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Thomas K. McInerny, Peter G. Szilagyi, George E. Childs, Richard C. Wasserman and
Kelly J. Kelleher
Pediatrics 2000;106;930-936
DOI: 10.1542/peds.106.4.S1.930

This information is current as of February 8, 2007

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Uninsured Children With Psychosocial Problems:
Primary Care Management

Thomas K. McInerny, MD*; Peter G. Szilagyi, MD, MPH*; George E. Childs, BA‡; Richard C. Wasserman, MD, MPH§; and Kelly J. Kelleher, MD, MPH‡

Abstract. Objective. Nearly 14% of children in the United States are uninsured. We compared the prevalence of psychosocial problems and mental health services received by insured and uninsured children in primary care practices.

Methods. The Child Behavior Study was a cohort study conducted by Pediatric Research in Office Settings and the Ambulatory Sentinel Practice Network. Four hundred one primary care clinicians enrolled an average sample of 55 consecutive children (4–15 years old) per clinician.

Results. Of the 13,401 visits to clinicians with 3 or more uninsured patients, 12,518 were by insured children (93.4%) and 883 were by uninsured children (6.6%). A higher percentage of adolescents, Hispanic children, those with unmarried parents, and those with less educated parents were uninsured. According to clinicians, uninsured children and insured children had similar rates of psychosocial problems (19%) and severe psychosocial problems (2%). For children with a clinician-identified psychosocial problem, we found no differences in clinician-reported counseling, medication use, or referral to mental health professionals.

Conclusions. Among children served in primary care practices, uninsured children have similar prevalence of clinician-identified psychosocial and mental health problems compared with insured children. Within their practices, clinicians managed uninsured children much the same way as insured children. 

Nearly 14% of children in the United States (between 9 and 11 million) are uninsured.1–4 Studies have documented that uninsured children are more likely than insured children to lack access to health care,5–11 to use fewer needed health services,6,7,9–16 to have poorer quality of care,17,18 to have worse reported health status,7,12,19 and in some cases to have potentially avoidable hospitalizations.20 However, little is known about mental and behavioral health care for uninsured children.

It is not clear if these differences in access and quality of care are attributable to different settings and places at which uninsured children receive health care, or if they are attributable to different types of care received from their primary care providers. Uninsured children are less likely to have a regular source of care than insured children,7,9,16 and by inference, less likely to experience the benefits associated with a regular source of care. Alternatively, clinicians in primary care settings may provide different diagnoses and treatment to uninsured children than they do to insured children either because they have concerns about the affordability of certain treatments or because they lack familiarity with uninsured children because of less frequent contact. Prior studies have found differences in primary care providers’ management and referrals for children covered by managed care, compared with children not covered by managed care, suggesting that differences in patients’ health insurance status can influence provider decisions.21 Thus, it is important to assess whether these differences extend to uninsured children. However, prior studies have had insufficient sample sizes, regional variation, and clinician variability to examine whether diagnosis and management of childhood illnesses are different for uninsured children.

The Child Behavior Study (CBS) examined the management of child psychosocial problems in primary care practices for 24,183 children seen by 401 clinicians. The large number of children, clinicians, and sites provided sufficient opportunity to explore whether different diagnoses and management are provided to insured and uninsured chil-
dren presenting with psychosocial problems in primary care. Psychosocial problems among children are particularly interesting to examine because they are common and their management is quite variable. Also, services are dependent on a number of patient and clinician factors and the majority of mental health services for children and adolescents are provided or initiated in the primary care sector.

The objective of this study was to compare the patterns of psychosocial diagnoses and treatments received in primary care offices between uninsured and insured children. We hypothesized that uninsured children would be less likely to be identified with psychosocial problems than insured children after controlling for severity of parent reported psychosocial problems, but that this relationship would be mediated by clinician familiarity with patients. We hypothesized that, among children with identified psychosocial problems, uninsured children would receive similar diagnoses, psychotropic drug prescriptions, and counseling from primary care clinicians as compared with insured children, but that referrals would be relatively lower resulting from concerns about the affordability of specialty care.

