THE HSSESI

THE HEALTH SERVICES SYSTEMS ENVIRONMENTAL SCAN & INTERVENTION

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The National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

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PART 1: BACKGROUND

MESSAGE FROM THE RESEARCH TEAM

Rural communities often have difficulty finding and retaining mental health services. Often, mental health services Health care in general, and mental health in particular suffers from urbancentrism Access to and quality of care, trauma-informed systems of care, the informal mental healthcare system, uninsurance and mental health parity, and other uniquely rural issues are at the core of rural mental health. Systems and expectations that arise from urban experiences may not fit rural communities. For example, referral to a traumatic stress specialist, or even a mental health professional, may truly not be available. When available, access may include waiting weeks to months for services and traveling considerable distances to the point of care. Specialty programs that exist at urban universities are for all intents and purposes inaccessible to people from rural areas.

Our team views “rural” as a special population. Those in rural areas who have suffered traumatic stress are particularly at risk. Not only are the resources more scarce, access to help can be vastly more difficult and at times even risky.

A child seeking help from a teacher may be asking for help from the local law enforcements’ family. Supporting the teacher in getting help for the child may run counter to the friendship and kinship relations within a rural town. Even when victims flee violent situations, it may be impossible to provide them with sanctuary: the shelters, if available, are likely to have known locations.

Research has shown us not only that we must recognize the varieties of rural and frontier, but also that we recognize that there are different program, policy, and treatment implications for children and their families across different socioeconomic groups, of different ethnic and racial heritages, across different climates, and more.

Rural trauma-informed care is at the same time a health system problem and in the most fundamental way, an economic problem.

We believe that taking a community systems approach to improving trauma-informed care is the only practical route for rural communities. We believe that it is important to address directly immediate organizational problems and to build structural plans that can be implements in order to strengthen the organizations that provide both formal and informal trauma-informed care.

ORIGIN OF THE HSSESI CONCEPT

Over the years we have learned that most formal and informal mental health systems are not aware of the plethora of resources that support rural physical health systems. Most who live in rural communities understand how important the rural community's economic and social strength is to accessing healthcare. Those from more densely populated and resourced areas often see healthcare as an industry unto its own. Consequently, few realize that undermining the economy of a community undermines both its mental health and its access to mental healthcare. Nonetheless, the link is recognized by U.S. law. The laws are primarily directed at general physical health care, they can also support mental health care.

Our intentions with the HSSESI are to assist mental health and social services, formal and informal, in rural areas access resources. The assistance may be in identifying ways to

access the same services and supports that are generally available in urban areas. The assistance may come in the form of accessing specialized programs for rural and frontier areas. The overall goal is to keep organizations and providers *able* to continue their work in rural and frontier areas.

As mental health professionals we typically have very little training in healthcare administration and policy and thus often do not know about rural support programs. Most were not designed for or directed at the mental health system. Yet, there are number of subsidy and support programs that the general medical systems use while the mental health and substance abuse community remain unaware of the programs' existence.

An example can be seen in the U.S. government's Medicare Rural Hospital Flexibility Program (Flex Program; Balanced Budget Act, 1997) which authorized Critical Access Hospitals (CAH) which are allowed to bill Medicare on a cost basis rather than on an urban model set fee schedule. By August 2007, 1,283 CAHs had been established across the United States.

While CAHs are the frontline for rural health care, they were not intended to be mental health facilities. Nevertheless, in reality CAHs are the also frontline providers for mental health care. A national study of 422 CAHs illuminates the role of mental health access through CAHs in rural communities.[1] According to the report, 43% of the communities surveyed had *no mental health service provider* leaving community members to go without mental health care or rely on the CAH. These same thin resources also mean that many CAHs are unable to respond well to mental health emergencies. Nonetheless, about ten percent of CAHs

[1] Hartley, D., Ziller, E., Loux, S., Gale, J., Lambert, D., & Yousefian, A. (2005). Mental Health Encounters in Critical Access Hospital Emergency Rooms: A National Survey was conducted by the Maine Rural Health Research Center, (muskie.usm.maine.edu/Publications/rural/wp32.pdf).

emergency department admissions are for a primary mental health or substance abuse problem. A painfully common issue is that 42% of those people seen in CAH Emergency Departments had a symptom of mental health or substance abuse disorder that was not addressed or unrecognized. Nearly half (42%) of people with mental health or substance abuse problems, including suicidal ideation and attempts, left the CAH emergency departments with no plan for how to address the presenting mental health problem.

No one wants to provide bad care; no one wants to provide no care. The HSSESI is a method to do an environmental scan of the community, identify resources, and implement access to them. Care that exists is improved care.

Some of the most commonly used resources that are identified through the HSSESI are access to training in evidence supported protocols; reduction in burnout and secondary trauma; improved ability to bill and follow up on payments for services rendered; linkages with schools, faith based organizations, public safety and physical health care; improved acess to technology; and improved relationships with children and their families.

PART 2: RESEARCH AND DEVELOPMENT

Rural, frontier and tribal health professionals express the desire and even motivation to change[2], but the press of the work environment is overwhelming and works against one's ability to change. Pressure on health professional caused by the well known problems in

[2] Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102-1114.

access and availability of care profoundly affect the acceptability and quality of care.[3] Moreover, the strain of providing care in under-resourced environments, literally doing the best one can in a difficult situation, coupled with the desire and often knowledge of ways to provide better care, has a negative effect on both the caregiver's quality of life, and even the potential to make errors in providing care.[4,5,6] Thus, rural, frontier, and Tribal area health professionals may well have the desire and motivation to change, but because of their environmental issues, may be prevented from changing or maintaining a change that has been made.

Typically, change unfolds one site or practitioner at a time, and can be a very slowly unfolding process. The well known statistic from the *Institute of Medicine* is that there is a lag of an average of 17 years between the identification of better practice and its incorporation into routine patient care.[7] Yet, there is a desire to change, for example the development of the *New Freedom Report on Mental Health*[8]

The HSSESI is an infrastructure intervention developed in response to the need for infrastructure changes to address (a) the need to improve quality of care and reduce patient

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[3] Stamm, B.H. (2003). *Rural Behavioral Health Care*. Washington, DC: APA Books.
[4] Stamm, B.H. (2002). Terrorism Risks and Responding in Rural and Frontier America. Invited article for *Engineering in Medicine and Biology, 21* (5) 100-111.
[5] Stamm, B.H. (Ed.) (1999). Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators, 2nd Edition,. Lutherville, MD: Sidran Press.
[6] Stamm, B. H., Higson-Smith, C. & Hudnall, A. C. (2004). The complexities of working with terror. In D. Knafo (Ed.). Living with Terror, Working with Terror: A Clinician's Handbook. Northvale, NJ: Jason Aronson.
[7] Institute of Medicine (2003b). *Health Professions Education: A Bridge to Quality.* A. C. Greiner and E. Knebel, eds. Washington, D.C: National Academy Press
[8] New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. Rockville, MD: DHHS Pub. No. SMA-03-3832.

care errors, (b) improve trauma-informed care and (c) the unique fiscal, structural and cultural issues faced by communities and health professionals in rural areas.

RESEARCH AND DEVELOPMENT OF THE HSSESI

The HSSESI was developed using both qualitative and quantitative date. Below is a summary of the processes and outcome data from the final version of the HSSESI reported here.

PHASE I: INITIAL DEVELOPMENT: 2002-2004

The nascent form of the HSSESI emerged in 2002. It was further refined for the submission of the National Child Traumatic Stress Initiative call for proposals in 2003.The content of the HSSESI was refined through informal and key informant interviews with the NCTSN rural grant. Important feedback came, in particular, from the National Rural Health Association and the National Association for Rural Mental Health in the form of broadening the issues addressed by the HSSESI. Ongoing discussions with the U.S. Department of Health and Human Services Health Resources and Services Administration Office for Rural Health Policy (ORHP) and the Office for the Advancement of Telehealth (OAT). Both ORHP and OAT provided information regarding various federal programs thinking critically with us about how these general programs could be formed to support trauma informed care.

Discussions officials with the NCTSI program as well as with state agencies in New Mexico highlighted how hard it was to convey the idea and worth of the HSSESI. Armed with these difficult interactions, the team refined both the formal documentation about the HSSESI but also the team's methods of explaining it.

