

Transcript for RHIhub Webinar: Mental and Behavioral Health of Rural Children - Insights from the CDC MMWR Rural Health Series

Kristine Sande: Hello everyone. I'm Kristine Sande, and I'm the Program Director of the Rural Health Information Hub. I'd like to welcome you to today's webinar, Mental and Behavioral Health of Rural Children and this is the second in our webinar series featuring the insights from the CDC MMWR Rural Health Work. And I just want to quickly run through a few housekeeping items before we begin. We do hope to have time for your questions at the end of the webinar. If you have questions for our presenters, please do submit those at the end of the webinar using the Q&A section that will appear in the lower right-hand corner of the screen following the presentation. We have provided a PDF copy of the presentation on the RHIhub website and that's accessible through the URL that's on your screen right now or by going to the RHIhub webinar page, which is www.ruralhealthinfo.org/webinars and then clicking into today's presentation. If you do decide to go download the slides during the webinar, please don't close the webinar window though. That will make you have to log back into the event.

If you have any technical issues, please call WebEx support at 866-229-3239. I will now turn the webinar over to our guest moderator for today's session, Ms. Heather Dimeris, who is with the Federal Office of Rural Health Policy ... Heather.

Heather Dimeris: Hi everyone and thank you Kristine for the introduction. I am, as Kristine said, with the Health Resources and Services Administration, Federal Office of Rural Health Policy. I serve as the Deputy Associate Administrator and it's my pleasure to moderate this session today. And just briefly, before I introduce the speakers, talk about the importance of this issue. 1 in 3 rural children live in poverty and so the impact of their health and social well-being is certainly something that our office focuses on, as well as others in the department in rural communities across the nation. Having a panel of speakers here today and an MMWR report that highlights the mental, behavioral, and developmental disorders in children in rural and urban areas is really an important issue. I'm so excited and pleased that we have this conversation that we'll have it available to those interested via the webinar.

So, having said that, I'll get straight to introducing the speakers and I'm just gonna go ahead and do all of them. Right now, we have four really great speakers lined up. The first speaker is Dr. Reem Ghandour. She is the Director for the Division of Epidemiology in HRSA, the Health Resources and Services Administration Maternal and Child Health Bureau Office of Epidemiology and Research. She oversees a range of programmatic investment, but her individual portfolio includes original research on a variety of maternity and child issues, with a special focus on children with special health care needs.

Then next up, I'm happy to also introduce Dr. Lara Robinson. She's a Behavioral Scientist with the Child Development Studies Team at the Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities. She is serving as the Semination and

Implementation Project Lead for the CDC's Legacy for Children Program ... And this is a really neat program that provides parenting intervention for improving child development outcomes among low income families. I'm happy to have her here.

And then following her presentation will be Kara Bower with the Ben Archer Health Center. She's a Social Worker with this program and I'll just note that the Ben Archer Health Center actually is a HRSA grantee, as a health center. They also receive a Healthy Start Grant, which she'll be speaking about. She's the Healthy Start Program Director at the health center there. And also, a third grant they receive from HRSA is through the Federal Office of Rural Health Policy and the Office for the Advancement of Telehealth. They get a Telehealth network grant through that. So, they're doing a lot of really great work. I'm happy to have Kara on this call as well, to talk about what they're doing on the ground with this grant and the multiple grants they have from HRSA.

And then, the last speaker today, to close it up, will be Linda, Dr. Linda Summers. She's a nurse, Clinical Nurse Specialist and a Certified Nurse Practitioner for Ben Archer Health Center, so she works closely with Kara Bower. And she completed her post-doctorate certificate as a Family Psychiatric Nurse Practitioner from Brandman University in 2012, so you can see we have an incredible line-up. I can't wait to learn more about this report and the things that are happening across the country and specific to the Ben Archer Health Center in New Mexico. And with that, I am gonna go ahead and to turn it over to the first speaker, Dr. Ghandour.

Dr. R. Ghandour:

Thank you so much Heather and good morning and good afternoon to all of you for joining us. Thank you for taking the time out of your day. As Heather mentioned, I direct our Division of Epidemiology in the Office of EPI and Research in the Maternal and Child Health Bureau. And so, one of my roles in that office is to direct the National Survey of Children's Health and that is the data source that was used for the report that you'll be hearing about today. So, I am just gonna take a little bit of time to introduce you to that data source because it's certainly one that is, can be uniquely used to look at the health and well-being of kids in rural communities, and so I just want to orient you to that survey. And then more importantly, to kind of tee-up the fact that we are going to be releasing a new round of data, probably much later this summer, very early fall ... But it'll be an exciting opportunity to look at these indicators specifically as they relate to kids in rural areas.

