

Pediatric Primary Care Providers' Use of Behavioral Health Consultation

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This column describes a qualitative study in which 32 primary care providers (PCPs) reported barriers to and facilitators of using a behavioral health (BH) consultation program. Barriers included program incompatibility with organizational culture, limited exposure to the program, existing access to referral sources, and negative beliefs about BH consultation. Reported facilitators included

having personal relationships with BH program staff, exposure to program information, and positive beliefs about BH consultation. PCPs recommended outreach activities and optimal program features to increase use of BH consultation.

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Supporting primary care providers (PCPs) in addressing youth behavioral health (BH) is one of several promising models guiding the integration of BH in primary care (1). However, PCPs report time constraints, limited BH training, lack of comfort with BH, and varying beliefs about their role in BH care delivery (2,3). Providing brief and focused clinical consultation by BH providers is one method to overcome these barriers and offers a feasible mechanism to increase PCP knowledge and service capacity (4). To date, more than 30 states have adopted BH consultation programs, which offer case consultation with a BH provider, referral and resource assistance, education and training, or direct case management and clinical care (5).

Initial evidence suggests that these programs are highly acceptable to PCPs and useful in improving their ability to address BH concerns (6,7). However, providers' use of these programs has varied substantially (8). Although a few studies have examined provider use of BH consultation and training programs (9,10), no studies to our knowledge have examined barriers and facilitators specific to telephone consultation, a common feature among PCP BH consultation programs. Thus, additional information from PCPs is needed.

To support PCPs' use of BH consultation, we explored PCPs' perceived barriers to and facilitators of using telephone consultation and sought recommendations to increase PCP use of BH consultation services. Given the dearth of research in this area, we used an inductive approach to inform areas of future inquiry.

The Study

Our study was part of a statewide effort to support pediatric PCPs in addressing youth BH. Maryland Behavioral Health

Integration in Pediatric Primary Care provides free, provider-centered telephone consultation, continuing education, resources and referrals, and social work colocation (for select sites) to pediatric PCPs. The PCPs can request telephone consultation weekdays from 9 a.m. to 5 p.m. Consultations are completed within 24 hours of the initial call, and PCPs receive a written summary for their records.

PCPs associated with the program are differentiated into three groups based on enrollment status and call history: enrolled-active (EA) providers; enrolled-inactive (EI) providers, who are providers who have not yet used the service; and nonenrolled (NE) providers, who are potential users who have not enrolled in or used the service. A fourth group, stakeholders (S), includes partners who work with PCPs.

Interviews were conducted with 22 PCPs and ten stakeholders (N=32). Data collection occurred within the first year of the program (2012–2013). Providers were identified with the program's outreach records. Criterion sampling based on urbanicity of practice location and on enrollment status (EA, EI, NE, and S) guided participant selection.

Recruitment e-mails notified providers about the potential to participate in an interview; if no response was received after one week, a follow-up e-mail and fax were sent. If we received no response, we made a final contact by telephone call after another week. Over the course of six months, 153 PCPs were contacted, and 22 (14%) agreed to participate (EAs, 30 contacted and six consented; EIs, 29 contacted, ten consented; NEs, 94 contacted, six consented), whereas 18 stakeholders were contacted and ten (56%) agreed to participate. Participants consented to participation and were compensated with a \$20 gift card. Interview length ranged 8–44 minutes, with the mean and modal interview times of

approximately 20 minutes. Institutional review board approval was obtained from all relevant institutional boards. [An online supplement provides additional information regarding demographic characteristics and interview questions.]

Using a grounded-theory approach, we used NVivo software to code digitally recorded and transcribed interview data. We developed a focus codebook and tested it in an iterative fashion with three coders who coded nine successive interviews without replacement. Once the codebook was finalized, we tested it and established reliability by having the three coders code five interviews. The remaining interviews were then divided among coders. Theoretical coding consensus meetings were held to review and analyze coded text and memos.

