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## CONFERENCE ABSTRACT

### Supporting Families Using a Rural Paediatric Integrated Care Model

16<sup>th</sup> International Conference on Integrated Care, Barcelona 23-25 May 2016

Victoria Venable, Amy Habeger

Salisbury University, United States of America.

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**Introduction:** Children in rural areas are 20% less likely to receive mental health and behavioral interventions than those living in urban areas (Lambert, Ziller, & Lenardson, 2009). This is largely due to isolated service providers and the families' lack of resources. To underscore the struggles of parents, it has been reported that 29.4% of parents report that pediatric behavioral health care services are hard to access and difficult to coordinate, especially in rural environments (Bronheim, Thomas, & McKay, 2007).

Rural families in Maryland struggle to access social and behavioral health care services due to stigma, transportation, provider shortages, and a lack of family education regarding the need for services. There is currently a lack of accessible integrated health care services available to support pediatric patients and their families in rural Maryland.

**Description of Practice Change:** Expanding shallow end care services within pediatric primary care offices in rural areas provides early screening, identification, brief treatment, and family care coordination for social and behavioral health conditions. The purpose of expanding these services through medical and social care integration is to increase access to care, normalize screening and treatment, and to facilitate the presence of social care in the primary care medical office. By increasing the services to families in the primary care office, wait times for screening and brief treatment are reduced, and the backlog for specialty care referrals and treatment is reduced. Increased supports available in the primary medical office increases the support families receive which reduces the struggle families have faced in the past to coordinate care for children.

BHIPP was established in 2012 through a partnership between Johns Hopkins University, University of Maryland, and Salisbury University, with funding from Maryland's Behavioral Health Administration. The overarching goal of BHIPP has been to increase the capacity of pediatric primary care providers to identify and treat social and behavioral health concerns. BHIPP serves the patients treated in pediatric offices whose ages range from birth through 22. Key stakeholders through this process have included the providers, local health departments, Departments of Social Services, Departments of Juvenile Justice, parent advocacy agencies, local school systems, and state coordinating agencies.

**Key Findings:** Thus far, 29 student interns have made over 1950 patient contacts. The interns have reported that the model increases the parents' receptivity to services and interventions,

and empowers them in the decision making process related to their children's behavioral health care.

This most recent evaluation project is focused on measuring the patient and family experience with the interns in the host environment. The results of this research will be presented.

**Highlights:** The innovative components of the Salisbury model include the collaboration and partnership with a Child Psychiatry Access Program (CPAP), which provides additional training and telephonic support for the integrated workers and the medical care providers, and ultimately increases the expertise of services available in the rural pediatric medical office. In-office interventions include intensive care management for families, motivational interviewing, screenings and referrals, and family skills training. By having an on-site student care provider, the parents are able to build relationships, develop trust, and are more likely to follow through with recommendations.

The relationship with the physicians and families is built upon an adaptive feedback loop, where the families and student care providers work with the physicians to make decisions about what social and behavioral health services will be most beneficial. The student care providers then respond by adapting their interventions and work with patients on such topics as bullying prevention, nutrition education, boundaries and rule setting, behavioral charting and rewards, concentration exercises, and relaxation training. Families have responded favorably to the increased care supports in the medical office, which enhances their commitment to creating and sustaining a healthy family.

**Discussion and lessons learned:** The BHIPP Salisbury model is an example of effective implementation of integrated behavioral health and social care to support families in rural settings. This largely underserved population has increased their access to social care and behavioral health services. Feedback from providers, students, and families will be shared and discussed.

**Conclusion:** There is evidence of sustainability and transferability at it relates to growing number of patients served across the state of Maryland. The contact rate continues to increase each year as well as the number of providers who sign up to host a student. Sustainability is supported by the growth rate, publicity, and state-level funding support. Consistency in practice participation and continued growth supports the applicability of this model across host settings.

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**Keywords:** social work interns; host environment; collaborative care; paediatric; people-centered

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