So, to that end, I'm just going to take a few minutes to provide an overview of our national survey. Just if you haven't used the survey or don't know much about it, this will tell you kinda historically where we've been. I'm gonna touch on a process that we recently underwent to redesign the survey to hopefully better meet the needs of folks across the country. And then finally, I'll be talking about some future direction and opportunities. So this is really just to contextualize the data and the information that Lara is gonna present in just a few minutes.

By way of background, we've actually historically funded two separate surveys in the Maternal and Child Health Bureau. The one was really designed to produce national and state level estimates for a wide range of indicators of kid's health ... and that's kids 0-17 years old. And we fielded that survey in 2003, 2007, and 2011, and 2012. We've also had a sister survey in the field on, in alternating years and that was the National Survey of Children with Special Health Care Needs. This was also a national survey that produced state level estimates, but really the focus was on providing estimates of the prolonged impact of special health care needs across the country.

Though different surveys with slightly different foci, but also some common element, so they've always have been funded and directed by HRSA, Maternal and Child Health Bureau. We've historically fielded them as telephone surveys and uniquely they both provide national and state level estimates and that state level piece is what's really important here because it allows us to get to that granularity of the data that lets us look at some of these really important differences by rural-urban location.

And finally, the data are all parent and caregiver reported, so that can be a limitation, but in many cases it's a strength because it allows us to ask knowledgeable caregivers about a wide variety of topics and I will give you just a flavor for some of the breadth of the content in just a minute. In terms of the history and uses of this survey, you know, again speaking to this sort of really close tie to our state stakeholders, one of our primary uses of the survey has always been to support our Maternal and Child Health block grant services program. And so states use these data to basically do program assessments and to apply for funding each year.

With the state level use and focus on the data, we also obviously have federal policy and program work that comes out of the survey and specifically healthy people is sort of one example of that. But we also do a lot of research with the data and that's sort of how I came to them. What I've tried to do on this slide is to give you a flavor for the different kinds of topics that you can investigate. You can look at everything from specific conditions like asthma or ADHD. You can look at broader systems' indicators.

And then what I really draw your attention to is examples under the third and fourth bullet, because this shows you how folks have been able to publish by using these data to do state level analysis and then to draw down even further to look at county. So the sooner you get it, some of that rural-urban differences and also regional analysis because certainly some key maternal mental health topics really do track by region and it's an important opportunity to look at the way states can work together to tackle problems.

In terms of using the data, one of the things we've tried to do in the Bureau is to make sure everyone regardless of their comfort level with data and statistics has a chance to use the data for decision making, to really get a data driven decision making in a timely way. So, in addition to being able to download a data file if

you want to poke around with it yourself, you can go to a HRSA funded, HRSA supported website, which is childhealthdata.org ... And this is basically a portal that can get you to a user defined query system where you can search all of our data systems. And just to give you a sense of what that might look like, I did a screenshot so you can choose one of our previous surveys from 2011, 2012 ... The data that or actually the most recent right now and what the Lara will be presenting from and you could do a basic search. It's just a by variant search, but it lets you look at a key indicator, like children's overall health by rural-urban status. So that's the kind of thing you could have at your fingertips if you choose.

In terms of the content of the survey, I wanted to just include this to give you a sense of the breadth of the survey and in many ways the depth. So the data that Lara will be presenting on really will kinda pull from various points throughout the survey, but we have eight core content areas. So these range from general health status ... We have a condition list, as we call it, of 24 different conditions that we ask about.

You can look at infant health including birth outcomes, as well as breast feeding. We have two sections, health services and then exponential health care providers that include a variety of content on health care access, utilization, and quality. And then we have two sections, health insurance and providing for your child's health, that really get at different sorta aspects of how folks pay for their care and the kinds of impacts that providing for their child care has on the family. And then finally, we have contextual factors. So these are the neighborhood and community level factors as well as measures of family functioning and family interaction.

In addition to these core content areas, we also have age specific content. So, for the first time in the new data coming out at the end of this summer, we will have measures of healthy and ready to learn for kids ages 3 to 5. And then for older children in that 12 to 17 age group, we have measures around health care transition planning ... So that move from pediatric care to adult care.