PHASE 2: FORMALIZATION OF THE INTERVENTION: 2003-2004

In the spring of 2003, a site visit with the Sidran Foundation provided an opportunity to test the new explanations about the HSSESI, its value, and the elements of it. Group and individual training of an audience largely made up of urban people showed that they grasped

not only the unique issues of rural communities, but also some of the unique solutions that the HSSESI could bring to fore. Building from the success of the training and from the questions asked by the participants, further refinements were made to the HSSESI.

In the early summer of 2003, the HSSESI was formalized into a structured interview. The interview uses the same format as the Structured [9]

PHASE 3: EVALUATION OF THE PROTOCOL: 2005-2008

During this phase, sites were recruited and enrolled in the HSSESI. Recruitment was conducted through multiple methods. The most successful recruiting method was face-to-face, particularly if there was some type of personal relationship. For example, if we were recommended to a site by someone they trusted, and we meet with them in person, the enrollment rate was very high. Enrollment also came through a variety of marketing methods including public service announcements, direct mail, our website and by meeting with agencies and organizations likely to be in a position to provide information to our potential customers.

During the evaluation phase, enrolled sites participated in the HSSESI as it would normally be conducted but also provided feedback about the process along the way. In addition, we collected data regarding the types or organizations recruited, their existing resources and

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[9] First, M.B. First, Spitzer, R.L.Gibbon, M., & Williams, J.B.W. (1997) "The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a semistructured interview for making the major DSM-IV Axis I diagnoses (American Psychiatric Association..."

needs, and their participation and processing through the HSESSI. Data were analyzed to identify the types of resources and technical assistance most commonly needed, and the level of information and assistance that was needed to bring about change. Additionally, data was collected on participation in the process including identifying what junctures were high-risk for drop-out, how people progressed, at what point did a site consider that they were done compared to the point at which we believed they were done, etc.

Evaluation Results

Participant Site/Organization Demographics

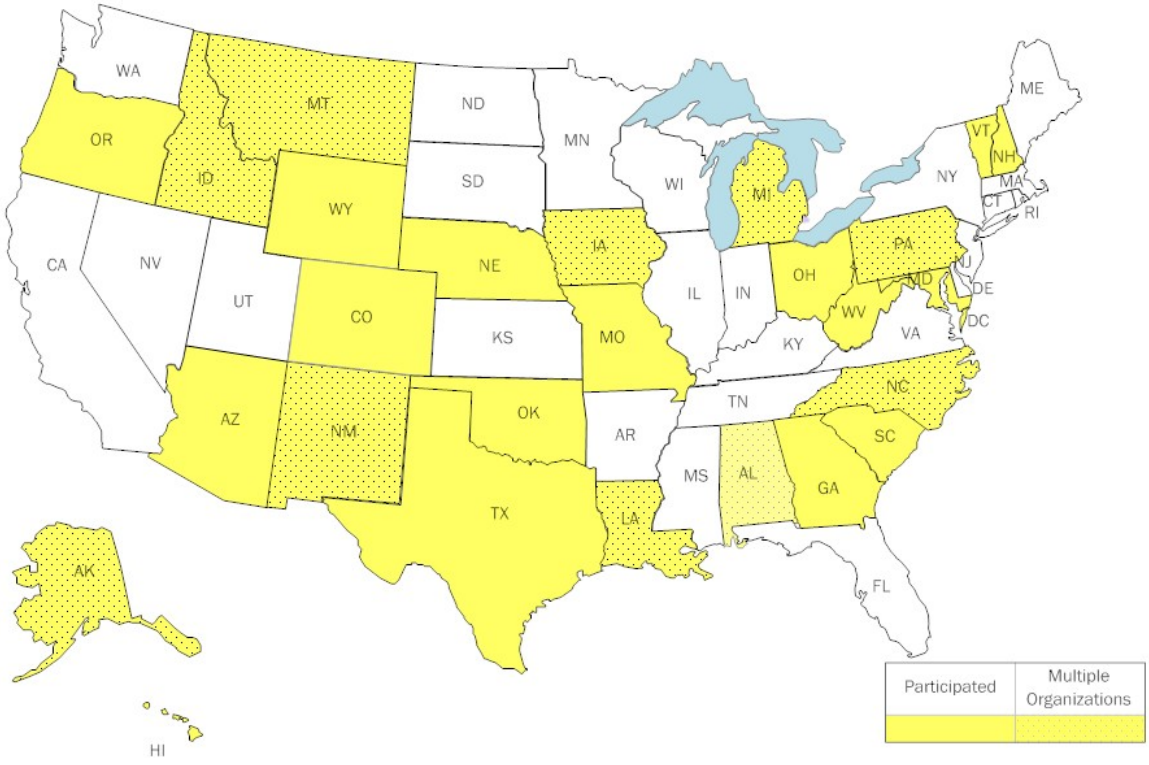
States With Participant Sites

Sixty-three (63) organizations in 27 states participated in the HSSESI. Some states had more than one site participate. A site is defined as an organization. One site may include more than one clinic or location. This configuration is typical in Community Health Centers where an agency has a “home” location and satellite clinics.

	State	Number of Participant Sites/Agencies/Organizations
1.	Alaska	2
2.	Alabama	2
3. 3	Arizona	1
4.	CO	1
5.	DC	1
6.	GA	1
7.	HI	1
8.	IA	2
9.	ID	5
10.	LA	3
11.	MD	1
12.	MI	3
13.	MO	1
14.	MT	3
15.	NB	1
16.	NC	2
17.	NH	1
18.	NM	6
19.	OH	3
20.	OK	3
21.	OR	8
22.	PA	4
23.	SC	1
24.	TX	2
25.	UN	2
26.	VT	1
27.	WV	1
28.	WY	1
	Total	63

The map below shows the location of states that has participants as well as showing where more than one site participated in a state.

States in which HSSESIs Took Place



Employee Number and Characteristics

Forty-two sites reported the number of their employees. Two sites had more than 100 employees. Among the remaining sites, the mean number of full time providers was 8.23 (SD 10). The median full time providers were 3 and the mode 2. On average there were 4.5 (SD 6.8) part- time provides, a median of 2 and a mode of 1. Twenty-six sites responded to concerns related full time providers and 21 regarding part-time providers; 42% (11) conveyed concerns regarding full time providers and 38% were concerned about not having enough part-time providers.

Education/Training and Turnover of Providers

Forty four (44) sites responded to questions regarding the education and turnover of providers. While most sites (34, 77%) felt that their providers had sufficient education, over half of the sites (14; 56%) of the sites had concerns about turnover. Fifty five percent (23) organizations did not feel they could support continuing education and 14% (6) did not know if they could or could not. 31% (13) did report being able to support continuing education.

Reimbursement

Of the 43 sites responding to queries regarding reimbursement, one third (14; 33%) reported concerns about reimbursements; 18% (8) sites did not know if they had problems or not. This group balanced against those who did not have concerns regarding reimbursements which were 47% of the respondents. Most sites were not interested in pursuing Federally Qualified Health Center status (no 18; 72%; yes 7, 28%). However, 37% (15) said that they would like information about how to become an FQHC.

Technology Access

Of forty one sites responding, 63% (n=41) indicated that they had internet access. Only six (9%) of sites indicated that they were concerned about having internet access. Of 41 sites, about half (20, 49%) reported having electronic billing. Seven sites (11%) reported that they were concerned about electronic billing. An equal number of sites had videoconferencing to the number of sites who did not (16; 38%). Seven sites (17%) reported not knowing if they had access to videoconferencing. Forty four percent (11) were concerned about their videoconference access. Only one site knew that they had funding through the Universal Services Technology fund. Almost half of the sites (18, 44%) did not know if they did or did not having Universal Services funding to support their technology expenses. Even though many of the sites would qualify for technology support funding 13 sites said that they were not concerned while only four sites reported concern.

Relationships with Other Organizations

Forty one (41) sites responded to queries regarding relationships with other organizations that typically served the same youth as they. 92% (38) reported having good relationships with other providers; 91% (38) with schools; 67% (28) with the justice system; and 74% (31) with churches.