METHODS

Setting

The CBS was conducted by Pediatric Research in Office Settings (PROS),26 and the Ambulatory Sentinel Practice Network (ASPN).27 2 large, practice-based primary care research networks. PROS is a pediatric network that was established in 1986 and currently comprises >1500 clinicians from >480 practices in all 50 states and the Commonwealth of Puerto Rico who provide care for approximately 1.75 million children in the United States. ASPN is a family medicine network that was established in 1978 and currently consists of approximately 680 clinicians from 141 practices in 41 states and 6 Canadian provinces who provide care for about 500,000 patients. Eighty-nine percent of ASPN clinicians are pediatricians, 10% are nurse practitioners, and 1% are physician assistants. Eighty-five percent of ASPN clinicians are family physicians, 7% are nurse practitioners, and 8% are physician assistants. ASPN also collaborated with 2 regional networks to expand the number of participating family physicians. The characteristics of the Wisconsin Research Network (WReN) and the Minnesota Academy of Family Physicians Research Network (MAFPRN) are similar to those of ASPN and contributed 38 and 24 participating clinicians, respectively. Recruitment of clinicians into the study has been described fully elsewhere.28

Prior research from both ASPN and PROS confirms the similarity of patients, clinicians, practices, and clinical behaviors of physicians participating in primary care network studies with those identified in national samples.29–32 A survey conducted as part of the CBS showed no difference in demographic factors or practice characteristics among participating pediatricians and a random sample of primary care pediatricians from the American Academy of Pediatrics (AAP). AAP pediatricians, however, had minimally higher rates of patients with either private insurance or no insurance.

We excluded 116 practices whose enrolled patient populations did not include at least 3 uninsured children because comparisons of their treatment of insured and uninsured children were less meaningful. The setting therefore included 235 pediatric and family practice clinicians from 90 practices in 38 states and the Commonwealth of Puerto Rico. Analysis of the data both before and after these exclusions did not significantly impact the results.

Sample

Each participating clinician enrolled a consecutive sample of approximately 55 children 4 to 15 years old presenting for nonemergent care with a parent or primary caretaker. Ninety-one percent of eligible children across all sites participated. No differences in age or gender were detected in a comparison of participating versus nonparticipating children. Children in the western United States were slightly more likely to participate. Results on 22,059 visits are reported. Among those visits, 909 (4.5%) had inadequate or missing data sufficient to preclude further analyses resulting in a final sample of 21,150 visits with adequate data. Limiting the study group to those children seen in practices with 3 or more uninsured children resulted in 13,401 children, of whom 12,518 (93.4%) were insured and 883 (6.6%) were uninsured. Clinicians identified 2562 children with psychosocial problems. Among these children, 2394 (93.4%) were insured and 168 (6.6%) were uninsured.

Procedures

Procedures and consent forms were approved by institutional review boards affiliated with PROS, ASPN, and the Universities of Pittsburgh and Arkansas. Study procedures have been described in detail elsewhere.28 Parents (or other caregivers) of eligible patients were approached in the practice waiting room for informed consent. Consenting parents completed a brief questionnaire before the visit assessing demographics, child and family functioning, and behavior problems. After the visit, the clinician completed a questionnaire describing patient insurance, reason for the visit, identification, and management of psychosocial problems. Participating clinicians received a glossary of terms for items included in the questionnaires and videotape instructions. Clinicians and/or their office staff personnel were asked to indicate the type of insurance coverage of children who were seen.

Measures

Clinician-Reported Items

Insurance Status

Children covered by any insurance plan, commercial or Medicaid, were defined as being insured. Those with no insurance of any type were classified as uninsured.