As I referenced very briefly early on, we have underwent redesign over the last four years and the main reason for that is basically the image that I have on the left side of the screen here. We were a telephone survey and now the majority of kids in this country actually live in a household that only has a cell phone, so that makes it pretty tough to call them up on a landline and get the information that you want. So what we did is, we underwent a redesign really to get at these four goals, so we shifted from calling folks to mailing them the survey. We shifted from having an interviewer sort of walk them through the questionnaire to them self-administering. And then we combined those two surveys that I talked about initially, so we have a single instrument that we are now going to be fielding every year. So, much more timely data.

I won't say too much about this, but it was a four year process to redesign the survey. So for those of you who were familiar with these data, what I can tell

you is that we really went into the process with a goal of ... And I think succeeded in doing this ... Of retaining as much of the content and the functionality that we've had previously. So basically, the work that Lara will be presenting on will be replicable going forward. But we really, with that, we also dramatically changed the sampling strategy and the mode of administration. So, important changes that make it impossible for us to really trend over time, but important maintenance of functionality and content that will allow you to do much of the work that you've done in the past with the survey.

And I'm just gonna close with this slide. So in terms of getting to the new survey, we conducted the survey in 2016, so that was our first year back in the field. We went from June 10 to February 10 this year. The questionnaires are all publicly available right now on our MCHB HRSA website. The link is on your slide. We expect to publicly release the data very late summer 2017. And again, you'll be able to access it in two ways, both through our data resource center and then through the census bureau if you wish to download the public use file and work with it yourself.

And now, we are currently working with ... You know, to develop a range of supporting documents to make sure kinda regardless of how you come to the data, you're able to make sense and understand the methods and the design behind it. The 2017 survey is already finalized. This is a very fast moving train, if you will ... So, we go in the field with the 2017 survey July this year. We have a few content changes that you see there on the slides, but basically, we kept it as much as similar to the 2016 survey as possible, for continuity.

And then, 2018 is really your next chance to inform content or tell us what you think about how we're framing. We'll be doing cognitive testing this summer and then we'll be finalizing content over the fall. So, I'll say that my contact information is on this slide. I'd love to hear from you if you have ideas about the content or the way the survey could better meet your needs. We would certainly love to hear from you.

And with that, I will turn it over to Lara, who actually speak more about the uses of these data.

Dr. L. Robinson:

Great. Thank you so much Dr. Ghandour for that overview of HRSA's National Survey then for, also for your collaboration on this report. It is my great pleasure to be here to talk to you about our recent morbidity and mortality weekly report during National Children's Mental Health Awareness Week. So, our report is entitled, Differences in Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders Among Children Age 2-8 Years in Rural Urban Areas - United States 2011-2012.

This is an overview of what I will be presenting today. I'll begin with a brief background of children's mental, behavioral, and developmental disorders. I'll talk more specifically about the details of our study and the results. Then I'll discuss what we can do to help children in rural communities thrive. I'll conclude

with study limitations, take home messages, and how you can learn more about the information presented today.

Mental, behavioral, and developmental disorders, or MBDDs can affect the life-long health and well-being. Children with these disorders face challenges at home, at school, and with friends. When children grow up in a safe and nurturing environment home environment, have opportunities to learn, and time to interact and build relationships with other children, they're more likely to reach their full potential. This is especially true for children with MBDDs.

Previous research has shown that children with MBDDs in their families face personal, financial, and neighborhood challenges more often than families of children without these disorders. These problems may make it harder for some parents to give their child the resources they need for healthy development. The type of community that children live in, for example, urban versus rural, may increase these challenges.

To better understand these differences by community types, we examine nationally representative data from the National Survey of Children's Health, 2011-2012. The National Survey of Children's Health is a cross-sectional, random digit-dialed telephone survey of parents or guardians that collects information on non-institutionalized children less than 18 years old in the United States. We restricted our data to U.S. children ages 2-8 years old, with valid responses for child's age and sex, each MBDD, and zip code.

So this resulted in our analytic sample of 34,535 children. Survey interviews included indicators of health and well-being, health care access, and family and community characteristics. Mental, behavioral, developmental disorder diagnosis was determined by parent report and was not validated by health care providers or with medical records. Rural status was defined by the rural-urban commuting area or RUCA codes. RUCA codes are determined by a census tract based classification system and daily commuting information. In this report, we used four rurality categories: urban, small rural, large rural, and isolated.

Several community factors differ across residential categories. Children in all rural areas more often lacked amenities such as parks, recreation centers, sidewalks, and libraries in their neighborhood, than children in urban areas. Children in rural areas more often lived in a neighborhood in poor condition. For example, with garbage, vandalism, or housing in poor condition. Children in large rural and small rural areas more often lived in families with financial difficulties than children in urban areas.

