Interprofessional Behavioral Health Scholars (RIBHS and HEALS) Poster Fair
Welcome

Thank you for joining us today as we celebrate the work accomplished by our 2017-2018 Interprofessional Behavioral Health Scholars.

Students have created a professional poster that visually demonstrates their interprofessional behavioral health work at their social work field placement. Each poster reflects a special project that each student participated in over the course of the year, along with lessons they learned in relationship to interprofessional collaboration and behavioral health. Students are excited to share this information with our university and community partners.

This Interprofessional Behavioral Health Poster Fair was made possible through funding provided by HRSA and CSWE. In addition, this day would not have been possible without the support of our Interprofessional Behavioral Health Advisory Board, along with the preceptors and field instructors that supported our students.

Sincerely,

Dr. Melissa Reitmeier
Dr. Aidyn Iachini
Dr. Teri Browne
Dr. Candice Morgan
Rural Interprofessional Behavioral Health Scholars (RIBHS)

The Health Resources & Services Administration awarded a four-year grant (PI: Melissa Reitmeier, PhD, Co-PIs Aidyn Iachini, PhD and Teri Browne, PhD), Rural Interprofessional Behavioral Health Scholars Program, to develop and expand the social work behavioral health workforce in rural, vulnerable, and medically underserved areas in South Carolina. Specifically, RIBHS develops advanced year master’s level social work (MSW) students’ interprofessional behavioral health competencies through development of a specialized training program over a four-year grant period from 2017-2021. There are currently 26 RIBHS students who completed an intensive and integrative field seminar (taught by Candice Morgan, PhD) and field practicum at a site that prepares students to implement high-quality, evidence-based rural behavioral health interventions within interprofessional teams with a minimum of two disciplines (i.e., nursing, pharmacy, medicine, law, education).

The following is a list of our Scholars:

**Antwan Adams**  
**Cara Bibeault**  
**Kenya Burton**  
**Gabrielle Butler**  
**Danielle Campbell**  
**Briana Carter**  
**Eric Clark**  
**Alyssa Colvin**  
**Zachary Cooper**

**Javonte Davis**  
**Brittaney Desjardins**  
**Allison Eacrett**  
**Flavia Gibson**  
**Nastassja Gibson**  
**John Greco**  
**Anne Greene**  
**Ashton Hammond**

**Andrea Johnson**  
**Zhayawna Johnson**  
**Lauren “Bailey” King**  
**Kaleigh McCormack**  
**Taylor Newman**  
**Bodequia Simon**  
**LaShawn Spencer**  
**Alfonso Woodward**  
**Linda Williams**
Social Work Healthcare Education and Leadership Scholars (HEALS)

The Social Work Healthcare Education and Leadership Scholars (HEALS), funded by The New York Community Trust (PI: Teri Browne; Co-PI: Melissa Reitmeyer), aims to educate and train emerging social workers to strengthen the delivery of health care services in the United States. Social Work HEALS is a partnership of CSWE and the National Association of Social Workers Foundation that aims to develop the next generation of health-care social work leaders who will stand ready to lead efforts to address system-level changes, to heighten awareness of prevention and wellness, and to address the issues of structural racism that are embedded in social institutions. The following is a list of our Social Work HEALS scholars.

Amanda Bohrer (MSW)
Katherine Wallace (MSW/MPH)
Shelby Thornhill (BSW)
Interprofessional Behavioral Health Advisory Board

Christina Andrews, PhD, MSW  
Assistant Professor at USC COSW

Jennifer Bailey, MEd  
Associate Program Director for Education and Evaluation, SC Area Health Education Consortium

Teri Browne, PhD, MSW, NSW-C  
PI HEALS Grant, Interim Associate Dean for Faculty & Research, Associate Professor at USC COSW

Aleksandra Chauhan, JD, PhD  
Attorney at Richland County Public Defender’s Office

Allison Farrell, MSW  
School-Based Program Manager at the South Carolina Department of Mental Health

Sarah Gehlert, PhD, MSW  
Dean and University of South Carolina Educational Foundation Distinguished Professor at USC COSW

Cynthia Holmes, LBSW, MHA, ACM  
Manager, Medical Social Work at Palmetto Health Richland

Aidyn Iachini, PhD, MSW, LSW  
Co-PI RIBHS Grant, Associate Professor at USC COSW

Sandra Kammermann, MS, EdS  
School of Medicine, University of South Carolina and Education and Research Director at John A. Martin Primary Health Care Center

Toni A. Kelly Campbell, MSW  
Coordinator, Social Work Services at Richland County School District One

Lindsey Kilgo, BSW, MSW  
Director of Network Development at South Carolina Office of Rural Health

Jeremy Martin, MSW  
Vice President of Treatment and Intervention at Lexington/Richland Alcohol and Drug Abuse Commission (LRADAC)

Melissa C. Reitmeier, PhD, LMSW, MSW  
PI RIBHS and CO-PI HEALS Grant, Associate Clinical Professor, Director of Field Education at USC COSW

Katherine E. Watts, LMSW, ACM  
Director, Medical Social Services at Lexington Medical Center

Roy Wilson, MD  
USC School of Medicine
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BACKGROUND

Hope Health located in Florence, South Carolina, was originally founded in 1991 as a support group exclusively for people living with HIV/AIDS. In 2007, Hope Health became a Federally Qualified Health Center. Hope Health now has a total of 12 locations in five predominately rural counties: Williamsburg, Florence, Clarendon, Orangeburg. The Hope Health site in Florence, SC provides comprehensive and supportive services for people living with HIV.

AIM

People who are Lesbian, Gay, Bisexual, Transgender, or Queer (LGBTQ) are at a greater risk of contracting HIV. Healthcare workers’ personal beliefs and attitudes regarding sexual orientations other than heterosexual, may interfere with the quality of services people who are LGBTQ receive. The aim of this current project was to examine healthcare workers’ attitudes towards clients who are LGBTQ.

BACKGROUND

According to the Center for Disease Control and Prevention, diagnosis rates for HIV are higher in the South than any other region in America. Southern states account for an estimated 44 percent of all people living with an HIV diagnosis in the U.S. The CDC also reports that Black gay and bisexual men account for 59 percent of all HIV diagnosis among African – Americans in the south. In comparison to any other region more people living in the south are unaware they are infected, People living with HIV in the South are less likely to receive medical treatment in a timely manner. Prolonged treatment increases the risk of mortality and transmitting to others. Cultural factors also contribute to people’s willingness to seek medical care. The CDC states, “Issues such as homophobia and transphobia, racism, and general discomfort with public discussion of sexuality may be more widespread in the South and can lead to higher levels of stigma, which may limit people’s willingness to seek HIV testing, care, or prevention services.” These findings influenced the present study.

SPECIAL FIELD PROJECT

After exploring the literature and learning that stigmas, perceptions, and stereotypes regarding people who are LGBTQ influences their willingness to seek HIV related medical care, I engaged in a project to examine the attitudes of health care workers who work within the HIV clinic towards clients who are LGBTQ.

PROCEDURE

There were a total of 16 health care professionals who work in the HIV/AIDS clinic who participated in this project. Professionals such as Social Workers, Medical Assistants, Prevention Specialists, Case Managers, Nurses, all participated in this study. Participants attitudes toward clients who are LGBTQ were measured using the Measure of Attitudes Toward Gay, Lesbian, Bisexual, and Transgender Clients - a 18 item questionnaire developed by Cochran, Peavy & Cauce (2007).

RESULTS

Agency provides a supportive environment for clients, regardless of their sexual orientation.

- Strongly Agree
- Moderately Agree
- Agree Somewhat
- Neutral
- Disagree Somewhat
- Moderately Disagree
- Strongly Disagree

Treats all clients the same, regardless of their sexual orientation.

- Strongly Agree
- Moderately Agree
- Disagree Somewhat
- Neutral
- Agree Somewhat
- Moderately Agree
- Strongly Agree

INTERPROFESSIONAL COLLABORATION

The agency’s current interprofessional team consists of:
- Social Workers
- Case Managers
- Nurses
- Medical Assistants
- Prevention Specialist
- Behavioral Counselors
- Psychologists
- Physicians (Infectious Diseases)

Client’s initial intake assessments are completed by a medical assistant. A follow-up assessment is completed by a social worker or behavioral counselor. The physicians have access to the assessments. Based on the information the client provides (and the uniqueness of the client’s circumstances), the client is then referred to meet with the behavioral counselor and/or the psychologist. The collaboration between the team continues based on the needs of the client. Each month the team meets to review client’s progress and discuss other organizational trends. The team also meets quarterly to discuss recent medical and treatment advancements.

In concluding, I would rate the agency’s current level collaboration a level four. Each profession is located within the same building and, they meet monthly to collaborate on ways to improve their services and enhance the organization.

LESSONS LEARNED

- Every client has their own unique circumstances.
- People who are LGBTQ face additional barriers and challenges.
- Assess and consider barriers.
- Consistently explore the literature for empirical data and evidence based practices.
- Trust is an important factor for building relationships with clients.
- It is important for workers to identify their own biases.

