patients with sleep issues, ADHD, and behavior problems were more likely (p< .01) to receive BH services than did PPCPs without on-site BH specialists.

Conclusions: PPCPs endorsed discomfort treating all common BH problems with the exception of ADHD but felt comfortable with differential diagnosis of these issues. Use of medication was deemed unlikely for most ages and BH problems and was less supported for younger children. PPCPs were highly confident their patients with BH problems received care when referred to an on-site psychologist but not off-site.
Lessons Learned: PPCP’s feel comfortable identifying BH problems but are substantially less comfortable treating the majority of these conditions, especially those presenting in young children. PPCP’s acknowledge that clinics with integrated BH providers improve patient care and enhance patient access to BH services. These findings indicate a need for integration of BH services within the primary care setting and provide insight on specific issues PPCP’s feel most ill-equipped to manage independently.

Limitations: It is unclear what accounts for PPCP’s higher comfort with treating behavioral health concerns relative to their likelihood of using medication.

Future Research: It would be useful to examine whether or not integrated care clinics influence PPCP’s management of BH problems in terms of diagnoses, treatment, and referrals.

Keywords: behavioral health