There were also some areas of strength identified in rural communities. Parents of children in small rural and isolated areas reported living in a neighborhood that felt less ... That felt unsafe, less often than children in urban areas. And parents of children in isolated areas reported less often that they lived in a neighborhood lacking social support. In addition, a lower percentage of children

in isolated areas, compared to children in urban areas, reported to lack a medical home or have a parent with fair or poor mental health.

According to parent report, in urban and the majority of rural community types, children with a mental, behavioral, or developmental disorder or MBDD, more often lacked a medical home, had a parent with poor mental health, lived in families with financial difficulties, and lived in a neighborhood lacking physical and social resources than children without an MBDD in each of those same community types. There is a higher prevalence of MBDDs among children in small rural areas than urban areas. This was 18.6% versus 15.2%. Parents of children with MBDDs in rural areas more often reported having trouble getting by on their family's income than parents of children with these disorders in urban areas. They more often rated their own mental health, or their partner's mental health as fair or poor. These parents also reported more often living in a neighborhood in poor condition and with limited amenities, such a recreation centers and libraries. And even after adjusting for race, ethnicity, and poverty, the only factor that was no longer associated with rurality was financial difficulties.

So what can we do to help children in rural communities thrive? All children with MBDDs can benefit from better access to mental and behavioral health care, programs that support parents and caregivers, and opportunities to learn, play, and socialize. Collaboration between health care systems, primary care clinicians, and family support programs may offset the challenges faced by children in rural areas. States can consider policies and programs that alleviate financial hardships for families in rural areas, or that support the delivery of affordable mental and behavioral health treatment and services to families in rural areas. States can encourage health plans to reimburse for mental health and behavioral health services for parents and children. States can also expand neighborhood resources in rural areas that allow children to play, read, and socialize.

Health care systems can collaborate with early learning programs, parenting support programs, and primary care clinicians, to help improve access to behavioral health care and community social and recreational resources. Health care systems can also explore ways to deliver affordable services for parents and children in rural areas, such as the integration of mental and behavioral health services into primary care settings and schools, as well as the use of Telehealth. Primary care clinicians can connect families with mental and behavioral health treatment, parenting support programs, and early learning programs. Providers can also screen parents and children for stress, depression and other mental health problems.

Although there are many strengths to this study, it's also important to note there are some limitations. First, MBDD diagnosis was not confirmed by medical record or provider. Second, the data are cross-sectional and therefore, causal association cannot be made. Third, urban and rural communities might define and conceptualize neighborhoods in different ways. Fourth, the RUCA variables

are based on 2000 census data and 2004 zip codes and the designations of urban areas can change over time. Fifth, these data represent a single point in time and they don't reflect changes in residence. For example, the possibility that a child moved from an urban area to a rural area or converse. Sixth, rurality may be associated with poverty and other demographic factors. Therefore, the individual contributions of factors in this report might be difficult to determine. Lastly, these data might be affected by non-response bias, even though they have been weighted to adjust for this.

In conclusion, I'd like to summarize a few take home messages from this study. Rural children with mental, behavioral, and developmental disorders face certain family and community challenges more often than children in rural areas with the same disorders. Children in rural areas with MBDDs may need additional support. All children with mental, behavioral, and developmental disorders can benefit from better access to mental and behavioral health care programs that support parents and caregivers and opportunities to learn, play, and socialize.

If you'd like to learn more about this study or similar studies, please see the web links provided for other MMWRs in the rural health series, a paired commentary in the New England Journal of Medicine about this study, and a policy brief published by the Milbank Memorial Fund on behavioral health integration in pediatric primary care.

I would like to thank and acknowledge my co-authors on this report: Doctors Holbrook, Bitsko, Ms. Hartwood, Ms. Hartwig, Dr. Kaminsky, Dr. Ghandour, Dr. Peacock, Ms. Hyde, and Dr. Boyle. In addition, I'd like to thank Ms. Ross for communications expertise on this report, webinar, and related product. And with that, I'm going to turn this presentation over to the Ben Archer Clinic.

Thank you.

Kara Bower:

Hey, hello. My name is Kara Bower, I'm the Healthy Start Director at the Archer Health Center in southern New Mexico. The Archer Health Center is a federally qualified health center serving four counties along the US-Mexico border.

What are we seeing in rural New Mexico? Poverty, language, and citizenship status can be significant problems for residents of southern New Mexico. The Hispanic population is 66.6% and 50.4% of the population reports speaking Spanish as a primary language. The majority of our staff speak English and Spanish to meet the language needs of patients. Many families suffer from high levels of divorce, physical and drug abuse, and domestic violence. Children from these families suffer from severe trauma and psychological problems that are manifest in anxiety, depression, attention deficit, and social interactions.