References


Center for Disease Control and Prevention, (2016). HIV in southern united states. CDC Issue Brief

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. LGBT Health, 3(6), 434-442. doi:10.1089/lgbt.2015.0124
Re-Engagement of Family Services in Rural Settings: Barriers and Solutions
Cara Bibeault, BSW, MSW Candidate

Kershaw County Mental Health Clinic (KCMHC)
Children and Families Section (CAF)

**Mission:** treat members of the community who are struggling with mental illness and ensure their access to needed services.

**Unofficial mission:** prevent the progression of mental illness and reduce psychiatric hospitalizations.

**Outcome:** supported recovery for those with mental illnesses and the prevention of needing high level care.

**KCMHC CAF:** serves individuals ages 3-18.

**Location:** All patients served are from the rural county of Kershaw which presents challenges such as: lack of resources, dual relationships and confidentiality

**Commonly treated disorders:** ADHD, ODD, conduct disorders, anxiety disorders, depressive disorders, and mood disorders.

**Methods of treatment:** CBT, Trauma Focused-CBT, parenting skills training, and psychoeducation through individual, family, and group counseling.

**Aim:**
Describe the barriers to treatment in rural South Carolina and evaluate the outcomes of re-engagement interventions.

Interprofessional Collaboration

The CAF section of KCMHC consists of three counselors and a tele psychiatrist. The counselors are licensed psychologists and social workers. **Other providers:** nurses, peer support specialist, care coordinators and administrative staff.

Results

**Results of Engagement Efforts**

- Re-Engaged with Services
- No Response
- Denied Services

**Barriers Expressed by Clients**

- Work Schedule of Parent
- No Response/ Phone Service
- No Longer Identified Need for Services
- Issues in Transportation

**Project Specifics:**

Efforts to reengage families:
- Multiple phone contact attempts
- Friendly postcard
- Impending discharge letter
- Next Steps if contact was made:
  - Identify barriers to treatment
  - Connect patients to needed services such as (transportation, housing, food, preferred appointment schedules, school based services, other mental health agencies)
  - Schedule families an appointment with their counselor if desired

**Lessons Learned:**

- How to foster motivation for treatment
- How the lack of resources in rural areas affects access to treatment
- The challenges parents face trying to balance schedules
- The large impact access to phones can have on engagement in treatment
- The importance of teaching advocacy skills
Background
Located in Columbia, South Carolina, Regency Hospice serves the aging population and those who have a health diagnoses of having six months or less to live.

Some diagnoses that our clients have are: heart disease, cancer, Alzheimer’s/Dementia, HIV/AIDS, neurological disease, stroke or coma, respiratory disease, liver/renal failure.

Regency serves hospice patients with comfort, compassion, and dignity.

Aim
1: Identify the benefits of an interdisciplinary team and client-centered care approach to hospice care for patients and their families.
2: To show the importance of hospice and the end of life.
3: Describe a special field project implemented by hospice team interns that helps and supports the caregivers and family members of patients.

As a Health Education and Leadership Scholar What Did I Learn This Year?
- The importance of end of life care for our elderly population.
- Having a deeper understanding of the importance of working on an interdisciplinary team.
- How to work with an interdisciplinary team and the roles of each profession.

The Agency
Regency Hospice is an Affiliate of Curo Health Services, along with seven other hospice agencies. Hospice care is for people who have a life expectancy of 6 months or less, and have chosen to focus on pain and symptoms relief over healing treatment.

How Did We Work as an Interdisciplinary Team?
At Regency Hospice, we worked as a team by having the same common goal which was our patient’s care. The team attended interdisciplinary team meetings every two weeks to discuss all of our patient’s care and compare notes of what everyone has seen when visiting the patient. Besides attending those meetings, we wrote notes in the patients’ chart through the tablet or charts in the nursing facility to look back on.

Special Field Projects
Caregiver Support Group
For 6 weeks during both semesters, social work interns implemented a caregiver support group at one of the nursing facilities in Columbia, SC. Each week a topic was assigned for discussion and peer-support.

Blossoms of the Heart
Weekly we were able to go to a local Publix and get a donation of flowers that we could use to make small flower arrangements to take to our patients. The flowers could bring a smile to someone’s face and brighten the patient’s living areas.

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Palmetto Baptist Children & Adolescent Inpatient Behavioral Care offers managed care in a therapeutic environment for children ages 5-18. A treatment team assists the patients and families in developing a treatment plan to safely stabilize the children.

Treatments options - Family Conferences, Psychological Evaluation, Play Therapy, Academic Services, Medication Management, Psycho-educational Groups, Coping Skills, Music Therapy, Recreation Therapy, Electro Compulsive Therapy

Palmetto Baptist Adolescent Recovery Center provides intensive outpatient and partial hospitalization to adolescents ages 14-18. The treatment team works with the families and children providing treatment to integrate back into a healthy environment.

Treatments offered - Substance Use, Mental Health, Brief Intervention, Cognitive and Dialectical Behavioral Therapy, Music Therapy, Art Therapy, Yoga Therapy, Family Conferences, Medication Management

Aim

This poster aims to share the comparison of inpatient behavioral care to outpatient recovery; and the need of more intensive and partial hospitalization programs as a transition or middle ground.

Field Project

Behavior Care - Complete assessments, integrative summaries, treatment planning, coordinate discharge planning, and family meetings.

Recovery - Complete assessments, file insurance, coordinate group and individual sessions, family meetings, treatment planning and discharge planning.

Why the rural and underserved community cannot access IOP and PHP programs?

Medicaid does not recognized Intensive Outpatient (IOP) and Partial Hospitalization (PHP) making it impossible for underserved population to receive care when transitioning from inpatient care. The Adolescent Recovery is the ONLY IOP and PHP program in the Richland, Lexington, Sumter Area. Palmetto Baptist Behavior Care does not accept patients with primary substance use disorders, which results in patients with Medicaid or no insurance not having intensive or inpatient care.

Lessons Learned

1. The importance of patience and trust with children.
2. Effective communication when working with inter-professional teams.
3. The lack of care given to rural and underserved counties.

Operation/Cost/Insurance

Behavioral Care - 7-10 days, 24 hours a day, $11,200 per week

Recovery - IOP-3 days a week, 6 hours a day, $3,600 per week

PHP-5 days a week, 6 hours a day, $6000 per week

Inter-professional Collaboration

• Licensed Master and Clinical Social Workers
• Psychiatrist
• Therapist (Art, Yoga, Music, Pet, Recreational)
• Counselors
• Nurse practitioners
• Lawyers
• Judges
• Department of Social Services
• Dietitian

Level of Collaboration

The inpatient and outpatient units uses all inter-professionals to establish an effective treatment plan during treatment teams meetings to establish patient care, medication management, patient goals, and discharge planning.
**Findings**

Health care options, comparable to little accessibility to primary care or behavioral health physicians, transportation to healthcare facilities, and elongated wait to destination and back, exacerbate clients’ symptoms surrounding mental health diagnoses and creates challenges in traversing to cope (Iezzoni, 2006). Clients also expressed these concerns during research. This reveals not only the challenges we see, but the frustration clients encounter through attempting to gain a better quality of life.

It is found that effective interprofessional practice has sustainable measures that help reduce cost per treatment for patients and the ability to have all healthcare/service providers in the same location helps reduce admission for clients and decreases the wait time (Mitchell, 2013).

- Lower Admission Rates For Chronic Disease
- Lower ICU Readmissions
- Reduced Length of Stay
- Lower Staff Turnover

Employee satisfaction goes up, professionals love what they do, and end up staying in jobs longer. The investment effects the entire approach systematically and clients more readily have multiple professions.

**Barbara’s Battle**

“When I can get transportation it takes forever. It takes time for me to get to the bus stop, waiting on the bus takes an hour, it moves slow dropping off everyone, and finally I make it to my destination. Well, that is only with my primary care doctor. The other places are too far. I depend on someone to give me a ride to my behavioral health physician. That person is barely available. Then, I walk two miles up the hill to get to the front door from the bus stop. I do it all again just to get back here. This is so frustrating. I leave feeling more drained and miserable than before.”

Barbara is on dialysis and experiencing trauma-induced depression and bipolar disorder. She is now receiving services from AMI and is trying to find her way to support groups, primary care doctor, and a behavioral health physician in our rural community.

**Background**

Action Ministries International (AMI), established in 1963, is a non-profit whose mission is to “mobilize communities to address the challenges of poverty by focusing on hunger relief, housing and education” (actionministries.net, 2017). It is located in Augusta, Ga (Richmond County).

**Special Field Project**

Observed and coordinated supportive services offered to enhance clients quality of life through connecting them with Pathways Emergency Transportation Assistance Program and monthly events facilitated by outer agency professionals.

**What is Pathways?**

AMI clients contribute to the Pathways store. The proceeds go to fund transportation for two free grocery trips per month and for doctor’s appointments when meeting qualifications.

**Aim**

Describe how supportive services gives opportunity to overcome rural health challenges, such as transportation, through Pathways Emergency Transportation Assistance Program and how clients are engaged with weekly education to help reduce behavioral health problems.