Immediate Crisis

Of the 58 sites reporting on the variable “Is there an immediate crisis?” only 7 sites (12% reported that there was an immediate crisis. Typically organizations experiencing an immediate crisis had contacted the HSSESI program for assistance. If a site was experiencing an immediate crisis, the activity was oriented to helping the organization manage their crisis. This management was not often provided by the HSSESI team. However, the HSSESI team often assisted in thinking through potential crisis management resources with the site.

Among those sites not experiencing an immediate crisis (n=51; 88%), the impetus for contacting the HSSESI team was rooted in concerns about rural resources and keeping their staff both employed and not burned out. Forty seven (n=47) sites responded to the query "are you concerned" about a crisis that could occur, 33 (70%) indicated that they were not concerned.

Characteristics of Clients Served by HSSESI Participant Site Agencies and Organizations

Ruralality

The inclusion criteria for participating in the evaluation of the HSSESI included serving rural populations. Nonetheless, some interactions were with sites who did not serve rural populations (n=5; 9%). These sites were included because they were located in communities that were surrounded by a significant rural population who may or may not be identified as rural when they sought trauma-informed care in the city. The majority of the sites reporting (50 of 55 sites; 91%) did serve rural populations.

As noted above, many sites that serve rural people are located in cities surrounded by rural areas. Of the 56 sites reporting, 29% (n=16) centers (home site) were not located in a rural area. The remaining 40 (71%) had their home site or center of their organization/agency in a rural community.

Poverty, Unemployment and Uninsurance

As could be expected, the people living in the catchment area served by the agencies and organizations experienced more poverty and included more uninsured than the national

averages (t (59) 5.29 = p<.001 M 16.87, SD 6.7; National M 12.3[10] Twenty-five sites (n=25) estimated the percent of their clientele who lived below the poverty line. The mean estimate was 48% (SD 30%) with a median of 50% and a mode of 50% indicating that not only was their catchment area impoverished when compared to the national average, their clientele typically were in the more poverty than the catchment area which was typically in more poverty than the national average. While the standard deviation of the estimated percent of clients in poverty is quite wide (SD=29) compared to the catchment area (SD 6.7) indicating nonlinearity of the data, the considerable difference between the means is compelling (t36=6.4; p<.001; estimated poverty of clients served M 48; estimate of poverty in catchment area M 16.8). It is important to note that the nonlinearity of the data in the t-test cautions against this as an established statistic.

Based on the unemployment rate reported by the Bureau of Labor Statistics in September 2008, there is no difference between the unemployment rates in the catchment areas served and the national average. The catchment area uninsurance rate was higher than the national average t (58) 4.4 = p<.001 M18.35, SD 6.2 National M14.8).[11] Taken together, as is not uncommon in rural areas, this would suggest that people served were employed in lower wage/benefit positions than their counterparts nationally.

Race and Ethnicity of Clients Served

Sites reported serving most race and ethnicity groups. Sites reported that they did not have concerns about their service to non-Caucasian clients. Sites seemed to value highly their ability and the appropriateness of serving their clients in culturally aware ways.

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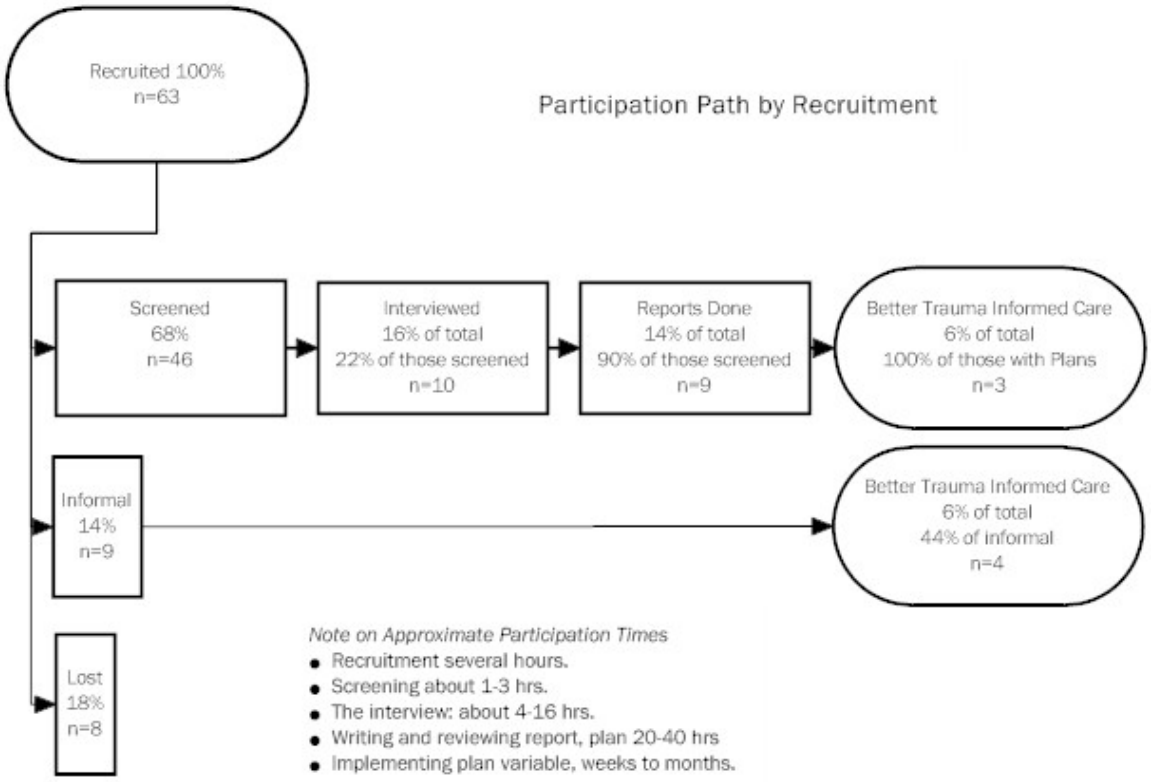
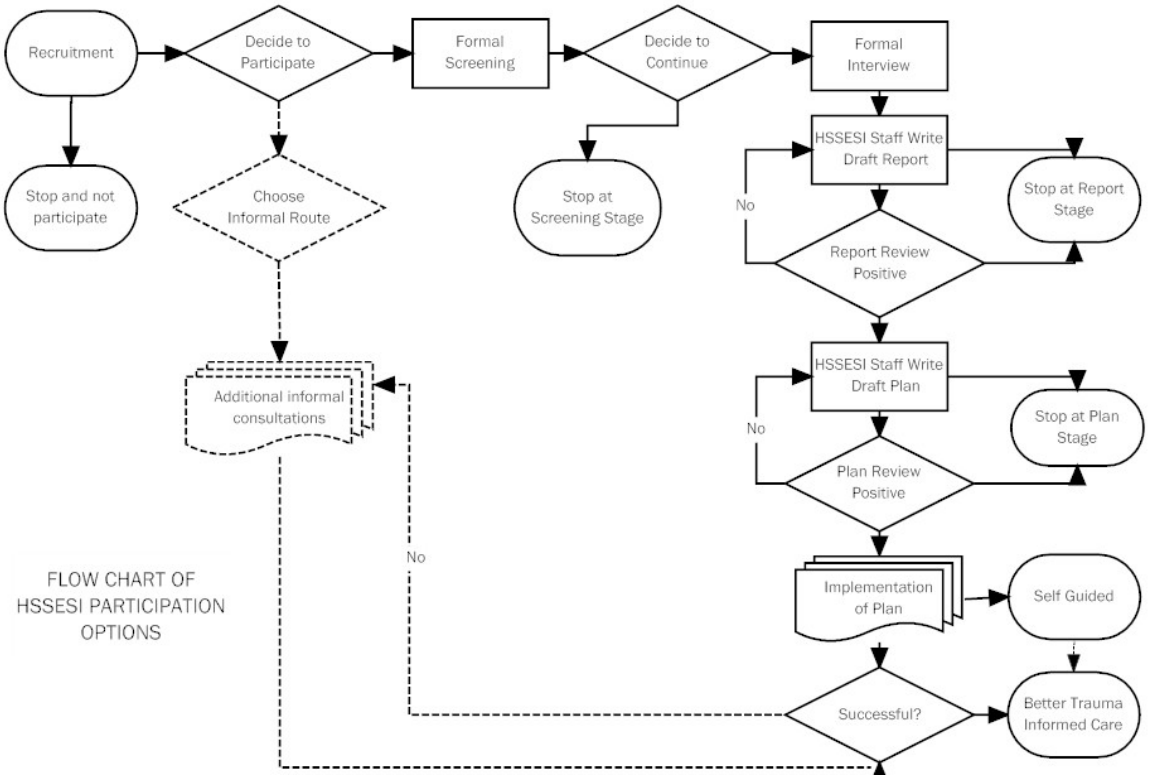
[10] U.S. Census Bureau, 2008
[11] CDC, Septeember 2008