Additionally, in 2010, according to the New Mexico IVA system, the rate of substantiated child abuse or neglect was 13.6 per 1000 children or nearly 3000

children. New Mexico is second in the United States for the most children that die from abuse, according to the U.S. Department of Health and Human Services. U.S.-Mexico border has a negative impact on health and health resources. Border counties have financial health issues and tend to have higher rates of health disparities. Additionally, access to adequate behavioral health services is a very big problem.

How are we addressing need? Some of the initiatives that we have include: early childhood intensive home visiting, mental health first aid, Circle of Security parenting classes, Comprehensive Community Support Services, National Health Service Corps, Eye Movement Desensitization and Reprocessing, integrated primary care and behavioral health, Telehealth, and school-based services.

Early childhood intensive home visiting ... We provide intensive home visiting services to pregnant women and children ages 0-3. During home visits, home visitors promote safe, nurturing relationships between young children and their caregiver and implement strategies to prevent adverse childhood experiences and to promote well-being. By providing services to this vulnerable population in their home, many of the barriers to accessing care are eliminated. Home visitors are trained using infant mental health principles such as reflective practice, attachment, relationship based practice, mutual competency, and parallel practice. The home visiting program is a prevention and promotion initiative aimed at establishing secure attachment between children and their caregivers.

Mental health first aid ... all of our home visitors and social services staff are trained in mental health first aid. Mental health first aid is an eight-hour course that gives people the skills to assist someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy and helps the public to identify, understand, and respond to signs of mental illness.

Circle of Security ... Our staff is trained in the Circle of Security parenting program, which is based on decades of research about how secure parent-child relationships can be supported and strengthened. At times, all parents feel lost about what our child might need from us. Imagine what it might feel like if you were able to make sense of what your child was really asking from you. Using the model developed by the Circle of Security originators, our trained facilitators work with parents and caregivers to help them to understand their child's emotional world by learning to read emotional needs, support their child's ability to successfully manage emotions, and enhance the development of their child's self-esteem.

Comprehensive Community Support Services or CCSS is available to children who have a mental health diagnosis that is interfering with their functioning. This service is provided in conjunction with behavioral health services and is designed to be a short term program to develop specific skills to improve their level of function. CCSS uses a variety of interventions, primarily face to face and

within a community location. CCSS coordinates and provides necessary services and resources to eligible children and their families to promote recovery, rehabilitation, and resiliency. The recovery and resiliency based outcomes are in the areas of independent living, learning, working, socializing, and recreation.

National Health Service Corps ... Because our service area is very rural, it is difficult to recruit and retain behavioral health professionals, especially those who serve children. Our services area is designated as a behavioral health shortage area. A vital strategy that Ben Archer uses to recruit providers that are interested in providing services to the underserved community, is that we are a National Health Service Corps approved site. Through this program, behavioral health providers are eligible to apply for loan repayment. This has allowed Ben Archer Health Center to recruit high quality professionals, including a Spanish-speaking child psychologist, other prescribing psychologist, and several therapists.

What is EMDR? EMDR or Eye Movement Desensitization and Reprocessing is psychotherapy treatment that is used by Ben Archer Health Center therapists. EMDR enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. EMDR can assist people who suffer from trauma, anxiety, panic, disturbing memories, post-traumatic stress, and many other emotional problems. In 2011, with funding from HRSA, Ben Archer Health Center was able to train six therapists in EMDR. These therapists have seen very good results using EMDR with children in rural settings, in particular, in treating children who have been exposed to cartel violence along the US-Mexico border.

At this time, I will now turn the presentation over to Dr. Linda Summers, who will tell you more about school-based services, integrated primary care and behavioral health, and Telehealth.

Dr. L. Summers:

So, school-based health based services. A lot has been written about school-based health service and we happen to have six Ben Archers running six, presently school-based health services. The idea is that there is no wrong door. So whether the adolescent or child come in because they have a cold or they come in for a stubbed toe or sports physical, all of them are screened for mental health services. So we normalize mental health services.

The teachers recognize we do that and then regardless of what they come in for, we then can screen ... Send them off to different providers that are available at the school. So the issues we treat primary care, mental health, substance abuse, and health promotion within the school and so the things that matter there are that we train providers to be knowledgeable about adolescents in general and children and mental health in particular. We presently train physicians and nurse practitioners within the school setting because we think that's the best place to do it. And that we address both the preventing and the pressing concerns.