**Interprofessional Collaboration**

AMI invites outer agency professionals and teams for monthly activities. Some of the professionals come from The Augusta Continuum of Care (CoC), to address the county’s homelessness and housing issues. The coalition consists of:

- Non-profits
- School Districts
- Social Service Providers
- Mental Health Agencies

**Lessons Learned**

Partnerships between agencies and inter-disciplined professions will help decrease exacerbating rural challenges, such as trauma and transportation issues.
Importance of Social Work Intervention with McKinney-Vento/ Unaccompanied Youth at Irmo High School
Danielle A. Campbell, MSW Candidate 2018
University of South Carolina

Background
- Irmo High School International School for the Arts is part of Lexington/ Richland 5 School District. Irmo serves 1,439 students grades 9-12. About 47% of the students at the school receive free or reduced price lunch.
- The students I focused on are the Unaccompanied Youth and McKinney- Vento (MV) population. Students who are served through McKinney- Vento do not have fixed, adequate, or nighttime residence. Unaccompanied youth (UY) are students who are not living with their parents or guardians. There are 23 McKinney- Vento students and 35 Unaccompanied students at Irmo High School.

Aim
The aim of this poster is to describe the importance of continual social work intervention with MV/UY students in schools. MV/UY students are some of the most vulnerable population in a school system because many of them do not have their needs met at home, yet are still expected to excel in school. Social work intervention is used to help provide support and resources to these students.

Demographics
- African American (49%)
- Caucasian (39%)
- Hispanic (4%)
- Asian (3%)
- 2 or more races (5%)

Field Project
Once a MV/ UY student is identified, the initial meeting with the student is to find out if they need any supplies, offer services, and to find out more about their living situation.

Rural Aspects:
The rural aspects of working with MV/UY students is that there is often a lack of resources in the area. There is not an abundance of community members to donate items for the students. There are also few other organizations in the area to refer the students and their families to in order to receive more help. One of the biggest needs in the Lexington/ Richland 5 district is alternative housing. There is a limited number of shelters available and all of the low income housing communities have a long wait list.

Lessons Learned
- No one type of intervention works for all students.
- Students need advocates in every part of school.
- Not everyone will see the value in social work intervention.
- Be prepared for any situation.

Interprofessional Collaboration
Interprofessional collaboration at Irmo High School happens in the form of “Triage” meetings:

At-Risk Meeting: (Co-located/ Level 4) All staff are in the same school and communicate in person/ on the phone daily.
- Social Worker
- Head of Guidance
- Nurse
- Mental Health Practitioner
- Special Education Director
In this meeting, staff discuss any students that during the week are considered at-risk (using drugs, suicidal, pregnant, have behavioral health needs, etc.) Staff decides in the meeting the best course of intervention.

9th, 10th, 11th, 12th grade Triage: (Co-located/ Level 4) All staff are in the same school and communicate in person/ on the phone daily.
- Administrator Assigned to the Grade
- Social Worker
- School Counselor
- Teacher
- Grade’s Disciplinary Staff
- Student
In this meeting, staff discuss with students about academic or behavioral concerns. The staff and students come up with an intervention together.

Other School Staff: (Co-located/ Level 4) All staff are in the same school and communicate in person/ on the phone daily.
- Working with attendance staff identifying truancy.
- Working with the school registrars on identifying MV students and meeting new students.
- Working with administration to implement new resources, discussing at-risk students, and collaborating.

Community Collaboration: (Coordination/ Level 2) All groups are in different facilities and communicate periodically about shared clients.
- Acts Metro
- Local Churches
- Optimus Club
- Community Members
- Blue House
- Hospitals
Hospital Social Workers

Briana Carter, MSW Candidate 2018
University of South Carolina

Background

Lexington Medical Center is a patient-centered hospital with 438 beds located in West Columbia. The primary population served are patients within rural areas. I work with people who are aging. “Lexington Medical’s mission is to provide quality health services that meet the needs of our community.”

Rural Nature of Hospital/ Lessons Learned

- The importance of developing and maintaining community resources for patients
- Making sure the patient obtains all their needs before they discharge to ensure the best care.
- The rural nature of this placement makes the role of social workers vital within this setting.

Aim

- The poster aims to demonstrate the advantages of having social workers be apart of hospital settings.
- The patient has access to the social worker who has resources that can help all patients especially the rural individuals.

Interprofessional Collaboration

Interprofessional collaborations are a necessary component to assist patients. The team includes the following:

- Social Worker (MSW): Follows up with patients and connects them with community resources to assist their needs. Patient has immediate access to social worker.
- Nurses: Educates the patients on their condition. Patient has 24 hour access.
- Physicians: Knowledge of diagnosis. Assist patients with medical needs and consults social work when needed.

Rural Aspects of Project

Social workers developed community resources that assist patients with their needs. Since there is a shortage of providers within rural settings having these resources in place for the patients before they are discharged are vital. So before the patients d/c I make them a packet of resources. They are listed to the left.
Barriers to Completing Trauma-Focused Cognitive Behavioral Therapy in a Rural Setting
Alyssa Colvin, MSW Candidate 2018

Background
Aiken-Barnwell Mental Health Center (ABMHC) is a community mental health center located in Aiken, South Carolina. It serves as the Main Hub for 2 satellite centers located in Barnwell, SC and North Augusta, SC. Clients seen at the Main Center are predominately from rural areas. ABMHC houses a Child, Adolescent, and Family (CAF) Services Department, which provides individual & family therapy (among other services) to youth and their families.

Aim
This project aimed to discover perceived barriers to completing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and to better understand suggestions from clinicians at ABMHC in regards to eliminating or reducing these barriers.

What is TF-CBT?
TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. It is a components-based treatment approach which incorporates trauma-sensitive interventions. TF-CBT has proven successful with youth ages 3-18 who have significant emotional problems related to traumatic life events.

Over the course of this internship, it became evident that completion of TF-CBT (all components) was a challenge. To better understand this, I interviewed multiple clinicians in the CAF Department at ABMHC to understand their point of view of why this issue exists, and suggestions to remedy this at client, therapist, and agency levels. Barriers included: working with children in foster care and the lack of stability that may exist in that environment, therapist’s avoidance of discussing the trauma, clients avoidance of discussing trauma, caregiver buy-in/participation, & transportation

Suggestions to overcome barriers included: Training in trauma-informed practice (including Motivational Interviewing Training), supervision, caseload management, collaborating more closely with DSS on cases involving children in foster care

Lessons Learned
Multiple challenges exist when it comes to completing trauma focused therapy. Professionals need support from those around them and above them to provide the best possible services to those who seek services of this nature.
The United States spends more money than other countries on healthcare, but ranks lower in the infant mortality rate, drug related deaths, and HIV/AIDS (Davis and colleagues, 2014). American Work is a Community Mental Health and Substance Abuse Clinic in Augusta, GA.

Many of the clients served come from rural areas in Augusta and travel long distances to make it to their appointments. American Work utilizes interdisciplinary care teams. It is therefore important to understand how other clinical staff view integrated care teams and to assess these attitudes. The survey was sent out to multiple agencies with 103 responding. These results will provide understanding and information that is useful for social workers who desire to further integrate treatment which is particularly importance for rural settings.

The aim of the study is to identify healthcare professionals’ attitudes regarding integrated care and social work competency.

Researchers drafted a survey with multiple Likert scale questions and a few open-ended questions to develop an understanding of how healthcare professionals view social workers and integrated care teams and to assess these attitudes. The survey was sent out to multiple agencies with 103 responding. These results will provide understanding and information that is useful for social workers who desire to further integrate treatment which is particularly important for rural settings.

Social workers engaging with providers regarding integrated care efforts must be mindful of the perceived challenges to integrating social work into healthcare settings. Understanding the attitudes and perceptions regarding social work will empower social work professionals to effectively engage with diverse healthcare professionals in integrating Social Work services into healthcare settings.

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Background

Palmetto Health made a commitment in 1998 to return to the community 10 percent of its annual bottom line. Palmetto Health Office of Community Health provides services to the underinsured, uninsured and medically underserved people in the Midlands, along with the general population. The clients we see are predominantly from rural areas and people of color.

Aim

The purpose of this poster is to describe how Palmetto Health Office of Community Health focuses on multiple innovative initiatives to improve the physical, emotional and spiritual health of all individuals and communities it serves.

Special Field Project

Chronic Disease Prevention:

This initiative was designed to detect and diagnose chronic health conditions at an early stage of development while providing education and intervention programs to those at risk. We addressed the chronic health conditions of hypertension, pre-diabetes, type 2 diabetes, and breast, cervical, lung, and prostate and colorectal cancer. We partnered with schools, faith-based, and civic organizations in rural areas to provide comprehensive prevention and screening programs.

Collaboration within Palmetto Office of Community Health includes: Public Health Educators, Nurses, and Social Workers. Both the Public Health Educators and Nurses go out into the rural areas to conduct assessments and screen the clients. They also provide the clients with free educational resources aimed to help improve their eating habits and overall health. The screenings are sent to the lab and any abnormal findings are sent to the Social Worker. The Social Worker follow up with clients and refer them to programs or specialty clinics based on their results. After a period of time the Social Worker follow up with the clients to ensure they are getting treated.