Barriers to and Facilitators of Engaging in BH Telephone Consultation

Barriers to and facilitators of engaging in telephone consultation were organized by theme and are presented in descending order of the frequency with which they were endorsed. Facilitators were coded only if provided by participants who had actually called the consultation line. [Representative quotes can be found in the online supplement.]

The most frequently endorsed barrier to use of BH consultation (N=8) was the organizational culture (fast-paced environment, high patient volume, and limited time) of the PCP's practice (for example, respondent EI7 stated, "I'm always hesitant to do something like that in the middle of my day because if I call this number and I get put on hold and transferred a million times . . . It would ruin my day.")

Certain program features, primarily related to the program's function as a "warm line" versus a hotline, were endorsed as barriers. For instance, PCPs expressed interest in having access to consultation before or after business hours and in obtaining feedback from the consultant more immediately. (Respondent NE5 stated, "If I get a call back like the next day at 11:00, chances are I have three patients waiting in the lobby and two more already in rooms, and at that point taking that call would be difficult.")

In addition, some PCPs indicated a desire for patient-centered consultation versus provider-centered consultation. Respondent EA5 indicated that a telephone number specifically for patients to call for direct care or follow-up would be more desirable.

PCPs who had existing access to referral sources reported less need to access phone consultation. This included BH referral sources outside or within the PCP practice, such as with colocation of BH providers.

The important role of personal relationships was noted by several PCPs as a facilitator of engagement in telephone consultation. This theme highlighted the positive impact of PCPs' having a personal relationship with someone affiliated with the program, which encouraged them to consider using the program.

Several participants emphasized the importance of exposure to the program, including reminders and easy access to the phone number. Even with tangible reminders, such as magnets showing program name and contact information, providers reported that remembering to call the program and make that a part of their regular practice was difficult, suggesting that other barriers (organizational culture) may be more salient.

Several providers endorsed beliefs that BH consultation in general was not feasible or acceptable:

I'm not sure that just being able to talk to somebody on the phone and get a question for the immediate problem [would help]. It doesn't provide any ongoing support. . . . Talking to somebody on the telephone still leaves us just as isolated, and just as liable if we have a problem.—Respondent EI1

Conversely, respondents shared some positive beliefs (facilitators) about telephone consultation. Respondent EA2 described the advantage of telephone consultation over outside referrals as providing more immediate access to care: "Because when you're dealing with mental health in kids . . . three months is a long time. So I was like 'oh this [phone consultation] will be great, maybe we can get intervention quicker than three months, and it might be something simple that we could just do here in the office.'"

Some responses indicated that PCPs might not always be aware of patients' BH concerns or could benefit from clarification about the wide range or age of patients' presenting BH concerns. In some cases, this appeared to lead to an underidentification of BH concerns or lower motivation to access BH consultation.

Recommendations for Outreach and Program Features

Consistent and repeated outreach via multiple modalities (including social media and direct practice outreach) in which "selling point" features are highlighted was emphasized. Participants also strongly emphasized the importance of building and maintaining relationships with providers. In a related vein, leveraging the support of a champion, whether another PCP or stakeholder, to promote the service was referenced by several participants:

If you can get buy-in from one pediatrician who can champion that and approach the others in some way, I think that might be helpful . . . and the real life stories from providers who have used it and how it's been helpful to them. They (PCPs) really look to each other for things that work.—Respondent S1

Participants also mentioned the advantage of having one provider within a group practice with a particular passion for BH to take the lead in engaging in consultations. The potential benefit of partnering with professional organizations to support dissemination of program information was also noted.

Participants recommended extending consultation operating hours as well as offering immediate callback.

Patient-centered consultation was mentioned as a preference, in some cases without the PCP present, such that the consultation could transition from a provider-centered consultation to a direct visit with the patient. Finally, having a member of support staff serve as a designee was referenced on several occasions as a potential method of overcoming barriers related to organizational culture and thus permitting the use of the consultation service.