Participation Process

One of the key points that arose with the evaluation of the HSSESI was that having access to an informal entry to technical assistance was of equal importance, and apparently of equal success, to that of a formal process. Of the 63 full sites participating, 9 were an informal entry leaving 54 that came through the "process". Of that 54, 46 completed the screening, 10 were interviewed, 9 reports were written, 8 plans were written, 5 of those plans were reviewed by sites, 3 plans were written and as best we know, all three of these involved system change. Of the informal entries, 4 systems showed evidence of change (e.g. new methods or work based on grants received, etc.). Technical assistance of an informal type typically worked with organizations that were on the “right track” but needed information. Systems that were less mature benefited from the formal HSSESI process.





FLOW CHART OF HSSESI PARTICIPATION OPTIONS

PART 3: HOW TO USE THIS MANUAL

SELF ADMINISTRATION FOR SELF ASSESSMENT

The HSSESI can be self-administered. This is particularly helpful with organizations who are aware of resources but need to focus their system change options. Self-administration is not recommended for organizations that are experiencing either community or organizational crises. It is also not recommended for new organizations who do not have experience with system management.

EXPERT ADMINISTRATION FOR INTERVENTION PLANNING

Formal administration of the HSSESI is most helpful with organizations who have made a commitment to change but who are not sure where to start of how to identify the potential sources of fiscal and organizational support that may be available.

FINDING RESOURCES

At the core of the usefulness of the HSSESI is its ability to link concerns to resources. Once concerns are identified, and a plan is made, organizations can typically identify programs through the internet or talking with their State Offices of Rural Health. Many programs, however, are not immediately identifiable. For example, for understaffed clinics, an AmeriCorps or Vista volunteer may provide much needed support. These programs typically require organizations to provide 25% of the employee costs. Each state typically has an AmeriCorps program. However, few think of placing volunteers in rural mental health clinics. It is these types of experiences and ideas that can come from an expert in rural health who has reviewed an organization's concerns and assist with building an implementable plan.

PART 4: OVERVIEW OF THE HSSESI INTERVENTION

The Health Services Systems Environmental Scan and Intervention, also known as the HSSESI (pronounced hes-see) strengthens healthcare organizations and their employees in order to improve the quality of care provided children and their families who have experienced trauma and to improve the professional quality of life for those people in the organization. Consultants at the Center for Rural, Frontier, and Tribal Health (CRFTH) have developed a standardized assessment and intervention strategy using the HSSES Self-Report Screening (aka "HSSES short form"; a multiple-choice pre-screening form which identifies target domains for the HSSES structured interview) and/or the HSSES Structured Interview (aka "HSSES long form"). The HSSES Self-Report Screening and the HSSES Structured Interview elicit information regarding a number of domains, including community characteristics, immediate crises, provider demographics, treatment populations, fiscal resources, training, technological resources, institutional/administrative support, and community involvement. This process is multifaceted in order to foster an understanding of the targeted organization and community, its strengths and needs, and what will work best for all these considerations. In general, a CRFTH consultant will oversee the three phases of this process: the needs and resources assessment, the plan development, and the plan implementation.

NEEDS AND RESOURCES ASSESSMENT

During the Needs and Resources Assessment, a CRFTH consultant gathers information about the participants' backgrounds, people who work or volunteer with the organization, the people served, and the community in which the organization works. During the information-gathering process, the consultant will consult multiple sources. For example, he/she might

talk to multiple people in the organization. The consultant may talk to community leaders or to consumers or gather information from databases, such as demographic data from the U.S. Census Bureau. Of course, the consulting assessor will not gather information from anyone without prior approval from the organization.

The Needs and Resources Assessment is a structured evaluation and may be approached by using two potential processes, both of which include the HSSES as a measure. The first process includes the use of a brief HSSES Self-Report Screening (See Appendix A), which allows the organizational representative to identify specific domains that may be of particular interest or need for their organization or community based on sample items. The HSSES Self-Report Screening is formatted in closed-ended multiple-choice questions (e.g., yes, no, don't know, n/a, etc.) in order to facilitate web-based administration.

The HSSES Self-Report Screening is then followed by the more detailed HSSES Structured Interview (See Appendix B) targeting the specific domains of interest identified in the initial screening. If the HSSES Self-Report Screening is completed, the entire HSSES structured interview would not typically be administered, unless the reporting individual identified needs in all domains when completing the initial screening. Only the domains of interests identified in the HSSES Self-Report Screening would be administered in the structured interview form. This process streamlines the time commitment necessary for the one-on-one HSSES Structured Interview as domains irrelevant to the respondent are automatically omitted.

The second option for the Needs and Resources Assessment with the HSSES is to complete the full HSSES Structured Interview, skipping the initial screening option with the Short Form. Although lengthier, some organizations may prefer this strategy if they are certain that there

are a number of domains of concern or if they would prefer the one-on-one consultation format of the Structured Interview. Regardless of which option is pursued, the result of the Needs and Resources Assessment is a summary report which specifically identifies strengths, resources and needs for the organization and specific recommendations for addressing identified needs. (See Appendix C for a sample summary report.)

PLANNING STAGE

During the planning stage the consultant provides key players of the organization with the written summary report. When reviewing the report with these individuals, the consultant also discusses the recommendations regarding technical assistance and training that might be useful for the site/organization given the HSSES information. Participants will be encouraged to review some of CRFTH's available technical assistance and training opportunities at the electronic archive, www.telida.isu.edu/telida/child, if those resources are relevant to the identified needs. The consultant will provide the organization with specific options to pursue for technological and training solutions. The planning stage culminates in a written implementation plan for that identifies specifically identified goals in relevant domains for the organization. This will include assignments for organizational members, things for the consultant to do in providing assistance, and things they will do together. It also includes an opportunity for feedback regarding progress in the "progress note" column. A sample goal of a potential plan domain (technological resources) is noted below. (See Appendix D for a complete sample plan based on the sample report in Appendix C.)

HSSES DOMAIN: TECHNOLOGICAL RESOURCES

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
DSL services currently available at the main office	Unreliable phone line internet connections from outreach homes and director's home	Seek support from Universal Services Funds as available in service areas	CRFTH-provide information links for application materials and general orientation SITE- Complete application process seeking support as needed	___fully completed ___partially completed ___deferred _____# of participants _____Satisfied? (0=not at all; 5=extremely satisfied)

It is important to note that the organization members will prioritize the identified needs for their own organization in the course of plan development. It is possible for and organization to identify several needs through completing the HSSES and recommended solutions will be provided. The organization will then select, during the Planning Stage, which specific

domains are the highest priority and will be included in the plan. Essentially, this allows the consultation process to be consumer driven, meeting the needs the organizational members perceive as being most important.

IMPLEMENTATION STAGE

During the implementation stage, CRFTH consultants will work cooperatively with organizational members to accomplish the plan goals. CRFTH consultants may assist in linking the organization to other organizations for technical assistance or training, or we may provide the technical assistance or training ourselves. Sometimes it will be appropriate for the organization to implement part of the plan independently without CRFTH assistance. The overall goal will be for the organization to become stronger by knowing more about potential resources, empirically supported interventions for [*child traumatic stress and trauma informed services],* improved ways of preventing the negative aspects of caring such as burnout and secondary traumatic stress, and improve the positive aspects of caregiving.