Lessons Learned

- Understanding client needs
- How to work on an interdisciplinary team
- Importance of incorporating other professions in the decision making process
The Importance of Rural Social Work

Brittaney Desjardins, MSW Candidate, 2018
University of South Carolina

Background
Lexington Medical Associates (LMA) is a patient-centered clinic that offers primary care to uninsured and underinsured patients.

Aim
The purpose of this poster is to highlight case management services in rural social work and its benefits as it relates to patient success.

Case Management Services
- Connection to counseling
- Housing assistance
- Transportation assistance
- Patient assistance programs
- Financial assistance programs
- Food banks
- Lexington Council on Aging
- Employment assistance
- Connection to Medicaid

Special Field Project

This project aimed to connect rural patients with much needed resources to improve their quality of life. Additionally, I developed community relationships that can provide the means to assist at-risk patients.

Interprofessional Collaboration

Social Workers (LMSW): Aware of and has the connections with many community resources in their area to assist with the patients’ needs.

Nurses: Educates the patients about their condition(s) and ways to manage it.

Physician (MD): Has extensive knowledge of diagnoses. Serves as the primary care provider on the team, assists patients with medical needs, and aware of when patients need to meet with the social worker.

Nurse Practitioner: Has knowledge of diagnoses and serves as a secondary provider on the team. Assists patients with medical needs and aware of when patients need to meet with the social worker.

What I Learned
- How to direct patients towards resources
- Understanding patients’ needs
- Understanding of medical terminology and its implementation into documentation
- Importance of creating and maintaining community relationships

Special Thanks
Thank you to Dr. Candace Morgan for providing excellent mentorship during this project. Also, thank you to Sara Sims, LMSW and Anita West, LMSW for providing wonderful supervision and assistance during my time at LMC.

References
Group Goal: The goal of the field project was to teach students from a rural background skills needed to succeed in and outside of school. This group was a way to talk about some of the things that affect elementary school students while keeping in mind that they are from a rural community. Group discussions included things such as active listening, classroom behavior, confrontation and conflict resolution, self-confidence, bullying/teasing, building friendships, how to maintain a positive school and classroom environment and benchmark testing.

Sessions: Each session took place during the students related arts time. The sessions lasted 30-40 minutes and there was a different topic planned for each week.

Student Demographic: The group consisted of four third grade girls from three different classrooms.

Pre/Post Test: A pre and post test was created to measure the outcomes of the group.

Results: The results showed some students scoring higher by a few points on their post test from their pre-test and some students scoring a few points lower on the post-test than their pre-test.

1. Living in a rural community can have an effect on how a student learns and behaves as well as an effect on the overall school climate.
2. Students living in rural communities can deal with a different set of challenges than those living in urban communities.
3. Students living in rural communities have the same ability to succeed in and outside of school as those living in urban communities even though they may have less resources.
4. Social workers are extremely important to student success in both rural and urban communities.
5. Learned how to successfully facilitate a counseling group in a school setting.
6. Learned how to work both autonomously while also collaborating with multiple disciplines.

Acknowledgements: I would like to thank my professor Dr. Candice Morgan for providing support and feedback on this project, my field supervisor Georgia Gibson for helping me to grow as a social work professional and for a year filled with incredible learning opportunities and the Burton-Pack Elementary School staff and students for letting me be apart of your school this year.

The purpose of this poster is to illustrate how I used a girls group as a way to teach skills needed to succeed in and outside of school with lessons created with those living in a rural community in mind.

I worked with many different disciplines including teachers, administrators (principal, vice principal), the school’s social worker who was also my field supervisor, the school counselor and other support staff. We worked as a team to provide students with the support and resources they needed to succeed socially and academically by collaborating on referrals and classroom observations, sharing resources and information, meeting with students and/or parents, and planning or facilitating student events. When it comes to collaboration, I believe that there is a level 5 collaboration between disciplines. This is because working as a team is the only way for us to help our students.
Educating Caregivers: Understanding Trauma and the Importance of Therapy

Flavia Gibson, MSW Candidate 2018

Background

Nettie Dickerson founded the Dickerson Children’s Advocacy Center in the 1940s. This non-profit organization is located in Lexington, SC. The mission of the Dickerson Children’s Advocacy Center is to provide comprehensive assessment and treatment services to physically and sexually abused children ages 0-18 years throughout South Carolina. From 01/01/2017 through 12/31/2017, DCAC served a total of 571 children during the reporting period. The following figures show the breakdown of the demographics of children served.

Aim

The purpose of this project is to implement a new program that will educate the caregivers of the children we serve at DCAC. The need for more education around trauma and therapy for caregivers of children who have experienced a traumatic event is necessary, especially for those who live in rural areas around SC.

Special Field Project

In order to address the rural uniqueness of the children we serve at DCAC, I have created a one-page flyer where interns/staff will be able to use to give a brief 5-10 minute psychoeducational session to caregivers about trauma, therapy, what TF-CBT is, symptoms of trauma, and the importance of children seeking help. I gathered information through my organization to create the educational flyer.

Lessons Learned

Some of the key lessons I learned about being a behavioral health social worker through this Interprofessional Behavioral Health Scholars program are that one needs to be aware of the constant changes in policy and how those could potentially harm the clients we work with who live in rural areas. I have learned the power of advocacy and how important it is to fight for resources and services in rural areas. I have learned that social workers play a big role in these areas, and are very important when it comes to assisting clients.

Interprofessional Collaboration

DCAC works hand in hand with other disciplines to ensure justice and accuracy with every child that comes through our center.

The disciplines include:
- Law enforcement
- Childhood protective services
- Solicitors’ office
- Mental health professionals
- Medical professionals
- Victim advocates
- Child advocacy centers around the state.

Everyone works together to assure cohesion and understanding from each discipline. Every month, there is a Multi Disciplinary Team (MDT) meeting that takes place at DCAC where members of each discipline are present and as a team, discuss each case and each child that comes to DCAC, and what the next steps should be according to the case. The level of collaboration the interprofessional team is at is currently a work in progress. It is being evaluated and re-designed in order to be able to accomplish the goals and objectives it is meant to do.

References

DCAC, 2017. Dickerson Children’s Advocacy Center: A place where healing begins [PowerPoint Slides].
Continuous Care for Individuals Living with HIV

Nastassja Gibson, MSW Candidate

Background

Palmetto Health–University of South Carolina (USC) Medical Group provides compassionate care, preeminent medical education and transformative research. The primary purpose of the USC Immunology Center is to provide a continuum of services to patients infected with the human immunodeficiency virus (HIV).

Aim

The purpose of this poster is to examine the proportion of individuals living with HIV that are engaged in each stage of the HIV Care continuum, while highlighting the ways in which the USC Immunology Center Case Management services insists patients in establishing continuous care.

Special Field Project/Activity

Examined how the USC Immunology Center Case Management Staff assist clients in providing services that allow patients to stay in continuous care.

Case Management Continuous Care Services

HIV CARE CONTINUUM:

- THE SERIES OF STEPS A PERSON WITH HIV TAKES FROM INITIAL DIAGNOSIS THROUGH THEIR SUCCESSFUL TREATMENT WITH HIV MEDICATION

<table>
<thead>
<tr>
<th>HIV Case Management</th>
<th>Clinic Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAT (Benefits Assessment Tool)</td>
<td>Routine Visit Checklist (Action Plan)</td>
</tr>
<tr>
<td>Initial Intake</td>
<td>Provide Adherence Counseling</td>
</tr>
<tr>
<td>Mid-year Assessment (Completed Every Six months)</td>
<td>Complete ADAP Recertification</td>
</tr>
<tr>
<td>Reassessment (Six Months)</td>
<td></td>
</tr>
</tbody>
</table>

Interprofessional Collaboration

The Immunology Center operates under a high level of interprofessional collaboration. The Immunology Center interprofessional collaboration team consists of the administrative staff, Physicians, Clinical Staff, Front Desk & Medical Records, Outreach Services, and Supportive Housing Services. The collaborative efforts have resulted in the overall maintenance health of each patients, providing a holistic approach to patient-centered care.

Lessons Learned

I learned that the ability to remain in continuous care plays a critical role in achieving improved health outcomes. The USC Immunology Center provides a holistic approach to care that has resulted in the successes of continuous care for patients. Despite the advances in HIV medication, many individuals with HIV do not seek long-term clinical care.
**BACKGROUND**

-Heritage Academy (HA) is a private, non-profit primary and middle school located in downtown Augusta, Georgia. They serve families from diverse financial and ethnic backgrounds by providing robust financial assistance through scholarship awards.

-All families receive some level of tuition aid and approximately 90% of families receive significant support from this donor-funded program, helping bolster community access to quality and individualized education.

-Due to the lack of zoning regulations for the school, children come from rural and more urban areas within the traditionally underserved communities in the Central Savannah River Area (CSRA).

-The student body of 250 is predominantly African American with the addition of Caucasian and Latino students. The faculty and staff are predominantly Caucasian.