Clinician Identification

Clinician identification of a psychosocial problem was noted as a positive response to the question on the clinician survey, “Is there a new, ongoing, or recurrent psychosocial problem present?” Psychosocial problems were defined as any mental disorder, psychological symptom, or social situation warranting clinical attention or intervention in the opinion of the primary care clinician.

To classify the types of psychosocial problems, 11 categories based on prior work were modified through focus group discussions and pilot testing before the study. All the problems were grouped as either new or previously identified. These 11 categories were later grouped into 4 divisions: Attentional/Hyperactivity problem, Internalizing problem, Other problem, and Multiple problems. Internalizing problem includes adjustment reaction/reaction to stress, other emotional problems (eg, anxiety, sadness), and physical manifestations (eg, sleep, enuresis, or eating problems). Other problem includes behavioral or conduct problems, specific developmental delays (eg, learning disabilities), childhood psychosis, substance abuse, mental retardation, and family dysfunction. Multiple is a combination of problem types.

Visit Characteristics

Clinicians recorded the time spent with each patient by choosing from 8 discrete categories grouped in 5-minute intervals ranging from 0 to 5 minutes to ≥16 minutes. In addition, they indicated whether counseling was provided to the patient in the office that day, whether psychotropic medications were prescribed that day or in the past, and whether the patient was referred for mental health treatment that day or in the past. Clinicians also reported on the reason for the visit (acute or chronic medical concerns, psychosocial concerns, or well-child care and preventive services).

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**Parent- or Guardian-Reported Items**

**Psychosocial Problems**

The Pediatric Symptom Checklist (PSC) is a parent-report brief symptom list for primary care.\textsuperscript{36-37} The PSC consists of 35 items with never (0 points), sometimes (1 point) and often (2 points) responses for parents on particular behaviors. An overall sum represents parental impression of psychosocial functioning.\textsuperscript{38} The PSC has demonstrated strong internal consistency, test-retest reliability, and validity with psychiatric assessments of child functioning.\textsuperscript{39-41} For this study, standard scoring of the PSC was used; ie, all children with a PSC score of \( \geq 28 \) were considered positive as were those \(< 6 \) years old with a PSC \( \geq 24 \). PSCs of children with \( > 5 \) items missing were considered incomplete. For PSCs of children with 5 or fewer missing items out of the total number of items (35), each of the missing values was replaced by the average of 5 random draws of that item from the sample of children with no missing items.\textsuperscript{42}

The PSC scores were then recalculated using these imputed values. Uninsured children were neither more nor less likely that insured children to be excluded from the sample because they had \( > 5 \) missing items on the PSC.

**Family Functioning**

Family functioning was measured using the Family Apgar, a 5-item instrument designed to measure adult satisfaction with family support. The Family Apgar was introduced by Gabriel Smilkstein in 1978 to assess adult satisfaction with social support from the family.\textsuperscript{43} The psychometric properties of the instrument have been examined with general support for its validity and reliability.\textsuperscript{44-49}

**Analysis**

We used \( \chi^2 \) tests to examine broad differences between insured and uninsured children in terms of the percentages of children identified and treated by clinicians for psychosocial problems. In cases where these analyses indicated possible differences between the 2 groups, we reported the results of logistic multiple regression analyses to separate out the influence of other factors related to uninsured status and the management of psychosocial problems.

Classical regression techniques assume that selected samples are representative of the entire population being studied. Because of the sampling technique necessitated by this study, namely the recruitment of patients through office practices, this assumption was not valid. Because groups of patients were sampled from practices and seen by the same clinicians, we expected their treatment decisions to be correlated with each other within practices. This correlation can affect the significance levels of statistical tests of regression coefficients, leading to too-frequent rejections of null hypotheses of no effect. To correct for this problem, we used the generalized estimating equations regression technique which corrects the significance levels of these statistical tests for this correlation. The term generalized refers to the breadth of regression types that can be estimated using the technique. In this study we used the logistic distribution because the dependent variables were categorical. In the median pre-scribed regression discussed in the "Results" section below, we included a repeated effect for practice variation to capture this correlation. We used the \( Z \) scores to determine the statistical significance of the variables in this regression using the GENMOD procedure from SAS (SAS Institute, Inc., Cary, NC).\textsuperscript{45,46}

Because of power considerations, we were not able to include all of the related factors that might have an influence on the medication decision; however, it is unlikely that such inclinations would have a major effect when included with insurance status because in prior analyses using the entire CBS data set, their effects on treatment decisions have been insignificant.