Additionally, during the implementation stage each goal will be regularly reviewed with feedback and discussion about progress in each domain between the CRFTH consultant and organizational members. CRFTH consultants will be in contact (at least monthly) to specifically review the progress on goals of the plan. If barriers to the original plan are encountered during these reviews, alternative solutions and goal prioritization will be discussed to explore new solutions. The implementation plan may then be modified accordingly in order to address barriers or modified priorities. These changes will then be reviewed in a similar manner in subsequent progress review.

PART 5: HSSESI INSTRUMENT

HSSESI
SCREENING

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Welcome to the National Child Traumatic Stress Network Center for Rural, Frontier and Tribal Health

Welcome

Project Description

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Health Services Systems Environmental Scan (HSSES) Short Form Screening

The HSSES is a process to help strengthen your organization and its employees, in order to help improve the quality of care you provide [for children and their families who have experienced trauma] and to improve the professional quality of life for those who work in the organization. This screening tool allows us to identify areas of your organization and its activities which should be targeted for further evaluation. Please respond to the questions below in the answer column and then rate the question as a current concern by selecting "yes" or "no". If an area is of concern to you, we will explore it in more detail later.

Question	Answer	Is this a current concern?
1. Is there an immediate crisis you are attempting to address?	○ Yes ○ No	○ Yes ○ No
2. Does your organization serve rural, frontier or Tribal populations? (Rural is a consolidated block of not more than 50,000 people. Frontier is defined as 7 or fewer people per square mile. Tribal refers to people or places that are associated with federally recognized tribes in the United States, Alaska Natives, and Native Hawaiians).	○ Yes ○ No ○ Don't Know ○ N/A	○ Yes ○ No
3. Is your site physically located in a rural area?	○ Yes ○ No ○ Don't Know ○ N/A	○ Yes ○ No
4. What percentage of your clientele would you estimate qualify as having an annual income below the poverty level?	[ ] % ○ Don't Know ○ N/A	○ Yes ○ No
5. Do you have specific concerns about working with any of the following ethnic groups? ☐ Hispanic/Latin ☐ Asian (group: [ ]) ☐ African American ☐ Caucasian ☐ Native American ☐ Pacific Islander (group: [ ]) ☐ Alaska Native ☐ Other (group: [ ])	< -- Check those that apply	○ Yes ○ No
6. How many full-time providers work at your site?	[ ] Full-time	○ Yes ○ No

HSSESI INTERVIEW

Health Services Systems Environmental Scan and Intervention (HSSESI)

Date	**Name of Site**	**Location of Site (city. State, zip code)**
Name of Interviewee/contact person	**Phone & email address**	

The HSSESI is a process to help strengthen your organization, and its employees. in order to help improve the quality of care you provide [*for children and their families who have experienced trauma]* and to improve the professional quality of life for those who work in the organization.

This process is multifaceted because we need to understand your organization and community, its strengths and needs, and what will work best for you. In general, there are three phases, the needs and resources assessment, the plan development, and the plan implementation.

During the **Needs and Resources Assessment**, we will gather information about your background, people who work or volunteer with your organization, the people you serve, and the community in which your organization works. During the information gathering process, we will gather information from multiple sources. For example, we might talk to multiple people in your organization. We may talk to community leaders. or to consumers. We will gather information from databases such as demographic data from the U.S. Census Bureau. Of course, we won't gather information from anyone without making sure that it is ok with your organization to talk to these people.

During the **Planning Stage**, we will bring to you the information we have gathered and discuss what technical assistance and training might be useful for your site. You can review some of the TA and Training opportunities that we have available at our electronic archive on the web at telida.isu.edu/telida/childts [give URL if they do not have it already]. [*I believe you have already reviewed our archive, as our initial contact came as a result of seeing the archive]*. The planning stage will culminate in an implementation plan for your organization, with assignments of things that you will do and things that we will do, and things that we will do together.

During the **Implementation Stage,** we will work cooperatively to accomplish the goals in your plan. We may assist you in linking to this or that organization for technical assistance or training, or we may provide the technical assistance or training ourselves. Sometimes it will be appropriate for you to implement part of your plan on your own, without our assistance. The overall goal will be for you and your organization to be stronger by knowing more about empirically supported interventions for [*child traumatic stress and trauma informed services]*, and improved ways of preventing the negative aspects of caring such as burnout and secondary traumatic stress, and improve the positive aspects of caregiving.

Q: Do you have any questions you would like to ask? [respond to questions, then summarize by saying].

OK! Let's start with the Needs and Resources Assessment Phase. Remember, if you have any questions along the way, feel free to raise them. We are here to work together to help strengthen your organization and its ability to provide [*trauma informed services to children and their families*].

I'd like to ask a few questions about your role and background, and then we'll talk about characteristics of your work and the individuals or families you organization serves. Is that okay?

Remember, we will be gathering information from multiple sources. If you don't know the answer to some questions, that's ok. If you think you know who could answer the questions, you could tell us. Sometimes, we will find the information in places like the Census Bureau or something like that. We do not expect that you will know all the answers to all the questions we will ask. If you think of something important that we did not ask, please make sure to tell us.

I. INTERVIEWEE INFORMATION	Summary	Concern
A. Are you the clinical supervisor for this program? If no, what is your position/role?	Y N	Y N
B. How long have you worked in this field? C. How long at this program/organization? D. How long in your current position?	Years:_____ Years:_____ Years:_____	 Y N
E. What degree do you hold? In what field of study?	___Assoc ___Bachelor ___Master ___Doctorate	Y N
II. IMMEDIATE CRISIS	**Summary**	**Concern**
A. Is there an immediate crisis you are attempting to address? (If no, skip to next section)		Y N

B. Time and location of crisis:		
C. Crisis event (brief description):		
D. Who were the immediate responders?		Y N
E. Who is currently coordinating response to the crisis? (Include contact info if it is not the caller)		Y N
III. COMMUNITY CHARACTERISTICS Population	Summary	**Concern**
A. Could you tell me something about the size of the community you serve? For example, how large is the population of the city/town/village you are located in?	Pop_____	Y N
B .How large is the broader population that you serve? (Is it a larger population than just the town such as the county or a region?)	Service Pop_____	Y N
C. How large is the geographic area (i.e. 100 mile radius, county size, etc) you currently serve?		Y N

D. Does your community have a public transportation system? ____bus ____train _____subway ____other_____	Y N	Y N
E. What are the primary industries in your community? (list)	___Agriculture ____Lumber ___ factory ____other	Y N
F. What would you guess is the average annual income of families in your area?	$_____	Y N
G. What percentage of families in your community would you estimate live below poverty levels?	%_____	Y N
H. What is the ethnic make up of your community? (what minority groups and what % of each minority resides in the community?) Hispanic/Latin_____ Asian _____ (grp_____) African Amer._____ Caucasian_____ Native Amer._____ Pac. Islander _____ (grp_____) Alaska Native_____ Other_____ (grp_____)		Y N
I. What proportion of your current caseload(s) consists of these ethnic groups? Hispanic/Latin_____ Asian _____ (grp_____) African Amer._____ Caucasian_____ Native Amer._____ Pac. Islander _____ (grp_____) Alaska Native_____ Other_____ (grp_____)		Y N
J. Do you have specific concerns about working with any of the following ethnic groups? Hispanic/Latin_____ Asian _____ (grp_____) African Amer._____ Caucasian_____ Native Amer._____ Pac. Islander _____ (grp_____) Alaska Native_____ Other_____ (grp_____)		Y N

IV. TYPES AND NUMBER OF PROVIDERS	Summary	Concern
A. What is the administrative organization of your site? (i.e., do you have a flow chart illustrating this?)		Y N
B. How many full time providers do you have at your site?	#_____	Y N
C. How many part-time providers do you have at your site?	#_____	Y N
D. Of your providers, how many have the following degrees of education?	___Assoc ___Bachelor ___Master ___Doctorate	Y N
E. How many volunteers do you have working for you at your site?	#_____	Y N
F. What is the education level of volunteers working at your site?	____HS/GED ___Assoc ___Bachelor ___Master ___Doctorate	Y N
G. What is your average tenure of an employee?	_____yrs.	Y N
H. Is turnover a problem you struggle with in your organization? If so, are particular positions more likely to be problematic?		Y N
I. Is burnout or compassion fatigue (secondary/vicarious trauma) a problem for your personnel?		Y N