**AIM**

The students at HA experience challenges endemic to underserved and impoverished areas, specifically related to Adverse Childhood Experiences (e.g. community violence and family interpersonal violence). The school recognized their current services were unable to address childhood traumatic stress, which led to a partnership with the College of Social Work to begin the integration of social work services into the schools programmatic structure. This poster highlights the process of developing and enacting a responsive social work program for the students and families of HA.

**FIELD PROJECT**

Our project was designed to establish a foundation for later trauma training centered on flexible responding, restorative justice, and cultivating resilience. We believe this will create an environment where students can thrive despite environmental and individual risk factors.

**INTERPROFESSIONAL COLLABORATION**

Interprofessional collaboration is central to the effectiveness of social work at HA. Due to the novelty of the program, the current collaboration is between level 3 and 4. Social work operates within the school and has coordinated systems of referral and frequent face-to-face meetings about students (level 4). In contrast, the department somewhat functions in tandem with the school rather than as a fully collaborative partner (level 3). We hope to deepen the integration of social work into the structure of HA as the placement grows.

Some stakeholders in the collaborative process are:

-Teachers
-Community service providers
-Administrators
-Students and Families

**LESSONS LEARNED**

-School social work happens best when social workers have well defined roles and have a more central role in school functioning.

- School social workers need to be well versed in crisis response and brief intervention while maintaining a diverse repertoire of longer-term therapeutic interventions.

- School social work needs to be supported as a primary source for behavioral and mental health services for underserved and/or rural communities due to the prevalence of ACEs and general dearth in services.

-Confidence and competence is a critical professional social work skill when confronting colliding worldviews in the school environment.

-Repetition, consistency, and reliability are central to building trust and establishing working relationships with faculty, staff, students, and families.
The Importance of Social Workers in Legal Services

Anne E. Greene, MSW Candidate 2018

University of South Carolina School of Law Clinics operate 7 legal clinics in which third year law students are allowed to practice as student attorneys under the supervision and license of their professors. Working as the only social worker in the clinics, I worked with the domestic violence clinic, education rights clinic, medical-legal partnership, and the juvenile justice clinic.

Aim

Demonstrate the importance of incorporating a social worker on to a legal team, specifically for people living in rural communities.

Field Activity

Practicing case management and interprofessional collaboration, my work included:

- Assessing client needs
- Connecting clients to resources
- Creating treatment plans and making referrals
- Contributing a biopsychosocial lens
- Helping student attorneys guide client interviews
- Constructing safety and privacy plans

By addressing the barriers and social needs of clients, I was able to help the student attorneys uncover mitigating circumstances that could be used to negotiate their legal case.

The integration of a social worker on the legal team broadens the scope of work for the clinic in terms of providing more holistic services and ensuring the implementation of a more sustainable legal and social intervention.

Rural Focus

27% of South Carolina’s population lives in rural communities (South Carolina Office of Rural Health, 2017, p. 29). The graphic below demonstrates the rural composition of South Carolina by census tract (South Carolina Office of Rural Health, 2017).

The availability of free legal services is generally scarce and people living in rural communities face a number of barriers when navigating systems that provide legal, social, and medical support. Specifically, the following list highlights the social needs and barriers existing in rural communities.

- Transportation
- Affordable Housing & Emergency Shelters
- Primary Care Service Providers
- Mental and Behavioral Health Service Providers & Programs
- Navigation of Social Programs (SNAP, TANF, SSI, SSDI, Medicaid)
- Safety and Privacy Planning
- Child care
- Employment

By addressing the barriers and social needs of clients, I was able to help the student attorneys uncover mitigating circumstances that could be used to negotiate their legal case.

Lessons Learned

- Integrating social workers in settings providing free legal services to vulnerable populations allows for more holistic interventions and the opportunity to address the social determinants of health and symptoms of poverty.
- Social interventions paired with legal interventions create the opportunity for a client to establish secure and sustainable resources.
- Interprofessional collaboration requires constant role defining, clear communication, an understanding of a profession’s ethical code, a willingness to learn, and an open mind.

Interprofessional Collaboration

According to SAMHSA’s definitions of levels of collaboration/integration, The USC School of Law Clinics operate as a level 4.

- The clinics include approximately 40 student attorneys, 6 licensed law professors, 1 administrative assistant, and 1 social worker
- All clinic work is done in the workspace of the clinical suite.
- The student attorneys, law professors, and social workers must also communicate and work with many other professionals to accomplish the needs and goals of a case.
- Interprofessional collaboration allows for holistic assessments of client needs and goals and well-rounded social and legal interventions.
- Communication with professionals outside of the clinic space ensures appropriate referrals are made and follow-ups are achieved.

References:

## Background:
Lexington-Richland Alcohol and Drug Abuse Commission is a non-profit agency that aims to assist people with substance use disorders through their addiction, and attempts to place them on a path to recovery. LRADAC is a federally and state-funded agency that is a part of the 301 system, meaning it is part of a network of 32 other substance abuse agencies in counties around South Carolina. LRADAC uses Detox, Outpatient, and ADSAP programs to educate clients about the effects of substance use, tools to achieve and maintain sobriety, and resources that may better clients' living conditions. At the Lexington location, the majority of clients are Caucasian, live in rural areas, and belong to a lower socio-economic class.

## Aim:
While at LRADAC-Lexington, I co-facilitated AOD groups and conducted limited individual sessions which focused on educating adolescents on the negative effects of substance use, helped them gain insight into their past choices, and promoted more positive decision-making skills.

## Field Project:
One of the things I did at LRADAC-Lexington was go to FOCUS alternative school in Lexington, SC to co-facilitate AOD Education groups for adolescents who were expelled from their schools due to substance-related incidents. This was one of the highlights of my field experience because I was able to interact with another agency and see how the clients live outside of our agency. I enjoyed the notion that LRADAC was willing to interact with the school because Lexington is such a rural setting, and there are not many resources regarding AOD treatment. The intertwining of LRADAC and FOCUS exemplifies good community collaboration in my opinion.

## Interprofessional Collaboration:
- **Lexington School System**
- **FOCUS**
- Informing schools/providing clients with documentation when they successfully complete services
- **Arbitration/Juvenile Justice**
- Converse with clients’ Parole Officers about client progress or lack thereof
- *(With client consent)* send copies of urinary drug screen results
- Communicate with/provide client with documentation when they successfully complete services

While I cannot legally interact with the school system(s) or arbitration office about clients, to my knowledge, there has always been good communication between them and LRADAC.

## Lessons Learned:
- **Professional Boundaries**
  - Drawing the line between “counselor and colleague”
- **Group facilitation skills**
- **The depth of counseling/social work jobs**
  - ex: documentation

*Contact information available upon request*
The VA Dorn Community Living Center

The Community Living Center is a skilled nursing facility on the campus of the William Jennings Bryan Dorn VA Medical Center. Veterans who reside at the CLC must be:

- 70% Service Connected or 60% Service Connected or unemployable
- Terminally ill but medically stable
- Skilled level of care (3 ADL Deficits)

Veterans who are not Service Connected may be admitted to the CLC for short-term rehab if they sign a memo of understanding prior to admission stating that he or she must be discharged prior to 30 days in the CLC.

Aim

Objective 1:
- Identify the benefits of an interdisciplinary approach to skilled nursing care for Veterans and their families

Objective 2:
- Discuss the barriers to healthcare for Veterans living in rural communities

Objective 3:
- Describe the process of reaching out to Veterans who are not as accessible due to the lack of resources in rural areas

Six Levels of Collaboration/Integration: Where the CLC Stands

Level 1: Minimal Collaboration
- Separate systems; communicate rarely
- Have limited understanding of roles

Level 2: Basic Collaboration at a Distance
- Separate systems; communicate periodically
- Appreciate each others roles

Level 3: Basic Collaboration Onsite
- Separate systems; communicate regularly
- Collaborate; part of informal team

Level 4: Close Collaboration with Some System Integration
- Share some systems; communicate in person
- Collaborate; have basic understanding of roles/culture

Level 5: Close Collaboration Approaching an Integrated Practice
- Seek system solutions; communicate frequently in person
- Collaborate frequently; have in-depth understanding of roles/culture

Level 6: Full Collaboration in a Merged Integrated Practice
- Function as one integrated system
- Blended roles/culture

Rural Interprofessional Behavioral Health Scholars Program: Lessons Learned

- The importance of integrated care when providing social work services in a nursing home setting
- The unique struggles that patients in rural communities face when trying to seek health and mental health services
- The growth of technology based healthcare services and how this may impact the VA
- The importance of individualized care for Veterans living in rural communities and ways to address these inequalities

The Interdisciplinary Team

The medical staff at the CLC consists of many different professionals who work together to provide care to these Veterans. Discharge planning for short-stay Veterans is a team effort that includes input from every staff member.