So if they come in for acne, but they've also had a fight with their boyfriend, or they're homeless, we can then address that at the same time. And that we use a screening tool for all adolescents, therefore, the definition is that all adolescents are at risk. We don't just say, "Oh, that one, that one, and that one". And clearly in rural settings, the school based health center is the best medical home. The kids have to go to school. They get bussed to the school and to provide those services there, is the best idea.

I already mentioned integrated a little bit when I was talking about the school-based health services, but one of the things that's really important, and when you're thinking about school, is that we're in the same site. So, it's not silo care, it's not mental health over here and primary care over here, and education over here, it's all mixed. We have access, we know information that you may not know, which is whether they're showing up at school at all, and their missed dates ... And we're always available, so on the day they do show up, we can make the appointment.

So we have things like accessibility, availability and acceptability. Clearly accessibility, the child's there. The parents can go there and there's not the issue of travel. There's also the availability because we're always there. Ben Archer presently has full service mental health and full service primary care in the high schools and has mental health services in the elementary schools. And as far as acceptability, while schools are a good place to get education and our premise is that, if you treat the mental and the physical health, you definitely will be improving education. And therefore ... We also provide services, by the way, to teachers, which is a very stressful ... And the people who work in the schools.

Next slide, TeleHealth. How do we do that? One of the ways that we think is the best is we can provide Telehealth. An example of why we need to use Telehealth is, I am Spanish-speaking, but there not a lot of Spanish speaking psychiatric nurse practitioners. And so the parent comes in on a certain date and it's the only day they can come, but it's not a day that I'm there ... I'm at another school. I can actually link in and see that child. Because of that, there's no waiting list to get service for the schools right now. If you need service, you get seen right away and that includes med management. In rural areas, kids sometimes have to travel quite a bit to get their medication and wait a long time and miss school. The very thing that we don't want.

So, that's it. Thank you.

Heather Dimeris:

All right, I want to thank all of our presenters for providing the background of their specialty areas that have done research or on the ground work with the children and the providers. At this point ... You know, what I think about from the Federal Office of Health Policy at HRSA, is sort of those on the line may be interested in resources that may be available to them. So I just briefly want to mention the Federal Office of Health Policy. There is a Rural Health Outreach Services grant program, as well as the Telehealth Network grant program that

are competed on a regular basis and if you're interested in more information about that, we are happy to provide those funding opportunity announcements to you as they come out.

Additionally, the Rural Health Information Hub does have a mental health and substance abuse tool kit for rural communities to use. It's not specific to the pediatric population, but it is general and broad and may of interest to those on the phone because this topic. And at this point, I think just recognizing the folks on the phone today ... The work that they do ... Everyone who is listening ... And also that tomorrow is Children's Mental Health Awareness Day, May 4 and there are a lot of activities that will be occurring and certainly some of these same presenters will be presenting on panels tomorrow. So you may hear more of this, but just really happy to have this call.

And at this point, I have to turn it back over to RHHub to facilitate questions.

Kristine Sande: Great! Thanks so much to all of our presenters and to Heather. And at this time, we will open the webinar up for questions. So you should see a Q&A box on the lower right hand corner of your screen. You can enter your questions in there and as you enter those questions, I just ask that you please select the option to send the question to all panelists. That will help so your question doesn't get missed.

We do have one question at this time for the folks at Ben Archer. And that is, how do you evaluate the effectiveness of your mental health programs?

Dr. L. Summers: Well, I can answer for the school-based health centers, for the Telehealth. We actually use a screening tool on all our adolescents. So we gather data all the time, like on a daily basis. When an adolescent fills out that tool, then we discuss it with them and that automatically goes to a data bank. Then, we use that tool to see whether or not the adolescent that needed services, got that services and how long did they have services and then we evaluate every year the adolescents of the survey. So we are constantly evaluating ... We have like a short screening, so that we then say, okay that worked, that didn't work and we change it as we go.

Kristine Sande: Great, thank you. Another question is, how do you recruit participants for your community based programs?

Dr. L. Robinson: For community based programs, we use a variety of methods to recruit and recruiting is always ongoing. Some of the things we do is we'll run internal reports through our medical records to see who might qualify for programs. Then we reach out to them that way. We also do door to door recruitment strategies. We do word of mouth. We just have a variety of ways that we try to engage people within the community.

Kristine Sande: Great. Next question is how did the two national surveys reviewed at the beginning account for demographic differences and responses that might occur, such as among minorities and/or other cultural and ethnic groups?