J. What would you estimate to be the greatest personnel strength in your organization?		Y N
K. What is your greatest personnel challenge at this time?		Y N
V. TREATMENT POPULATIONS	**Summary**	**Concern**
A. What childhood mental health disorders are commonly seen at your site? ____ODD ____anxiety dx ____PTSD ____CD ____depress dx ____DD/MR ____LD ____autism spectrum ____Other…. ____ADHD ____toileting prob.		Y N
B. Of individuals seeking assistance at your site, what percentage is primarily seeking assistance with a traumatic incident or symptoms relating to trauma?	%_____	Y N
C. What percentage of patients seeking assistance at your site have experienced the following types of trauma even if it is not the primary presenting problem? ____physical abuse ____sexual abuse ____traumatic grief ____domestic violence ____other_____	Highest %: ____p.a. ____s.a. ____t.g. ____d.v. ____oth	Y N
D. What percentage of individuals/families you work with is court mandated to treatment?	%_____	Y N
E. What is the expectation in terms of direct patient treatment hours for your full time clinicians in a typical week?		Y N

F. What is the most pressing problem currently experienced by your clinicians in their treatment work?		Y N
VI. FISCAL/REIMBURSEMENT RESOURCES	**Summary**	**Concern**
A. Which of the following does your site receive reimbursement from: _____ Indian Health Services _____ Medicaid _____ Medicare _____ CHIP _____ Private Insurance _____Private Pay _____Victims of Crime _____State contract/grant		Y N
B. What percentage of your patients are uninsured medically? C. What percentage of your patients are uninsured for mental health treatment?	_____% _____%	Y N
D. Do you work with the sliding fees?	Y N	Y N
E. Is your site a Federally Qualified Health Center (FQHC)?	Y N	Y N
F. Are you aware of the qualifications for becoming a FQHC?	Y N	Y N
G. Do you need information about how to become a FQHC?	Y N	Y N
H. Are there any other reimbursement sources you receive funding from that we have not already mentioned? (list)	Y N	Y N
I. Do you need assistance with identifying potential grant funding applications?	Y N	Y N

VII. TRAINING INTERESTS/NEEDS	Summary	Concern
A. What would you identify as your staff's greatest training needs at this time? What specific training opportunities/topics would you like to have available for your organization?		
B. How many of your staff are interested in this training?		Y N
C. Of these interested, how many have had the following levels of experience with the specific intervention targeted in the potential training? ____None ____ Exposure ____ Limited Experience ____ Moderate ____ Extensive		Y N
VIII. TECHNOLOGY RESOURCES	**Summary**	**Concern**
A. Do you think of your organization as being? ____low tech and we like it that way____ low tech but interested in more ____ moderate tech ____ high tech		Y N
B. What is your most frustrating technical issue right now?		Y N
C. Do you have internet access?	Y N	Y
D. Do you use it?	Y N	N
E. Do you have an electronic patient or billing record?	Y N	Y N
F. Do you have concerns about HIPAA (data privacy and security)?	Y N	Y N
G. Do you know what type of telecommunications connections you have, perhaps you know your service provider? (Broadband, etc.) ____56k phone ____Broadband/high speed internet/DSL ____other ____don't know		Y N

H. Do you have access to videoconferencing?	Y N	Y N
I. Are you aware of any sites in your community (e.g. high school, Kinko's, justice dept.) that may have equipment you could use for teleconferencing purposes? (list)	___No __Yes: list	Y N
J. Do you use the Universal Services Fund?	Y N	Y N
K. Is there anything specific you would like to do with technology?	List_____ N	Y N
IX. INSTITUTIONAL/ADMINISTRATIVE SUPPORT	**Summary**	**Concern**
A. Will your institution provide financial support for any of the following relevant to training activities: _____travel _____equipment use _____food _____telecommunication connection fees _____CEU fees _____other expenses_____		Y N
B. Do you have release time from your job to attend these trainings?	Y N	Y N
C. Do you have shift/case coverage from coworkers during training activities?	Y N	Y N
D. Do you have a formal mechanism in your organization for identifying specific training needs?	Y N	Y N
E. Do you have a formal mechanism in your organization for requesting specific training activities?	Y N	Y N

F. Do you have a formal program evaluation method for your organization?	Y N	Y N
G. What is your greatest institutional or administrative strength as an organization?		Y N
H. What is your greatest institutional/administrative challenge at this time?		Y N
X. POTENTIAL COMMUNITY INVOLVEMENT	**Summary**	**Need**
A. Do you work with any of the following: ____ Health and Welfare ____ Juvenile Justice ____ Elementary and Secondary Schools ____ Child Protection Services		Y N
B. Do you work with any of these volunteer organizations (List names): ____ Church Groups _____ ____ Peer Support groups_____ ____ Civic Organizations _____		Y N
C. What other community organizations does your department work with?		Y N
D. Are there any other groups that you would like to connect with?		Y N
OTHER RESOURCES	Date (if Applicable)	**Need**

Health Services System Environmental Scan and Intervention

(HSSESI) Summary

REPORTING PARTICIPANT: XXXXXXXX

CRFTH STAFF: KELLY DAVIS & DEBRA LARSEN

ORGANIZATION: PIEDMONT HEALTH GROUP

DATE: 04/24/2007

INTRODUCTION

COMMUNITY CHARACTERISTICS

IMMEDIATE CRISIS

SERVICE POPULATION

PROVIDERS

FISCAL/REIMBURSEMENT RESOURCES

TRAINING NEEDS

TECHNOLOGY RESOURCES

ADMINISTRATIVE SUPPORT

COMMUNITY CONNECTIONS

OTHER RESOURCES

RECOMMENDATIONS:

_____

CRFTH STAFF

HSSESSI PLAN FORMAT

ORGANIZATION:___ _____Contact Person:

CRFTH Consultant:_____ DATE:

HSSES Domain: COMMUNITY CHARACTERISITCS

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: SERVICE PROVISION CHARACTERISITICS

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH R ECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: PROVIDER CHARACTERISTICS

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: FISCAL/REIMBURSEMENT RESOURCES

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed

				___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: TRAINING INTERESTS/NEEDS

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants

				____Satisfied? (0=not at all; 5=extremely satisfied)
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: TECHNOLOGICAL RESOURCES

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: **INSTITUTIONAL/ADMINISTRATIVE SUPPORTS**

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: COMMUNITY INVOLVEMENT

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH RECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

HSSES Domain: OTHER RESOURCES

ASSETS / STRENGTHS	DIFFICULTIES / PROBLEM AREA	CRFTH R ECOMMENDATIONS	RESPONSIBILITIES	PROGRESS NOTE
				___fully completed ___partially completed ___deferred ____# of participants ____Satisfied? (0=not at all; 5=extremely satisfied)

PART 6: ADMINISTRATION OF THE HSSESI

RECRUITING ORGANIZATIONS

There are multiple ways in which an organization can become involved in a HSSESI. Listed below are examples of the most common methods for connection between an organization and a HSSESI team.

PERSON-TO PERSON CONTACTS

Typically, the portal is through personal contact. Presentations and participation in professional conferences provide a good opportunity to share the concept of the HSSESI. Organizations need to have buy-in if the HSSESI is to be successfully accomplished. Other contacts may come through existing professional relationships. Additionally, contacts may come from organizations who have successfully participated in formal or informal HSSESI process.

MASS AND TARGET MARKETING

In our marketing efforts, we try to connect with the needs of those serving children and families who have experienced trauma. We do not directly advertise the HSSESI, but provide a message that leads individuals who perceive the need to address child traumatic stress issues to contact us. The most common initial contact is through a website that leads an individual within an organization to a member of the HSSESI team. Section 8 contains specific information about social methods and materials used for the HSSESI.