The Interdisciplinary Team includes:
- Social Workers
- Physician
- Dietician
- Physical Therapists
- Occupational Therapists
- Nurses
- Nurse Assistants
- Pharmacist
- Nurse Practitioners
- Recreation Therapist

Special Field Project: Rural Outreach

This year at my field placement, I focused on reaching out to Veterans who were recently discharged from the CLC and returning to their rural communities. Because these Veterans did not have easy access to their primary care social workers for follow up, I thought it was important to create a way to check patient progress after discharge. This included:

- Contacting Veterans in rural communities within 48 hours of their discharge from the CLC
- Providing Veterans with all contact information for their primary care social workers, as well as providing them with transportation information if access to follow up appointments was difficult
- Providing a continuum of care for these Veterans by allowing them to continue to use me as a resource even after discharge

Figure 1. Percentage of Veterans Living in Rural and Urban Areas by Region: 2011–2015

Note: For more information, see: https://www.census.gov/prod/2016pubs/p20-572.pdf

Contact

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Field Placement:
William Jennings Bryan Dorn VAMC
Columbia, SC
www.va.gov
IDENTIFYING DEPRESSION IN CANCER PATIENTS

Zhayawna Johnson, MSW Candidate 2018, Rural Interprofessional Behavioral Health Scholar

BACKGROUND
The McLeod Center for Cancer Treatment and Research (Cancer Center) in Florence, South Carolina provides adult cancer patients in the Pee Dee and surrounding areas the opportunity for cancer diagnosis, treatment, recovery, and rehabilitation resources in one place. Noninsured patients within income requirements have access to free cancer treatments and monthly doctor visits in the Cancer Clinic.

CANCER AND DEPRESSION
Cancer can cause or exacerbate feelings of depression. Issues with treatment and physiological changes to one’s body due to cancer can contribute to the development of depression. Depressed cancer patients not only deal with fighting cancer, but also with depressive symptoms such as feelings of worthlessness and hopelessness, and have higher mortality rates.

AIM
To illustrate how cancer and depression relate to one another and the implementation of the PHQ-9 screening tool in conjunction with the NCCN distress thermometer to identify depression in cancer patients.

SPECIAL FIELD PROJECT
Behavioral health needs were identified using the NCCN Distress Thermometer (DT), and the patient health questionnaire (PHQ-9). New radiation patients received the PHQ-9 along with the DT. Patients who scored a 10 or above (moderate to severe depression) on the PHQ-9 were followed up with to discuss their results in relation to cancer and determine if a referral was needed. Patients’ choice of depression on the DT was used to monitor patients’ ability to recognize feelings of depression and depressive symptoms.

RESULTS
- 108 patients completed the PHQ-9 depression screening tool.
- 47 of the 108 patients surveyed scored mild depression or above. 43.5%
- Of the 47, only 19 self indicated depression on the DT. 40.4%
- 26 patients did not indicate depression on the DT yet scored positive for mild to severe depression. 55.3%
- These results indicate that many people are either unaware of their depression, or are reluctant to identify as depressed due to stigma associated with depression.

LESSONS LEARNED
Patients are so overwhelmed with the demands of having cancer that emotional needs are left unaddressed. Screening in addition to the DT is essential in addressing behavioral health needs. Patients can benefit from speaking with an oncology social worker or a therapist to address their feelings of depression and cope with cancer-related issues.

- It can be difficult to maintain contact with all patients who need support, consistent follow up is important to provide mental and emotional support.

RURAL UNIQUENESS
Patients locations play a major role in the limitations of access to care. Many patients do not have reliable transportation or are unable to transport themselves due to the effects of cancer treatment. Because of the ruralness of Florence, SC and other areas, it may be more difficult for patients to access services. Patients who were given referrals to counseling services received internal referrals or outside referrals near their home town.
Enhancing Collaboration Across Health Disciplines in an Outpatient Infectious Diseases Clinic

Bailey King, MSW Candidate
Rural Interprofessional Behavioral Health Scholars Program, College of Social Work, University of South Carolina

**Background:** The Immunology Center provides comprehensive care to patients living with HIV/AIDS through an interprofessional team of specialized health care staff including, medical providers, nurses, pharmacists, case managers, and counselors. Patients have wider access to centralized, multilevel care to encourage active involvement in their own care and continued viral suppression (Phaup, Franco, & Collier, 2017). The clinic also partners with community agencies to coordinate services such as emergency financial and housing assistance, access to care and other health care needs.

**Aim:** Interprofessional (IP) Education program’s purpose is to facilitate effective approaches with future health professionals by promoting IP collaboration as the mechanism of providing quality, patient-centered care. Students are offered the opportunity to understand the roles/responsibilities of each team member, to engage in effective IP communication and to advance their skills in relationship-building and cultivating healthy team dynamics (AETC).

**High Level of Collaboration:** The program reflects the high level of collaboration in the outpatient clinic by engaging students in didactic lectures on varied topics on HIV care, provider shadowing, and the Team Capstone Visit. The clinic has recently introduced administrative changes intending to improve policies and procedures, which has given students a unique opportunity to witness the way in which an intricate, integrated system approaches substantial change and how health professionals adapt to those system changes.

**Implications for Rural Care:** The pervasive deficits in economic opportunities, education, and quality health care, related to the nature of geographical isolation in rural areas, present unique challenges for both practitioners and residents. The aim of the program is widen future professionals’ understanding of other disciplines’ practice/perspectives, and heighten awareness of effective collaboration strategies while working across disciplines. As rural areas experience provider shortages, IP practice emerges as a relevant and essential approach to providing comprehensive, quality care in rural areas.

**Lessons Learned:** This opportunity allows students to practice providing comprehensive care by utilizing skills within their particular expertise to achieve a shared goal of providing quality, patient-centered care tailored to the needs of a vulnerable population. There is a current trend of coalescing IP clinical teams across the U.S. to centralize services and close gaps in patient care, of which the natural result is a heightened need for cooperation, collaboration, and mutual respect across disciplines. By fostering these skills early, well-informed students will become highly effective clinicians, improving health outcomes for both patients and the community at large.

**Student Collaborative Team**

![Student Collaborative Team Diagram]

**Three-Part Learning Experience**

1. **HIV Education:** Students receive HIV/AIDS education by field experts in topics of epidemiology, pathophysiology, pharmacology, and access to care.
2. **Shadow Providers:** Students shadow providers from their own discipline and the other disciplines for a well-rounded experience in providing patient-centered care to a specialized population.
3. **Team Capstone Visit:** Students collaborate on an interprofessional team to interview a volunteer patient diagnosed with HIV/AIDS, then create and present a team SOAP note at the end of the rotation.

**Literature cited**

**AIDS Education & Training Center Program (2016). Interprofessional Education Curriculum.**

**Acknowledgments**


AIDS Education & Training Center Program (2016). Interprofessional Education Curriculum.

IPE Program Faculty: Devra Abusa, MD, Christopher Goodman, MD, Donna Ray, MD, Caroline Derrick, PharmD, BCPS; Iren Durr, PharmD; Brandon Brookssav, PharmD; Betsy Blake, PharmD, Biv Baliko, PhD, RN, PMHNP-BC; Tricia Phyp, P, Tina Reiteiner, PhD, Adena Harrison, RN, MSN, ACNP & Ken Crawford.
Defining the Need for a Tele-Support Group
Kaleigh McCormack BSW, MSW Candidate 2018
College of Social work, University of South Carolina

Background
Palmetto Health USC Pediatric and Endocrinology group provides specialized treatment care for children and youth between the ages of zero to eighteen years old. The specialized care is provided to those who have been diagnosed with the following: Type One and Type Two Diabetes, Hypothyroidism, Growth disorders, Puberty disorders, and Adrenal gland disorders. Palmetto Health’s mission and vision for the practice group is providing compassionate care, preeminent medical education, transformative research, and to be known for clinical excellence (Palmetto Health USC Medical Group, 2016).

Aim
The aim of this specialty field project is to re-define and expand the idea of a support group in an out-patient specialized clinic. Expanding the idea of a support group and making it virtual, was a way to meet the needs of patients who live in rural parts of South Carolina. The implementation process will take time. The interest is out there, but it will take time for individuals to act upon it.

Specialty Field Project
• Created a virtual support group to provide access for diabetic individuals between the ages 10-18 and their parents, who live in rural areas of South Carolina.
• Group provided for the adolescents: meet new individuals with similar diagnosis, provide peer-to-peer support on current issues or discuss their behavioral health needs and how it relates to their diagnosis, and increase positive diabetes management.
• Group provided resources in the community for the parents, such as: financial support, proper food access, reliable transportation, social support, addressed school concerns. It also provided support to the parents depending on the timing of the child’s diagnosis.

Intercollaboration
This facility is a Level 4 on the scale of collaboration (Heath, Wise Romero, & Reynolds, 2013).

Lessons Learned
• Results: 25 out of 99 contact strips were taken. 0 individuals have RSVP for the Tele-support group.
• The implementation process will take time. The interest is out there, but it will take time for individuals to act upon it.
• Being self aware of what the client and clinic need right now, which is to have their basic needs met.
• Being aware of the rules and regulations of HIPPA, because this policy can create barriers.
• Requires commitment and collaboration from everyone in the interdisplinary team.