Dr. R. Ghandour: That's a great question, thanks for raising it. That's certainly something every surveillance system has to grapple with. Primarily, how we handle it is through weights. The way that we are able to say that an estimated nationally representative or state representative is that individual, there's a weight that is applied to literally every observation in there, in the data system. Those are usually developed through very complex algorithms, again, based on the likelihood of response, the rarity of the combination of characteristics, socio-demographic characteristics of the individual. That allows us to then sort of make statements that are generalizable.

We'll be doing a similar process for the new data that are coming out and they're usually tracked against or based on another, what is considered, sort of gold standard data source. In this case, we will be matching against the American Community survey for the new data coming up. It's a complex process but it's one that we put a lot of time and effort into addressing in a methodologically sound way.

Kristine Sande: All right. Looks like the next question relates to the Ben Archer School Based Health Center. The question is how have you handled treating the kids of teachers and the possible dual relationships?

Dr. L. Summers: That's a good question. Actually, Telehealth helps because we have several school based centers, actually six. You can actually see a child at a school that you're not even working, or that you don't know any of the teachers. I frequently have seen someone that I don't know the name of the principal. I couldn't identify anybody in the school other than that child. Telehealth really helps. Kids are very receptive to it, and I have found that parents are very receptive to it.

Kristine Sande: Great. This next question is also for you, Linda. What survey or screening tool are you using?

Dr. L. Summers: We're presently using Just Health, it's part of the CDC's tool. It's called ... The ESHQ was adopted to the Just Health and it's electronic but it also is available by paper. Apex designed some of it. Actually, the state got together asked a lot of the questions and now Apex runs the system but it's pretty great. The advantage to this particular tool is that whether you're the nurse practitioner, the physician, the therapist, the respiratory therapist, you can get something out of it. We require that all providers review the tool once the child has filled it out with the child.

We look for the things that are more pertinent to us. It allows you to refer out. It has some, the PHQ-2 is on there, the PHQ-9, the GAD score, things that are very well known and well researched.

Kristine Sande: Great, thanks. Let's see, the next question relates to funding for transportation to get youth to activities. I'm just wondering what sort of funding program exists, for example, getting them to camping and outdoor trips, and learning a skill they might be able to incorporate into their lives like skiing, or hiking, those sorts of things. I would just mention, in regards to this, that they can always call or email the RHHub, and we can help you look for funding opportunities. With our presenters, are any of you aware of opportunities?

Heather Dimeris: This is Heather Dimeris and I'll just say that through the Rural Health Outreach Services Grant Program, it is a program that communities can do an assessment and apply for funding to help improve in areas that they need to focus on. That could be a variety of different topics because it's non categorical. If the entire program were to be about transportation for activities for youth, it probably would not fit the legislative requirement, however, that could be a component of a larger project to help provide services around mental and behavioral health for children.

If anybody's interested in that, please do connect with me. My email address is hdimeris@hrsa.gov, and I'd be happy to connect you with the project officers to assist with determining whether or not your application is something that will fit within the scope of the grant.

Kristine Sande: All right. This next question may also be something that you could answer, Heather. Asking about, what is the process involved in becoming a National Health Service Corps site?

Heather Dimeris: Sure, thanks Kris. Yes, there is a process for it and the first step is to determine whether or not your site is eligible to become a National Health Service Corps recipient. With that, I don't have all of the details in front of me, but I will turn folks over to the National Health Service Corps website that HRSA has. It's www.nhsc.hrsa.gov, and the first webpage will be about becoming a National Health Service Corps site, and it has the application and the details on there.

Kristine Sande: Great, thanks Heather. This question says, we have a school based health clinic using Telehealth in our rural area. How do we promote it within our schools and community? Maybe Linda, do you have some ideas on that?

Dr. L. Summers: Well, when we first got our first tele-medicine unit, our first Telehealth unit, we did a contest in the school to name it. The name they ended up giving it was Seymour, and it made the yearbook that year. We didn't but it did. The kids usually have some kind of news things and letting them do the publicity really helps. It became very, very popular. We took it from class to class, too. We

wheeled it from class to class and teachers were very excited about introducing it.

Kristine Sande: Great. Looks like this is also for you, Linda. You mentioned that you have access to student attendance data in your health center. How did you work to overcome any HIPAA or FERPA limitations with those data?