**RESULTS**

Table 1 compares the demographic characteristics of uninsured versus insured children. Uninsured children (6.6% of the total population) were more likely to be adolescents, Hispanic, and to come from families with less educated parents.

This result was consistent with the structure of Medicaid (which has a higher income of eligibility for young children) and the joint association of education with income, poverty, and lack of insurance. Although the \( \chi^2 \) tests showed statistically significant differences for age and marital status, \( t \) tests from a logistic regression (results not shown) including these 4 factors plus gender could not reject the null hypothesis that the coefficients for age and marital status were 0. Therefore, age and marital status were only correlated with insurance status through their correlation with other demographic factors.

Table 2 compares parental report of child’s overall health, the presence of psychosocial problems as measured by the PSC, child’s average grades in school, and family functioning based on the Family Apgar. Uninsured children were more likely to have fair or poor health, more likely to have a positive PSC score, and more likely to have fair or poor grades than insured children.

Clinicians identified 19.1% of insured children and 19.0% of uninsured children as having psychosocial problems. When compared with PSC-indicated problems (13% overall), for 75% of patients, clinicians agreed that there was no psychosocial problem and for 7% of the cases they agreed that there was a problem. For 12% of the patients, clinicians identified a psychosocial problem when none was indicated by the PSC score and in 6% of the cases clinicians did not identify a psychosocial problem when the PSC indicated that one existed.

Table 3 compares clinician-reported characteristics of those children identified as having a psychosocial problem. Uninsured children were more likely to have been seen for a sick visit and less likely to have presented for a well-child care visit. Although not statistically significant, uninsured children seemed to present more often with a newly defined psychosocial problem that may re-
reflect the higher level of PSC-indicated problems among uninsured children. We performed a multiple logistic regression to determine if new problem identification was correlated with insurance status after adjustment with our observed demographic factors. We regressed new problem identification on child/visit factors, clinician/practice factors, and uninsured status. Child/visit factors included sex, age, race, PSC score, Family Appgar score, overall health rating, health care utilization, parent education, reason for the visit, region of the country, season, clinician’s relationship to patient, how long patient was known to practice, and whether the patient was enrolled in the first half of the clinician’s study period. Clinician/practice factors included sex, age, discipline, training, beliefs about psychosocial problems, practice structure, practice location, degree of managed care penetration in the practice, and whether a specialist works onsite. The t test for the coefficient on uninsured status indicated that uninsured children were not identified as having newly identified psychosocial problems more frequently than children with insurance (odds ratio [OR] = 1.45; P = .07). There were no significant differences in severity or type of the psychosocial problems between uninsured and insured children.

Table 4 examines 3 types of clinician treatment provided for insured and uninsured children. Notably, rates of counseling, prescription of psychotropic medications, and referral for mental health treatment did not vary significantly based on insurance status. Despite these negative results, we were concerned enough about the higher proportion of psychosocial problems reported by parents of uninsured children, that we performed a multiple regression to determine if treatment was correlated with insurance status in a way that was confounded by our observed demographic factors. We examined the prescription of psychotropic medication regressed on PSC score, age, gender, race, parental education, and uninsured status. The t test for the coefficient on uninsured status indicated that uninsured children identified as having a psychosocial problem by the clinician were not treated with psychotropic medications more nor less frequently than children with insurance (OR = 1.43; P = .31).