Reference
**BACKGROUND**

- **CASA/Family Systems** is a not-for-profit agency located in Orangeburg, South Carolina.
- The agency serves survivors of domestic violence and sexual assault by providing cognitive processing therapy, psychoeducation assessments, intakes, and a temporary emergency shelter for women and their children.
- The agency’s service areas are Orangeburg, Bamberg, and Calhoun counties.
- Its primary clients are low-income, African American women.
- CASA Family systems participates in community engagement events at elementary and high schools, college campuses to advocate and educate about sexual and domestic violence.
- The agency receives its clients through walk-ins and referrals from law enforcement and The Regional Medical Center.

**AIM**

The goal of this poster is to showcase barriers domestic violence survivors face in rural settings when seeking services. The domestic violence and sexual assault assessments conducted aim to determine the most important need for the client at that particular time.

**SPECIAL FIELD ACTIVITY**

Clients of CASA/Family Systems receive intakes, assessments, counseling, and referrals to additional substance use treatment when applicable. As an MSW intern, the vision is on comprehensive assessments focusing on domestic and sexual violence, healthy, lethality risk, safety planning, and Orders of Protection.

The assessment process includes working with SC Legal services for representation and the Regional Medical Center SANE nurse for medical care following abuse.

Since there is a lack of domestic violence resources available in rural settings, a Likert-scale survey was distributed to 3 providers to gauge the largest barriers. Services for domestic violence in rural areas contain many barriers of their own as most survivors are isolated and lack access to transportation (Krishnan et al., 2011).

The purpose was to determine what providers believe is a hindrance for their clients receiving necessary services to promote healing. The service areas lack an abundance of resources, so the questions asked were for the agency and providers to understand what barriers need to be addressed in Orangeburg, Bamberg, and Calhoun Counties. The focus was on community buy-in regarding trust in providers and transportation.

Of the professionals surveyed, many indicated transportation was the largest barrier following getting the community on board for domestic violence prevention and intervention. The agency has implemented transportation requests so clients can arrive to behaviorial health appointments and interviews on time and partner with taxi services and provide transportation for clients when possible. Research finds lack of transportation hinders safety.

**INTERPROFESSIONAL COLLABORATION**

CASA/Family Systems has a level 2 collaboration: basic collaboration at a distance. While the agency shares aspects of level 3, it mostly operates on its own system but continuously discuss clients’ needs with one another. With basic collaboration at a distance, certain needs may be treated separately but each member is updated to ensure the appropriate quality of care and service for the client (SAMHSA, 2018). We work with an MSW, law enforcement of Orangeburg Department of Public Safety and Orangeburg County Police Department including victim’s advocates, an MSW intern, and attorneys from SC legal.

**LESSONS LEARNED**

- Individuals living in rural environments are even more vulnerable due to lack of resources and safety.
- Getting community members in rural areas to buy-in to domestic violence prevention and intervention.
- Each interdisciplinary team member should collectively be involved in the assessment process to determine the best treatment for the client.

**REFERENCES**


Taylor N. Newman, MSW Candidate 2018

**RURAL DEFINITION BY CENSUS TRACT**

Figure 1 represents demographics from January 2017-June 2017 across the three service areas.

Figure 2 displays the rural nature of South Carolina specific to counties (South Carolina Office of Rural Health, 2017).
• For many of the students at HPES, the breakfast
• A very prevalent trauma that many of the students
and traumas in their home-life.
• HPES is located
• 4% of White students, .6% of Native, and 1.1% of students that are two races or
Hispanic/Latino, .2% of American Indian or Alaska
• More. All of Hyatt Park’s students receive free and reduced price lunches.
• A majority of students at HPES come from low-income families and face many different adversities and traumas in their home-life.
• The district chose HPES to become 1 of 3 of the district’s first trauma-informed schools this school year.
• A very prevalent trauma that many of the students at HPES face daily is the lack of access and affordability of food for their families.
• For many of the students at HPES, the breakfast and lunch served at school are the only meals that they have.

Background

My field placement during my advanced standing year was completed at Hyatt Park Elementary School (HPES), which is housed through Richland School District One serving grades K-5. HPES is located off of North Main Street in Columbia, SC. HPES serves a total of 462 students, with 97% African American students, 4% of White students, 6% of Hispanic/Latino, 2% of American Indian or Alaska Native, and 1.1% of students that are two races or more. All of Hyatt Park’s students receive free and reduced price lunches.

Aim

The purpose of this poster is to illustrate the revamping and improvements made to a snack pack program addressing the food and nutritional health of students facing food access disparities at Hyatt Park Elementary School.

Interprofessional Collaboration

• Referrals for services are encouraged from all school staff.
• All students that receive McKinney Vento are referred to the program
• The level of collaboration for HPES is coordinated level 2 with basic collaboration at a distance.
• The disciplines that complete referrals are in separate facilities and have separate systems. They communicate with the shared goal of combating weekend hunger.

Sacks of Love Program

• School Social Worker at HPES collaborated with a network of five local Presbyterian churches to establish a snack pack program, Sacks of Love.
• Boxes of food items to serve 30 students are delivered to the school every month.
• Each student is given a bag of different food items every Friday of each week.

Program Concerns

• A list of referrals from members of different disciplines started to pour in and a waiting list was created.
• While delivering bags to each student, there would be a handful of students that were not carrying or did not own a book bag. These students have all been on each occasion in the 2nd grade and younger, which accounts for 21 of the 52 students that are served.
• The food items given to students are packed in plastic bags from grocery stores and the younger occasion had difficulties carrying these bags home.
• The bags that carried the food did not leave much discretion for students.

Special Field Project

The Special Field Project consisted of expanding the Sacks of Love program and improving the delivery of services. To expand the program to extend services to more students, a connection with Harvest Hope of the Midlands was created and a partnership with HPES and the agency’s Child Feeding Program was established. The collaboration provided additional food items to serve the students on the waiting list and more. After the connection with Harvest Hope of the Midlands, the Sacks of Love program now serves 52 students, which is a 73.3% increase from the initial total of students served.

Rural Component

All of the students served by the Sacks of Love Program reside in an area that is considered a food desert. According to the Centers for Disease Control and Prevention (2017), “Food deserts are areas that lack access to affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full range of a healthy diet (p.1).” According to the United States Department of Agriculture (2009), “…findings show that a small percentage of consumers are constrained in their ability to access affordable nutritious food because they live far from a supermarket or large grocery store and do not have easy access to transportation (p.15).” The zoned area for HPES only has one supermarket that serves the area, which is Harvey’s Supermarket on North Main Street. The average distance from Sacks of Love’s students’ homes to the local Harvey’s Supermarket is 1 mile.

Lessons Learned

• The importance of understanding and researching the population served and the conditions of clients’ communities were proven to be a huge factor to inform practice.
• The concept of interprofessionalism was highly used providing services to students within the Sacks of Love program.
• The competencies that were gained through the Interprofessional Behavioral Scholars program was versatile in that they are applicable to vulnerable populations within the school setting as they are in behavioral health settings.

References


Utilizing CIWA-AR Protocol for Substance/Alcohol Abuse
LaShawn Spencer BSW, MSW Candidate 2018
University of South Carolina

Background
• Palmetto Health Richland mission is being committed to improving the physical, emotional and spiritual health of all individuals and communities served; to providing care with excellence and compassion; and, to working with others who share fundamental commitment to improving the human condition.
• Psychiatric Consultation is the collaboration of a psychiatrist and a licensed social worker who provide management, recommendations, and referrals to patients with emotional and behavioral problems related to their illness, upon nursing and interdisciplinary staff request. The population served are all individuals that are 18 years of age and up.

Field Project
Clinical Institute Withdrawal Assessment (CIWA-AR)
• 10 item scale that measures the severity of alcohol withdrawal symptoms.
• Items measured are: nausea & vomiting, tremor, paroxysmal sweats, anxiety, agitation, tactile disturbances, visual disturbances, headaches & fullness in head, orientation & clouding of sensorium.

Rural Aspect
• Psychiatric consultation treats patients from different regions of South Carolina. Certain regions are limited to or have no access to hospitals, health clinics, or treatment facilities, therefore making accessibility a barrier for rural populations.

Interprofessional Collaboration
• The consult team consists of a license social worker, psychiatrists, medical students, and a social work intern. As a team we make daily rounds to present patients and discuss medications, treatment and discharge planning.
• Additional staff: medical doctors, nurses, physical therapist, medical students, social workers. We work closely with this staff to gather more information to help make proper recommendations for patients.

Lesson Learned
• Rural populations have multiple barriers in receiving treatment.
• Understanding efficiency is to understand how to work closely with an interdisciplinary staff.
• Identifying withdrawal symptoms and taking the next step for treatment.
Increasing Clients’ Knowledge: A Patient Education Program
Shelby L. Thornhill, BSW Candidate

**Background**
Leukemia & Lymphoma Society’s (LLS) South Carolina Chapter serves clients across the entirety of the state. With three offices, in Greenville, Columbia, and Charleston respectively, the agency provides local resources and raises money for research to cure all blood cancers. Its mission is three-fold, with focuses in research, patient access, and policy/advocacy.

