Which Pediatricians Comanage Mental Health Conditions?

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Abstract

Objective: Given the prevalence of mental health (MH) conditions (MHC) in children, pediatricians should initiate treatment alone or in collaboration with a specialist for children with MHC. However, the majority of pediatricians do not manage or comanage common MHC even with an on-site MH provider. We examined which physician, practice, and training characteristics are associated with pediatricians' comanaging at least half of their patients with MHC.

Methods: We analyzed responses of general pediatricians (n = 305) from the American Academy of Pediatrics 2013 Periodic Survey. Practice characteristics include presence of an on-site MH provider and perceived access to services. Independent variables included sociodemographics, training experiences, and interest in further training. The outcome was comanagement of ≥50% of patients with MHC. Weighted univariate, bivariate, and multivariable analyses were performed.

Results: Of the pediatricians who reported comanaging ≥50% of their patients with MHC, logistic regression analysis showed that pediatricians who completed ≥4 weeks of developmental behavioral pediatrics training had 1.8 increased odds (95% confidence interval 1.06, 3.08, $P = .03$) of comanagement, those very interested in further education in managing/treating MHC had 2.75 increased odds (95% confidence interval 1.63, 3.08, $P < .001$), and those with more training in MH treatment with medications had 1.4 increased odds (95% confidence interval 1.12, 1.75, $P = .004$) of comanaging children with MHC.

Conclusions: Specific educational experiences and interest in further education in managing or treating MHC were significantly associated with comanaging ≥50% of patients, suggesting that enhanced MH training among pediatricians could increase the comanagement of children with MHC.

Keywords: behavior problems; comanagement mental health; developmental behavioral pediatrics; pediatric education learning problems

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What's New

Educational experiences, especially targeted training in treating mental health problems with medications, were associated with increased the odds of general pediatricians who were surveyed nationally comanaging more than half of their patients.

MENTAL HEALTH (MH) conditions (MHC) affect 1 in 5 children and have surpassed physical conditions as the most common reasons children have impairments and limitations,[1] with only a minority receiving appropriate services.[2] To improve access to services, given the shortage of MH specialists, policy statements from professional organizations have called for integrating MH care into the primary pediatric medical home.[2] In response, the American Academy of Pediatrics (AAP) generated a set of proposed MH competencies for pediatricians to better define their new role in MH care, acknowledging that new educational approaches and system changes were needed in order to achieve these competencies.[3] These competencies include not only performing a diagnostic assessment but also initiating treatment, either alone or in collaboration with MH professionals, for children with common MH conditions. However, the majority of pediatricians are still not managing or comanaging most common child MHC.[4,5]

Integrating the care for other chronic conditions into the medical home has been done successfully. In the 1990s, studies demonstrated that children with asthma had difficulties accessing quality care,[6] and national efforts, including clinical guidelines, physician education, and learning collaboratives, improved asthma care in the medical home.[7,8] Currently, children with asthma are more likely to have access to a medical home and their health care needs met compared to children with attention-deficit/hyperactivity disorder (ADHD) or autism spectrum

disorder.[9,10] Similar efforts have been taken to enable pediatricians to assume a more active role in MH care. In 1998, the Accreditation Council for Graduate Medical Education mandated a 4-week developmental behavioral pediatrics (DBP) rotation.[11] In 2000 evidence-based clinical guidelines were created for ADHD,[12] followed by the creation of a MH tool kit (2010)[13] and a residency curriculum (2014).[14] Practitioners who completed the full 4 weeks of DBP were more likely to manage or comanage MHC,[15,16] but recent studies demonstrated that less than a quarter of pediatricians treated MHC other than ADHD,[5] and two-thirds of pediatricians endorsed training as a barrier to providing MH care.[17]