**DISCUSSION**

This study of the frequency of psychosocial problems among 13,401 patients seen by 235 clinicians yields some expected and unexpected results in the comparison of insured and uninsured children. As expected, uninsured children are more likely to be Hispanic and to have parents with lower education levels. They were also more likely to have poor to fair health, poor to fair grades, and psychosocial problems as reported by parents. Physicians noted that uninsured children were less likely to present for well-child visits than insured children, as expected. However, there were no significant differences in percent, severity, or treatment of patients with psychosocial problems identified by physicians for the insured and uninsured groups, not even for referrals where we expected to find such differences.

One explanation for the unexpected findings may be that physicians diagnose and treat insured and uninsured children similarly, once they visit the physician’s office. Thus, the differences in visit rates to primary care providers and mental health professionals may be attributable to lack of access to these caregivers, while diagnosis and treatment, once seen by a clinician, are similar. Of significant importance is that although a greater percentage of uninsured children are rated as having behavioral problems by their parents, there is no difference in rates of identification for psychosocial problems by clinicians for uninsured versus insured children. This disparity implies that clinicians are underrecognizing behavioral problems in uninsured children. This may be explained by the fact that uninsured children have fewer clinician visits than insured children, especially for well-child care. Because clinicians’ sense of responsibility for their patients’ overall well-being is related to frequency of visits (especially well-child visits), then the likelihood of recognition of behavioral problems is related to the number of patient visits to their primary clinician. Thus, it is reasonable to postulate that uninsured patients’ relatively low number of visits with a primary clinician leads to underrecognition of psychosocial problems. This implies that improving access to continuous care for uninsured children (by providing them with insurance of some sort) will improve the likelihood of clinician recognition of psychosocial problems.

Unfortunately, although there was a 6-month follow-up of a subset of children identified as having psychosocial problems, the numbers of uninsured patients in this follow-up group were too small to yield any statistically significant information about whether or not those referred to a mental health...
TABLE 3. Clinician Reported Characteristics Among Children With a Clinician-Identified Psychosocial Problem (N = 2562)

<table>
<thead>
<tr>
<th>Reason for the visit</th>
<th>Insured Children</th>
<th>Uninsured Children</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 2394</td>
<td>n = 168</td>
<td></td>
</tr>
<tr>
<td>Well visit</td>
<td>26.4</td>
<td>15.7</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Mental health visit</td>
<td>28.9</td>
<td>30.7</td>
<td></td>
</tr>
<tr>
<td>Sick visit</td>
<td>44.8</td>
<td>53.6</td>
<td></td>
</tr>
<tr>
<td>Newly identified problem</td>
<td>25.6</td>
<td>32.1</td>
<td>.06</td>
</tr>
<tr>
<td>Severe problem</td>
<td>9.0</td>
<td>11.9</td>
<td>.21</td>
</tr>
<tr>
<td>Problem type*</td>
<td>25.6</td>
<td>32.1</td>
<td>.06</td>
</tr>
<tr>
<td>Internalizing</td>
<td>29.9</td>
<td>32.9</td>
<td></td>
</tr>
<tr>
<td>Attention/Hyperactivity</td>
<td>34.8</td>
<td>29.9</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>20.9</td>
<td>22.8</td>
<td></td>
</tr>
<tr>
<td>Multi</td>
<td>14.4</td>
<td>14.4</td>
<td></td>
</tr>
</tbody>
</table>

* Internalizing problem includes adjustment reaction/reaction to stress, other emotional problems (eg, anxiety, sadness), or physical manifestations (eg, sleep, enuresis, or eating problems). Other problem includes behavioral or conduct problems, specific developmental delays (eg, learning disabilities), childhood psychosis, substance abuse, mental retardation, and family dysfunction. Multi is a combination of problem types.