As a HEALS student, I work with many diverse populations, as cancer does not discriminate. During the 2017-2018 school year, I brokered resources for clients of various genders, ages, and socio-economic statuses, including lower-income Medicare and Medicaid patients. Leukemia & Lymphoma Society serves all clients with a blood cancer diagnosis or those currently in remission. Alongside patients, we also work with their families and caregivers.

**Aim**
This poster aims to share information about the creation of a patient education program that sought to increase clients’ awareness of emerging cancer treatments and available LLS tools and resources.

**Interprofessional Collaboration**
During my time at LLS, I worked alongside many professionals including:
- Hospital social workers
- Marketing staff
- Doctors
- Local LLS employees
- National LLS employees
- Campaign managers
- Bachelor of Social Work interns

The team for this field project worked on collaboration level 2. The doctors, social workers, and interns worked to coordinate and communicate together, but were not co-located.

**Field Project**
This semester, I helped create a patient education program, held in Charleston, with the goal of increasing clients’ awareness of new cancer treatments. I helped secure a venue, budget for the event, advertise through social media, distribute invitations through a mailing list, discuss the upcoming event with clients, and work the registration table.

**Rural Uniqueness**
We decided to host this program in Charleston to reach the largest number of rural clients who are currently in treatment at Medical University of South Carolina. By hosting this program in Charleston, clients who may usually not have access face less barriers in terms of transportation, time commitment, and costs. I also sent out a physical mailing list, in order to make the event accessible to my clients without Internet connections.

**Lessons Learned**
1. Social media and email blasts are a great way to advertise your event but these methods are not all-inclusive. Many of my clients do not have internet access, so sending a physical mailing list increased accessibility for rural clients.
2. Co-location of services can easily increase efficiency and levels of communication between professionals and clients. I experienced firsthand the miscommunications that can occur when unable to speak with a coworker face-to-face.
Case Management and Acute Care Coordination Efforts to Address Barriers to Care Following Discharge from the Hospital

Katherine Wallace, MSW, MPH Candidate 2018
Social Work HEALS Scholar, College of Social Work, University of South Carolina

Background
Palmetto Health Richland (PHR) is a regional community teaching medical center and Level I Trauma Center that serves more than 225,000 people from across the state and beyond each year (“Palmetto Health Richland,” n.d.). PHR serves all populations regardless of socioeconomic status, including individuals who are unfunded or self-pay. Floor 8 East provides care for patients who have orthopedic needs, including surgery and rehabilitation following a skeletal injury or trauma. Many patients served on this floor are insured under Medicare/Medicaid, or are unfunded. A majority of the patients served on this floor are above the age of forty-five.

Aims
The purpose of this poster is to outline barriers patients face following discharge from the hospital and the intensive, interdisciplinary team work provided by case management, medical providers, and other professions necessary to meet the complex needs of patients served on 8 East at PHR.

Sources

Interprofessional Collaboration
Each social worker doing case management at PHR has a partnership with a nurse case manager. The nurse case manager is able to make orders for equipment and other services the patient needs. The social worker and the nurse case manager work together to determine what the best plan for a patient is, and what can be done to make that plan happen. Social workers at PHR also work closely with physicians, physical and occupational therapists, speech and language pathologists, and pharmacists to ensure the best plan is being put into action for each patient. The team at PHR works well together and forms a cohesive and relatively smooth running system. Everyone on the team seems to understand each other’s role and there is a sense of respect that permeates the team.

Rural Implications
One of the barriers patients who live in rural areas experience is access to care following discharge from the hospital. It can be difficult to find a rehab facility close enough to the patient’s home that the family doesn’t have to drive too far to visit the patient. There are overall fewer choices for facilities in rural areas, so patients are limited to the few that are in their area unless they choose one in the city farther from their home. Case management tries to address this by making referrals to as many facilities in a 30 mile radius of the patient’s home, as well as trying to find alternative forms of care that the patient can utilize. Based on the severity of the patient’s needs, they may be able to utilize home health services and receive care in their home rather than in a facility.

Lessons Learned
My time in this program has helped me learn so much more about different professions and how they all work together to provide the best care possible for the patients they serve. I have been able to participate in professional development programs that have helped me expand my knowledge about how I, as a Social Worker, can add to a team of health care providers. This program has allowed me to learn about patient-centered-care and how to best meet the needs of the people we are serving physically, emotionally, mentally, and behaviorally. All of the professions I have been able to observe and work with have widened my perspectives and shaped my approach as a Social Worker.

Special Field Activity
Interviews with patients were conducted to determine common barriers patients face when trying to receive medical or health care following a hospital stay. These interviews were approximately 15-20 minutes long and were conducted in patient rooms on 8 East. Data from these interviews was qualitative in nature and was used to help guide how case managers helped patient’s better navigate their discharge process. Most patients who were interviewed were either on Medicaid/Medicare insurance, or were unfunded or self-pay.

Special Field Activity
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Sources
Background

John A. Martin Primary Health Care Center (JAMPHCC) provides family and prenatal care and is located in Winnsboro, South Carolina.

JAMPHCC’s primary impact is to provide patient centered medical care while educating patients on various health issues that aid in their physical and emotional needs being met. The majority of SW referrals, consisted of African-American or White patients over the age of 18.

Activity

1. Researched, created, and modified materials on advanced directives
2. Created advanced directive packets to include:
   a. Introduction letter
   b. Informative PowerPoint
   c. Myths about advanced directives
   d. Step by step infographic
   e. Notary Officials in the Winnsboro area
   f. Health Care Power of Attorney and Living Will for the state of South Carolina
3. Consulted with clinic manager to obtain report of patients who indicated that they have an advanced directive. Composed and mailed letters to those patients.
4. Conducted a staff training on the protocol for advanced directives
5. Created an informative display for JAMPHCC’s waiting area
6. Implemented the program with the assistance of clinical staff and physicians.

Highlighting Rural Aspects

1. SW Intern observed that a lack of knowledge about advanced directives and the purpose of end of life care planning were issues present in the clinic.
2. Rural aspects highlighted at JAMPHCC were barriers such as transportation and insurance (lack thereof or uninsured)
3. Issues related to low socioeconomic status were also identified.

Interprofessional Collaboration

Overall, JAMPHCC has a moderate level of Interprofessional collaboration among staff.

Pharmacy Students
SW Intern and Pharm students have collaborated to identify and improve patients medication adherence. They also located and assisted patients with enrolling in medication assistance programs.

Nurse Practitioner and Physicians
The social worker would often consult with providers and follow his or her recommendations.

Education Specialist
The education specialist and social worker established a high level of Interprofessional collaboration. Together, they assessed, intervened, and evaluated patients.

Lessons Learned

1. Working in a rural area with an interdisciplinary team taught me the process of implementing a program, as well as the chain of command.
2. This project taught me that everything does not always go according to plan, things may not be completed in a timely fashion.
3. I learned the valuable lesson of being more proactive instead of assuming that delegated tasks are being completed.
4. Finally, I learned that things may have to be repeated multiple times which is a factor that I did not account for.
The Positive Impact of Re-entry Programs for Youth Returning to the Community After Leaving the Juvenile Justice System

Alfonso K. Woodward, MSW Candidate
University of South Carolina

Introduction
In October 2015, the Richland County Public Defender’s Office received a federal grant to start a Holistic Re-Entry Program that aims to provide reintegration planning and intensive case management for young people in Richland County. These youth are returning to their communities after serving a period of secure confinement. The program serves youth ages 12-17. The client population served by the program is 96% male approximately 91.3% African American. The program served a total of 23 clients between August 2017 and April 2018.

Aim
The paramount objective for a re-entry program is to aid in the client’s community re-entry and to reduce the rate of recidivism. This project focused on working to connect clients with needed resources to ensure both successful re-entry and sustained progress upon completion of the program. As a Youth Advocate, I worked directly with two clients to create an action plan to achieve this goal. This plan consisted of measurable goals to illustrate progress. Clients participated in community service opportunities, job readiness programs, mentor programs and individual and group therapy. I also conducted weekly school visits and occasional home visits when necessary. Because many of the program’s clients live in rural communities which do not offer many of the needed services, it was important for me to utilize my skills to locate not only the best resources but also the resources that were the most convenient for clients to access.

Field Project
The Holistic Reentry Project team included a Licensed Master Social Worker, Youth Advocates (master level social work interns), the case attorney who is the Project Director, and the support staff such as a paralegal and legal research interns. Additionally, school administration and teachers played an important role in the rehabilitation of the clients. The team worked together to establish the best course of action for each client. Over a seven to eight month period, the team conducted several Individual Education Program (IEP) meetings to determine how to approach aiding the clients. The degree of collaboration could be defined between a Level 2 and Level 3 according to the Six Levels of Collaboration and Integration. Though all members engaged copiously throughout the process, the team was not housed within the same location. This made the processing time longer at times. However, the quality of collaboration was not negatively affected.

Interprofessional Collaboration
- The importance of operating from the clients’ strengths
- The importance of knowing the resources available to clients
- The benefit of interprofessional collaboration
- The need for social workers in rural behavioral health systems

Lessons Learned

References