DIRECTED BY OUTSIDE AUTHORITY

Some HSSESI interventions were the result of an outside authority either recommending or requiring participation. These situations are most common when the organization is funded by grant or foundation funds and the funding agency believes it would benefit the

organization thereby improving the granting agency's investment. While this is not common, it is one method that can be used productively. For example, developing strong relationships with a state office of Primary Heath Care can be a vital linkage between struggling organizations and the HSSESI team. Similarly, working with a faith-based or youth organization area leader can link the HSSESI team to groups serving children and their families who have experienced traumatic stress. The key to success in this type of recruitment is the element of coerced participation. When an organization is either ordered or *strongly* encouraged to participate, the dynamic is not dissimilar to being court ordered participation in mental health care. It can be a positive experience for both the professional and the person ordered to participate but the reason for attendance must be managed as well as the issues that brought the person to the situation.

Portals of Entry

In many cases, the doorway into an organization is through a champion who understands and desires to participate in the HSSESI. Their enthusiasm can be infectious and can bring along an organization., This may be related to the organizational social status of the person within the organization. If the champion is respected for their vision and commitment to the organization, they may well be very successful. Alternately, a person with low status within an organization may not even be noticed if they bring forward the idea. If the champion is in the upper management structure it can work for or against a successful process. For example, if a director of a mental health clinic is concerned about employee work load interfering with continuing education, the director may look for solutions through opportunities identified through a HSSESI. However, forcing employees to participate can not only increase workload, already overworked employees may feel "put upon" or even angry.

When a champion tries hard but their efforts fizzle, it can be helpful for the HSSESI team to work with them to develop strategies to garner support for the project. This can be accomplished several ways. However, it is important to recognize that many people feel that their workload is already at or past capacity and adding one more thing is an unwelcomed idea. However the HSSESI is brought into the organization, recognition of the burden on the organization must be acknowledged. Typically, linking to a known trouble spot—a time sink—can assuage people's concerns and offer them the hope of positively dealing with the issue. Another door that can be useful is to highlight the potential for increased professional time and training. For example, it may be possible to increase a provider's skills through professional training making it easier for them to do their job. For those involved in management of an organization, paid or volunteer based, the promise of reduced cost or improved funding to meet costs can be a strong inducement.

While these recruitment suggestions can be powerful, it is critically important to recognize that the remedies for the ailing and underfunded social system, including healthcare, faith-based, and civic organizations are not easily found. The HSSESI is not a panacea. If it can provide one or two opportunities for improving the organization, it is usually worth the effort in fiscal as well as human capital investments.

Overall Estimates of HSSESI Process Timeframe

The HSSESI is not fast. Changing organizations is not fast. Understanding organizations is not fast. Change that is too slow loses momentum and literally becomes unhelpful. Change that is too fast can bring chaos to an organization due to the fact that people do not understand their jobs. However, change can move at a pace that it encourages further change. That pace is the pace to which a HSSESI team should aspire.

In this section, we describe generally the process and time taken to complete a HSSESI from recruitment to plan implementation that leads to positive changes in trauma informed care.

Recruitment was typically a several hour process either face to face or averaged over the time spent for advertisement such as radio, newspaper, or direct mail.

Screening typically takes about two hours of combined time for all participant and HSSESI time and may occur over several weeks.

The interview phase takes about 20-40 hours accounting for time spent scheduling and doing the interview. The initial contact through the completed interview typically takes place over about two weeks.

The report phase takes about 20-40 hours, accounting for time spent scheduling, analyzing data, writing the report, and delivering and discussing the report, as well as making adjustments to the report following initial delivery. This process typically takes place over several weeks.

The plan may take a few to many hours. This process includes time spent scheduling, analyzing jointly reviewed report, identifying resources that can be recommended, reviewing and making adjustments to the report, selecting items to be addressed. The plan phase typically takes place over a 2-4 week period.

The plan implementation takes variable time based on the complexity of the intervention and the amount of time and staffing resources the organization can commit to the changes. This stage lasts weeks to months.

In the informal route, the initial discussions are typically 1-6 hours and may occur over multiple interactions. The system changes typically take weeks to months and may involve additional consultations with the HSSESI staff over the change period.

SCHEDULING

As with any activity involving multiple parties, scheduling participating in the HSSESI activities can be difficult. In fact, scheduling in and of itself may define the point at which an organization decided actively or passively to stop participating in the HSSESI.

In order to reduce scheduling difficulties, the HSSESI team should have a single person scheduling for the HSSESI team. Nothing is more frustrating than receiving 15 copies of an email where everyone says, “that works for me” and the next person says, “no, I cannot do that.” The HSSESI team member should coordinate the times with as little visible scheduling confusion as possible. Ideally, the HSSESI scheduler can go to an organization with several times that the HSSESI team has already agreed upon.

In addition to having a well-identified single point of contract for scheduling, the scheduled time following the initiation of the discussion for the meeting should take place as soon after as possible. Setting a date several weeks in the future reduces the efficacy of the intervention because it creates the potential to lose momentum. Also, information may become stale and have to be re-gathered which is simply a waste of people’s time.

Setting a time frame for meetings should be specific. For example, the scheduling person should say, “in this meeting we will [conduct this activity] and it should take [this much] time. Will that work for you?” The scheduler needs to be sensitive to the workflow of the organization in setting up an appointment. For example, many mental health organizations are ruled by the 50-minute hour. It is thus not advisable to schedule a meeting for one and a

half hours. Better to schedule two 50-minute hours or compress the activities to be conducted so that they will fit into a 50-minute hour.

Screening

Screening is typically conducted by a point of contact within the organization who is interested in the HSSESI. Most people conduct the screening online with the participant's time limited to (a) registering and receiving a password and (b) completing the screening. The password process should be intuitive and take about 5 minutes. The screening should take 15 to 30 minutes, depending on the amount of time that the participant spends looking around the site and thinking about answers to the questions.

Once the screening data is provided to the HSSESI team, it takes about one to two hours to review and organize.

Interview

Preparing the Organization for the Interview

Sites should be instructed to review the HSSESI needs and resources form prior to the actual interview. This will allow a site to consider what information they wish to collect to bring to the interview. Sites should be instructed that they need not provide answers to all of the questions. One of the goals of the HSSESI is sometimes to find the information for a site, not have the organization provide the information during the interview.

Tools needed to conduct the interview

The full HSSESI interview is conducted as a paper and pencil process. Typically, the site and the interviewer have separate copies of the HSSESI forms to make it clear to everyone what is being discussed.

Distance vs face to face interviewing

One of the great challenges faced by rural sites is that of physical distance. Typically the interview is conducted by telephone as it is an operator-easy method. At times, a site visit is most appropriate. This is particularly true when larger numbers of people are going to be involved in the HSSESI process. It may also be particularly appropriate for sites with unique geographical of cultural perspectives. At times, videoconferencing is the best method of conduct. The method should be selected based on the ease of the site, not the HSSESI staff.

REPORTS

PURPOSE OF REPORTS

The purpose of the report is to gather the information about an organization into a digestible, coherent whole. Typically sites know individual pieces of information but rarely are able to "take the big view". The report also can be the basis of grant or program applications as much of it is the same as need-based grant questions.

CRFTH Staff

REVIEWING REPORTS WITH SITES

"Who is driving?"

The HSSESI is a "customer driven" process. It is at the behest and for the benefit of an organization. The time allotted and participation process should be the site's preference. This is part of the commitment made to the HSSESI. If sites cannot coordinate their efforts to participate, at an informal or formal level, it is probably not a good time to implement system change. The HSSESI administrator may provide the leverage to be in the process, however, by calling to set up appointments, have meetings, and review progress.

ALLOWING THE ORGANIZATION TIME TO REVIEW THE REPORT

Managing the Report Review Session(s)

Sites should be provided with the report prior to the scheduled meeting with the HSSESI administrator. As can be expected, some sites will review the report prior to the report review session and some will not. In the case of discussions with an organization who has not read the report, it is important to establish time boundaries If the site has time, and wishes to go through the report page by page, this is an option. Most often, it is important to move quickly to the "meat" of the report, the area where the most benefit cam come from. In some cases, this is done by affording to the site the opportunity to see what they have that is good and can be built on. It can also be a time to review areas of needed or desired change.

When sites have read the report prior to the meeting, they may come to the meeting with specific issues and sometimes with unhappiness with the report. When the latter arises, it is important to remind the organization that this is a joint process and that you can spend time working on the modifications together. Humility on the part of the HSSESI interviewer is important. It is unrealistic that an interviewer will be able to understand the nuances of an organization in a short time. Alternately, there will be times when an organization flatly refuses the report or information contained within. Since this is not a site evaluation, it is possible that the best alternative is to simply remove the offending information. Of course, it may be this very topic that is in most need of system change. As with any process, the door in is the door that will open. Entering the system through a less controversial issues can lead to success in managing a difficult concern.