Discussion and Conclusions

With the goal of supporting increased use of BH consultation among PCPs within this program as well as of contributing generalizable information relevant to programs seeking to support PCP use of BH consultation, we sought to understand PCPs' and stakeholders' perspectives on the barriers to and facilitators of using BH consultation, as well as their recommendations for improving use of such programs. Some findings were consistent with previous studies underscoring the importance of relationships with BH consultants as facilitators of BH integration generally (9). Access to BH care and the unique organizational culture of primary care as barriers to PCP use of consultation have also surfaced in similar work (10). However, our study expands on previous literature by offering a more complete picture of barriers to, facilitators of, and recommendations for BH telephone consultation.

Among the limitations of this study was the potential for sampling bias due to low PCP response rates and the occasionally brief interviews. Therefore, results should be interpreted as emergent and need to be replicated with a larger sample. Future research may seek to engage stakeholders and PCPs to consider methods to facilitate recruitment and data collection.

Results revealed numerous opportunities to further tailor BH consultation services to PCP preferences and the practice context, provided that these can be accommodated within the program's budget and mission. For instance, extending telephone consultation hours may meet provider preference and thus result in greater program impact, but adding these features may challenge program capacity. Thus, program modifications that are easier to implement (such as allowing a PCP designee to call) should be strongly considered.

In addition, programs may consider expanding BH integration services to better align with PCP interests. We learned that some PCPs prefer direct referral, patient-centered consultation, or colocation to provider-centered telephone consultation. Indeed, some programs include in their mission direct care or referral support to patients in addition to consultation to PCPs (7). Thus, while the tailoring of consultation programs may be sufficient for some, for others, provider-centered consultation may not be acceptable. Programs designed to integrate BH into primary care, particularly using phone consultation, should closely

partner with PCPs to inform a feasible and acceptable service array.

Programs hoping to increase PCP use of BH consultation may also consider engaging in repeated, targeted outreach to all PCPs and stakeholders, highlighting aspects of consultation that are "selling points" (access to written notes after the consultation). Outreach efforts may also seek to clarify possible PCP misconceptions and underscore how program features can be modified to best address PCP needs. Further, programs may attempt to partner with professional organizations and build relationships with PCPs, directly engaging practice-based BH "champions" in outreach efforts.

Finally, findings point to the need to more explicitly assess and address provider beliefs about BH consultation. Ultimately, BH integration modalities must fit with PCP belief systems about their role in BH care. However, if a provider feels isolated in regard to BH resources, being able to provide direct referrals or patient-centered consultation may be more appropriate. For PCPs who feel strongly that BH screening, identification, referral, or brief intervention is outside the scope of their practice, placing colocated BH providers in their practices may be a more effective BH integration strategy.

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Submissions Invited for Column on Integrated Care

The integration of primary care and behavioral health care is a growing research and policy focus. Many people with mental and substance use disorders die decades earlier than other Americans, mostly from preventable chronic medical illnesses. In addition, primary care settings are now the gateway to treatment for behavioral disorders, and primary care providers need to provide screening, treatment, and referral for patients with general medical and behavioral health needs.

To stimulate research and discussion in this critical area, *Psychiatric Services* has launched a column on integrated care. The column focuses on services delivery and policy issues encountered on the general medical–psychiatric interface. Submissions are welcomed on topics related to the identification and treatment of (a) common mental disorders in primary care settings in the public and private sectors and (b) general medical problems in public mental health settings. Reviews of policy issues related to the care of comorbid general medical and psychiatric conditions are also welcomed, as are descriptions of current integration efforts at the local, state, or federal level. Submissions that address care integration in settings outside the United States are also encouraged.

Benjamin G. Druss, M.D., M.P.H., and Gail Daumit, M.D., M.H.S., are the editors of the Integrated Care column. Prospective authors should contact Dr. Druss to discuss possible submissions (bdruss@emory.edu; gdaumit@jhmi.edu). Column submissions, including a 100-word abstract and references, should be no more than 2,400 words.