Dr. L. Summers: Right. We don't actually pull it up. We work side by side with the school nurse in our office. They can give us that information and we get parental consent when the child starts seeing us. As far as looking for whether or not somebody has been in the classroom, we'll say the school nurse looks because we're not allowed in that computer, but we can access the information they get whether or not he's actually attending, which is one of the child's I was seeing in a rural setting. I would drive up there, actually was missing school every single time I got there. Now, I'm seeing that same child via tele-medicine. It's a much better choice. If she's there, I see her. If she's not there, then I don't. The school is working on that absence issue.

Kristine Sande: Okay, great. Let's see, this question says locating behavioral health in schools is a great way to overcome geographic distance challenges. The question really is, how are most school based mental health services being funded? Anyone have an answer on that? I guess I'm not sure off the top of my head how most are funded. Certainly the health center program is helpful if you can actually have a health center based in the school. Beyond that, we need to do some research on that. If you want to send that question to the RHInfo information specialists, they'd be happy to take a look into that question. The email address is info@ruralhealthinfo.org.

Kara Bower: This is Kara Bower. Ours, we look at it as an expansion the federally qualified health centers. We do bill for the majority of services. We have expanded Medicaid in our state so a lot of things are billable. That's one way that we fund it.

Kristine Sande: Great, thank you for that. Let's see, can any of you speak to the opportunities for health profession students and trainees around rural children's health? What do you see as important for med students, nurse practitioners students, etc., in this area?

Dr. L. Summers: Well, I take students, both, I work with the residents, the medical residents, and medical students, and PAs, and nurse practitioner students. I think having an exposure to understand that it's not the same exact needs as the urban area. That there are special needs that come, transportation being of course one of them, and being able to work in that environment. We take them there and we also let them see them via Telehealth. That is one way that you can offer services. We found that students have very little opportunity to Telehealth. All of the sudden, they get a job and they're supposed to do Telehealth but they're off the screen or they don't really know how best to deal with it.

In our program, we actually teach students how to use Telehealth to the rural area. It's part of the curriculum and it's becoming more and more so in the curriculum of a lot of health programs.

Kristine Sande: Great, thank. Going back to the question about the National Health Service Corps, Margaret writes in that the application cycle for National Health Service Corps sits is currently open and closes June 6th, so that's good to know. You might want to check that out right away. The next question is, North Carolina has a large and growing non-public school population, so home schools, private schools. How do you reach students who do not participate in public school programming? Any thoughts on that?

Dr. L. Robinson: Hi, this is Lara. I think what some of the data give us clues to is the fact that integrating and building connections, systems that serve young children are often fragmented and siloed, and making sure that you can link to services in multiple different ways whether it's through health, whether it's through school, whether it's through community agencies. Building those connections across these multiple services that are serving children is important regardless of the system that they're in.

Kristine Sande: All right. It looks like we might have time for one last question here. This one says it's an admittedly broad question. It says, "I'm a psychologist now working in a rural university interested in extending my research program to focus more on rural youth mental health issues and interventions. What are some best first steps to take as well as helpful resources"?

Is that something you could answer, Lara?

Dr. L. Robinson: Can you repeat the question again, please?

Kristine Sande: Sure. This person is a psychologist working in a rural university and he's interested in extending his research to focus more on rural youth mental health issues and interventions. Just wondering what are some maybe good first steps to take as well helpful resources?

Dr. L. Robinson: To start working in rural communities?

Kristine Sande: I believe so.

Dr. L. Robinson: I think, at least from our study, with the data are showing is that all children with mental, emotional, and behavioral disorders need support. The supports are pretty similar across community sites, although, the parents in rural communities are telling us that they need more supports in terms of financial difficulties, neighborhood resources. Again, I think the important piece is thinking about the resources in the communities that serve these children and building connections across multiple programs. Finding what's out and what's available. Working with parents, parenting support programs. Parents are

children's primary caregivers and they can be powerful influences in children's development. Making sure that parents have the resources that they need in terms of supporting their own mental health and promoting enriching, positive experiences in the home and in their community.

Kristine Sande:

Great, thank you. Well, I think we've addressed all of the questions, so at this point I think we will wrap things up. On behalf of the Rural Health Information Hub, I'd like to thank our speakers for this really great webinar with great information and insights. I'd also like to thank everyone who listened in for participating. A survey will be emailed to you following today's webinar and we encourage you to complete that survey to provide us some feedback that we can use in hosting future webinars. Please note that the survey that appears on the screen at the end of this webinar will be a WebEx survey and not the RHHub survey which will be emailed to you.

The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and transcript of today's webinar will be made available on the website and also sent to you by email in the very near future. You can listen again or you can share the presentation with your colleagues. Thank you again for joining us today and have a great day.