Given the slow uptake in addressing MHC in pediatric care, collaborating with MH providers can serve as a first step for pediatricians to build their skills and manage MHC more independently.[18] Three main models for comanagement exist, two of which are when either the primary care provider or the subspecialist become the primary manager. The third is "collaborative and coordinated care that is conceptualized, planned, delivered, and evaluated by two or more health care providers, one being a primary care provider and the other a subspecialist."[18,19] This occurs when both providers share equal responsibility for their patients' care. Studies have shown primary pediatricians can successfully comanage patients with chronic physical illnesses with subspecialists and improve care.[18,19] In adults, comanagement improved mental and physical health outcomes and access to specialty care, and it led to better engagement and acceptability of MH services.[20] One study of adolescent depression demonstrated that pediatricians were more likely to prescribe medications for depression when working in a comanagement model.[21] However, our prior study demonstrated that only a third of pediatricians reported comanaging at least half of their patients.[4] Comanagement for MH care is understudied, and we know little about what factors influence pediatricians to comanage MHC.

Comanagement requires access to MH providers—a major barrier identified by pediatricians.[17] New models of care that incorporate on-site MH providers have been endorsed nationally as a way to facilitate the collaboration and comanagement between providers.[22] Organizations have defined 3 main approaches to integrate MH care (coordinated, colocated, and fully integrated), which differ on the proximity of MH providers and the level to which their systems and visions are united.[22] There is evidence that integrated models of care can affect providers' behaviors and improve MH outcomes in some, but not all, studies.[23] However, the presence of an on-site provider is still uncommon,[4,24] and a national study of practicing pediatricians found no association between the presence of an on-site provider and treating or comanaging MHC.[4] Therefore, it is important to explore other factors, beyond the physical presence of a MH provider, that influence comanagement.

The objective of this study was to investigate physician characteristics, practice characteristics, and training experiences associated with general pediatricians' comanaging more than 50% of their patients with MHC.

METHODS

PERIODIC SURVEY ADMINISTRATION

Data for this study cane from the 2013 AAP Periodic Survey (PS). The AAP has conducted a PS of pediatricians many times yearly since 1987 to inform policy, develop new initiatives, and evaluate current projects. Each PS is sent to a random sample of about 1600 of the >50,000 pediatricians who are nonretired members of the AAP. The details of the survey have been previously described.[17] This PS was sent up to 7 times to 1617 randomly selected US nonretired members of the AAP in 2013 (N = 54,491), of whom 594 (36.7%) responded. (http://www.AAP.org/research/periodicsurvey/). The questionnaire was pretested for clarity and was approved by the AAP institutional review board. These analyses included pediatricians exclusively practicing general pediatrics.

SURVEY QUESTIONS

The survey, which contained largely closed-ended questions, asked about physician characteristics (eg, age, sex, race/ethnicity, year completed residency, years in practice) and practice characteristics (eg, region, practice type, number of ambulatory visits per week, patient insurance, patient race/ethnicity). Years in practice was dichotomized, separating pediatricians who trained before and after 1998, because that is the year the DBP rotation was mandated. Pediatricians were asked questions about their current practices in response to common MHC: ADHD, depression, anxiety, behavioral problems, and learning disabilities, including the question, "In your practice, how frequently do you inquire about, screen for, treat/manage/comanage, and refer each of these problems/conditions?" The question on comanagement was, "Within the past 12 months, approximately what percent of your patients with mental health problems have you comanaged with any mental health care provider?" The outcome measure for this study was whether pediatricians comanaged <50% versus ≥50% of these patients, suggesting they comanage more often than they do not.

Pediatricians were asked whether 7 types of MH practitioners (child psychologists, child psychiatrists, developmental behavioral pediatricians, developmental service providers [ie, early intervention], substance abuse counselors, social workers [SW], and child life specialists) were located on site at their practices. The question was, "In column A, please mark which of the following mental health providers are located *on site* at your primary practice—that is, the practice where you spend most of your time? Please check Yes or No for each provider." If these practitioners were not on site, pediatricians were asked how difficult it was for patients who needed routine MH services to be seen by a MH provider in their practice community (very, moderately, somewhat, or not at all difficult).

Pediatricians were asked questions about trainings they received in child/adolescent MH. First, pediatricians were asked how many weeks of a DBP residency rotation they completed, which was categorized as <4 versus ≥4 weeks. Second, pediatricians were asked whether they