TABLE 4. Treatment for Children With a Clinician-Identified Psychosocial Problem (N = 2562)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Insured Children</th>
<th>Uninsured Children</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 2394</td>
<td>n = 168</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>52.7</td>
<td>54.2</td>
<td>.71</td>
</tr>
<tr>
<td>Psychotropic medications</td>
<td>27.3</td>
<td>23.2</td>
<td>.25</td>
</tr>
<tr>
<td>Referral</td>
<td>15.6</td>
<td>14.3</td>
<td>.64</td>
</tr>
</tbody>
</table>

provider actually received care. Clinician referral rates to mental health providers were similar for uninsured versus insured children, but we cannot ascertain if there were any differences in the receipt of care by mental health providers between the 2 groups.

These results must be interpreted with caution as the overall demographics of the population studied are not representative of US children as a whole, with certain minority and lower socioeconomic groups underrepresented. Only 6.6% of the study population were uninsured, which is significantly less than the 14% of the general population of children uninsured in the United States. Therefore, the uninsured children were underrepresented in the practices surveyed which suggests limitations to the generalizability of the results to all settings in which health care for children is provided. In addition, this study neither attempted to measure in detail the quality of psychosocial care nor the appropriateness of management by providers. However, this study is the largest of its type to examine the incidence of psychosocial problems in children presenting to pediatricians and family physicians who provide the vast majority of primary care for children. Thus, one can reasonably extrapolate the results to those children seen in similar settings.

As suggested by others studying health care of children in general, care for children with psycho-social problems can be expected to improve as access to primary care and mental health providers increases. It will be important to examine the impacts of the State Child Health Insurance Program (Title XXI) and other child health insurance reforms on children’s access to, and receipt of, services by clinicians. It is possible that increased overall access to primary care providers will translate into better identification of psychosocial problems among children and improved outcomes of care. Furthermore, it will be important to compare mental health care for children across states if there is variation in states’ provision for mental health services for eligible children. Such differences in outcomes may suggest methods of providing optimal services.

APPENDIX A: PARTICIPATING CBS PRACTICES

PROS Participating Practices

The pediatric practices or individual practitioners who completed this study are listed here by AAP chapter. Alabama: Drs Heilpern and Reynolds, PC (Birmingham); Alaska: Anchorage Neighborhood Health Center (Anchorage); Arizona: Mesa Pediatrics Professional Association (Mesa); Ambulatory Care Clinic (Phoenix); Orange Grove Pediatrics (Tucson); California 1: Anita Tolentino-Macaraeg, MD (Hollister), Paul Anderson, MD (San Francisco); Medical Foundation (Los Altos); Colorado: Arvada Pediatric Associates (Arvada), Family Health Center (Denver), Gino Figlio, MD (Lamar); Connecticut: Gerald Jensen, MD (Bristol), Barry Keller, MD (Danbury), Community Health Services (Hartford), St Francis Pediatric Primary Care Center (Hartford), Florida: Atlantic Coast Pediatrics (Merritt Island), Children’s Clinic (Tallahassee); Georgia: The Pediatric Center (Stone Mountain); Hawaii: Melinda Ashton, MD (Honolulu), Straub Clinic–Pediatrics (Aiea); Iowa: Newborn and Pediatric Specialist, PC (Des Moines), David Kelly, MD (Marshalltown); Illinois: SI Physicians and Surgeons (Auburn), Emalee Flaherty, MD (Chicago), Southwest Pediatrics (Palos Park); Indiana: Bloomington Pediatric Association (Bloomington), Community Health Access Program (Bloomington), Drs Mary Jo Stine and Richard Weiner (Indianapolis), Jeffersonville Pediatrics (Jeffersonville), Pediatric Advocates (Peru); Kansas: Bethel Pediatrics (Newton); Kentucky: Tri-State Pediatrics, PSC (Ashland); Louisiana: Children’s Clinic of John S大地; Maine: John Salvato, MD (Yarmouth); Maryland: O’Donovan and Ahluwalia, MD, PA (Baltimore), Children’s Medical Group (Cumberland), Shore Pediatrics (Easton), Clinical Associates Pediatrics (Towson/Woodlawn); Massachusetts: Holyoke Pediatric Associates (Holyoke), Medical Associates (Leominster), The Fallon Clinic (Worcester); Michigan: University Pediatricians, P. C. (Detroit), Pediatric Associates of Farmington (Farmington), Mott Children’s Health Center (Flint), H. M. Hildebrandt, MD (Ypsilanti); Montana: Stevensville Pediatrics (Stevensville); Nebraska: Southwest Pediatrics (Omaha); Nevada: Capital Medical Associates (Carson City), Physician’s Center West (Fallon); New Hampshire: Exeter Pediatric Associates (Exeter); New Jersey: Delaware Valley Pediatric Association (Lawrenceville); New Mexico: Albuquerque Pediatric Associates (Albuquerque); New York 1: Pediatric Associates (Camillus), Elmwood Pediatric Group (Rochester), Park Medical Group (Rochester), Edward D. Lewis, MD (Rochester), Panorama Pediatric Group (Rochester), Amherst Pediatric Associates (Williamsville); New York 2: Centro Medico (Jackson Heights); New York 3: Pediatric Office at Roosevelt Island (New York); North Carolina: Triangle Pediatric Center (Cary), Goldsboro Pediatrics (Goldsboro), Medical Association of Surry (Mount Airy), Peace Haven Family Health Center (Winston-Salem); North Dakota: MeritCare Medical Group-Pediatrics (Fargo), Altru Clinic (Grand Forks), Dakota Clinic ( Jamestown), Medical Arts Clinic (Minot); Ohio: Oxford Pediatrics and Adolescents (Portsmouth), St Elizabeth Health Center (Youngstown); Oklahoma: Eastern Oklahoma Medical Plaza (Poteau), Shawnee Medical Center Clinic (Shawnee), Pediatric and Adolescent Care...
(Tulsa); Pennsylvania: Pediatric Practice of Northeastern (Honesdale), Schuykill Pediatrics (Pottsville), Covellos and Moise Pediatric Associates, PC (Quakertown), Pennridge Pediatric Associates ( Sellersville); Puerto Rico: Ethel Lamela, MD (Isabela), Primary Pediatric Care Clinic Catano (Rio Piedras); Rhode Island: Marvin Wasser, MD (Cranston); South Carolina: Carolina Primary Care (Columbia); Tennessee: Johnson City Pediatrics (Johnson City); Texas: The Pediatric Clinic (Greenville), Department of Pediatrics (Lackland Air Force Base), MD Pediatric Associates (Lewisville), Winnbros Pediatrics (Winnaboro); Utah: Gordon Glade, MD (American Fork), Mountain View Pediatrics (Sandy), Salt Lake Clinic (Sandy), Granger Medical Center (West Valley City); Vermont: CHP Brattleboro Pediatrics (Brattleboro), University Pediatrics (Burlington), Rebecca Collman, MD (Colchester), Essex Pediatrics (Essex Junction), Mousetrap Pediatrics (Milton), CHP Timber Lane Pediatrics (South Burlington), Joseph Hagan, Jr, MD (South Burlington), Ten Practitioners of Pediatric Medicine (South Burlington), University Pediatrics (Williston); Virginia: Drs Casey, Goldman, Lischwe, Garrett and Kim (Arlington), James River Pediatrics (Midlothian), Pediatric Faculty Practice Office (Richmond); Washington: Jemima Tso, MD (Auburn), Redmond Pediatrics (Redmond), Rockwood Clinic (Spokane); West Virginia: Tessa Alejo (Martinsburg), Medical and Pediatric Associates (Parkersburg), Grant Memorial Pediatrics (Petersburg); Wisconsin: Beloit Clinic SC (Beloit), Middleton Pediatric Clinic (Middleton), Waukesha Pediatric Associates (Waukesha), Gunderson Clinic, Whitewater (Whitehall); Wyoming: Cheyenne Children’s Clinic (Cheyenne), Jackson Pediatrics (Jackson).

ASPN Participating Practices
Arkansas: Batesville Family Practice Center (Batesville); California, Foothills Family Medical Group (Auburn), Loma Linda Family Medical Group (Loma Linda); Colorado: Renee Julian, MD (Fort Collins), Harrington, Knaus, and Spence, PC (Carbondale), La Mariposa Clinic (Denver), Colorado Springs Health Partners (Monument), Penrose Family Health Center (Penrose); Florida: The Florida Doctors of Bellevue (Bellevue); Georgia, Titus Tabe, MD (Warner Robbins); Louisiana: Family Medicine Center of Baton Rouge (Baton Rouge); Minnesota: Eagle Medical (Excelsior), Ramsey Clinic–Maplewood (Maplewood); New Hampshire: Mascoma Valley Community Care (Enfield), Hillsboro Medical Services (Hillsboro); New Jersey: A. John Orzano, MD (Flimington), Community Care Center (Lebanon); New Mexico: Santa Fe Family Practice (Santa Fe); New York: Raj B. Kachoria, MD (Macedon), Canal Park Family Practice (Palmyra), Montefiore Comprehensive Family Care (Bronx), Mary Kay Nolting, MD (Fort Hall, ID); North Carolina: Bakoski Family Medicine Clinic (Bakosville), Nalli Clinic (Matthews); North Dakota: University of North Dakota Family Practice Center–Minot (Minot) Minot Center for Family Medicine (Minot); Ohio: Center for Family Medicine (Cleveland); Oregon, Dunes Family Health Care, Inc (Reedsport); Pennsylvania, John Farmer, DO (Waynesboro), Good Samaritan Family Practice (Lebanon), Tennessee: Michael H. Hartsell, MD (Greenville), Mountain City Extended Hours Clinic (Mountain City); Texas: Van Horn Rural Health Clinic (Van Horn); Virginia: June Tunstall, MD (Surry); Tappahannock Family Practice (Tappahannock); West Virginia: North Fayette Family Health Center (Hico); Wisconsin: Kronenwetter Clinic (Mosinee); Alberta: Foothills Family Medicine Clinic (Blackfalds); New Brunswick: David North (Moncton); Newfoundland: Newhook Community Health Center (Whitbourne), Ross Thomas, MD (Sackville); Ontario: Steve Nantes, MD (Kitchener), Metcalfe and Dowdell (Kitchener), Bryan Atton, MD (Hamilton).

MAFPRN Participating Practices
Family Medical Practice, PA (Willman), Family Medicine of Winona (Winona), River Valley Clinic (Hastings), Family Medicine Clinic of Lake Crystal (Lake Crystal), Gateway Family Health Clinic (Moose Lake), Eagan Medical Associates (Eagan), Fairview Uptown Clinic (Minneapolis), Bay Area Health Center (Silver Bay), West Side Health Center (St. Paul), Hennepin Family Physicians (Hopkins), Family Practice Center (St. Cloud), Mt Royal Medical Center (Duluth), North Memorial Family Practice (Minneapolis).

WeN Participating Practices
Wisconsin: Poynette Family Practice Center (Poynette), Medical Associates (Baraboo), Plymouth Family Physicians (Plymouth), Monroe Clinic (Monroe), UCC/Mona Grove (Madison), Family Doctors-Black Creek (Black Creek), Southwestern Family Practice (South Milwaukee), Family Health Plan (Elm Grove), LaSalle Clinic (Appleton), Marshfield Clinic–Merrill Center (Merrill), Tigerton Clinic (Tigerton), Doan Medical, (Oregon), Physicians Plus/Fitchburg (Fitchburg), Family Health Plan (Glendale), Franciscan Skemp Clinic (Tomah), Galesville Medical Center (Galesville), Medical Associates (Beaver Dam), LaSalle Clinic (Wauapa).
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