REVISING THE REPORT

As noted above the report revisions must be deftly handled. At times it is easy to adjust based on missed information or to make report changes to reflect organizational changes

that have occurred after the interview. At other times, revising the report is a lengthy, painful process that is a high-risk point for dropout.

DEVELOPING PLANS

WRITING PLAN

Plans typically originate with the HSSESI interviewer, based on the discussions with the sites, and on the site's desired changes. The draft plan is presented to the site.

NEGOTIATING PLAN WITH SITE

The plan suggestions are typically inline with the capacities and desires of an organization. However, there are times when the plan is too small or too large in scope, the problem has already been resolved, or is no longer of interest to the site. Some plans are complex and address long-term and labor intensive changes. Sometimes plan s are merely a formalization of "low hanging fruit" that an organization has already or has readily recognized as appropriate for them. As with the HSSESI in general, the organization is in the driver seat The key role of the HSSESI interviewer is to formulate the desires into an organized, implementable plan which may be scaling back or ramping up an organization's expectations.

FOLLOWING UP ON PLAN

Following the plan is the organization's responsibility. However, there may be responsibilities in the plan that belongs to the HSSESI interviewer. For example, a HSSESI organization may have access to social and physical geographic information that is needed to write a grant, but they do not write the grant.

TRACKING CHANGE ACROSS TIME

As with any plan, it is important to periodically check to see that the plan is (a) coming along and (b) still appropriate. Planned, periodic reviews of progress with HSSESI staff can formalize the checking process. Additionally, if the plan is not going well, the HSSESI staff can work with the organization to identify the problems and the remedy. These issues may range from poor timing to insufficient resources to simply a plan that does not work for that organization. It continues to be appropriate to assess the ability of the organization to commit to making change due to desire or workload. Plans should not fail because they should not have been in place to begin with.

PART 7: CASE EXAMPLES

Health Services System Environmental Scan (HSSES)

Summary CASE EXAMPLE: INTERVENTIONS FOR TRAUMA

Reporting Participant: J.W. Martin

CRFTH Staff: Tom Parsons

Organization: Crossroads Community Care

Date: Sept. 27, 2005

Introduction

Dr. J.W. Martin has been the director of Crossroads Community Care for 20 years. Dr. Martin is also a psychiatrist. Crossroads is a non-profit clinic that is funded predominantly by the Health Department, State of Wyoming. This clinic provides services for children and families across a broad range of problems. The clinic retains approximately ten employees.

Community Characteristics

Crossroads is located in Riverbend, Wyoming, (city population = 35,000; county population = 57,293; census 2000). It is primarily an agricultural (ranching/farming) community that is predominantly Caucasian (82%). There is also a significant Native American population (15%) and a nearby reservation with a significantly higher Native American contingency. There is also a small (3%) proportion of the population that is Hispanic.

Reason for Consultation

Dr. Martin indicated that he would like his staff to learn more about evidence-based practices for the treatment of child trauma. However, given his small staff and budget, it is difficult to make allowances for extensive time away from the clinic for training. He would also like for his staff to have specific training regarding cultural competence with Native American populations.

Service Population

Dr. Martin reported that therapists at Crossroads frequently treat children with conduct disorders, parent-child problems, and reactions to domestic violence and abuse. He noted that their current service population consists primarily of Caucasian families and children, but approximately 10% of therapists' caseloads are Native American families who are either not affiliated with the local reservation and tribes, or who have chosen not to seek services through these venues.

Providers

Crossroads currently employs two doctoral-level psychologists, a masters-level psychologist, a child development specialist, two licensed professional counselors, a part-time practicum student, and two support staff members.

Training Needs

Dr. Martin reported that clinical staff would benefit from training in Trauma-Focused CBT. Furthermore, he indicated a desire for all therapists to receive training in PCIT, especially

Native American adaptations to these protocols. None of staff are currently trained in these techniques.

Technology Resources

Current technology resources at Crossroads include DSL services available at only two computers. Crossroads does not currently receive any Universal Services Funds. Dr. Martin reported dissatisfaction with their current technology access due to their lack of office computer networking.

Recommendations:

- Explore training opportunities for TF-CBT, AF-CBT, and PCIT through the CRFTH archive, including webcasts and/or virtual grand round topics via the internet.
- Explore NCTSN connections (e.g., Oklahoma site) and training opportunities specifically addressing Native American cultural competence in therapeutic work.
- Explore technological options for interfacing all computers in the office.
- Access information regarding available Universal Services Funds in order to increase Crossroads' technology budget.

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CRFTH Staff

CASE 1: FOCUSING ON PERSONNEL AND TECHNOLOGY

HSSESI Reporting Participant: Jayne Smit HSSESI Staff: Dr. Debra Larsen

Organization: Rural Rescue Date: Sept. 27, 2008

Introduction

Jayne Smith, the reporting participant, has been the executive director of Rural Inc. for eight years. Her education/background is in social work.

Rural, Inc. is a non-profit 501-C that provides wrap-around services for children and families at risk and/or who are adjudicated because of child abuse/neglect and maltreatment. These services include forensic interviewing, legal prosecution of charges, psychotherapy, residential care, and foster care placement. Rayford estimates that all these services incorporate approximately 85 employees and/or foster parents.

Community Characteristics

Rural Rescue, Inc. is centered in Adamae, North Carolina, (city population = 67,939; county population = 106,065; 2000 census). The organization also serves additional rural counties within an approximate 80-mile radius. Many of these counties have no other service options. Rural Rescue includes two residential treatment facilities located in nearby rural Ponca City.

Reason for Contact

Rayford requested consultation because of issues regarding recruitment and retention of personnel. Specifically, her greatest concern is turnover of counselors andtherapists, who have an average tenure of approximately one year. As a result, the therapy needs of children and appropriate continuum of care is negatively affected. In addition, Rayford indicated that she would like to receive assistance and information regarding potential grants for technology development and foster care programs. Rural Rescue lacks a database to track referral and service statistics for their organization, thus inhibiting the directors' ability to track information relevant to the success of pursuing further grant funding.

Service Population

Rayford reported that therapists at Rural Rescue frequently treat children with anxiety disorders and depressive disorders. However, their service population primarily seeks assistance for trauma reactions.

Providers

Rural Rescue currently employs five full-time counselors, a half-time psychologist, and a consulting psychiatrist. All providers have either Masters- or Doctoral-level training. There are approximately 85 employees, including a prosecuting attorney, support staff, residential paraprofessionals, and foster parents.

Rayford reported that a number of issues appear to be contributing to retention difficulties. Although they provide salaries comparable to most facilities in the area for entry-level counselors, many of these employees report ongoing financial strain due to significant

student loans. Additionally, Rayford reported that treatment caseloads are significantly higher than her supervising clinician would recommend for entry-level counselors, creating conditions ripe for early burnout. Rayford would like to create funding for at least one additional counselor in order to reduce caseload demands.

Technology Resources

Current technology resources at Rural Rescue include DSL services available at the main office. The directors have phone line internet access from their homes, which provides limited or slower access. Rural Rescue does not retain an electronic patient record but may be interested in such if it provided assistance with treatment statistics. Rural Rescue does not currently have access to videoconferencing, but Rayford reported that the local hospital does have teleconferencing equipment. Rural Rescue does not receive Universal Services Funds. Rayford reported significant interest in connecting the residential homes to the main office and developing technological/record-keeping support sufficient to develop treatment and referral statistics for future planning and grant applications.

Recommendations

A technological database of demographics and services provided would facilitate closer tracking for the pursuit of organizational planning and grants.

Access information regarding Universal Services Funds available in service areas to facilitate telecommunication expansions.

Explore technology options for connecting residential homes and Rural Rescue's main office.

Explore opportunities for accessing teleconferencing through existing hospital equipment.

Explore options for additional assistance in rural service areas through AmeriCorp, Vista and/or SeniorCorp workers.

Explore eligibility for federal student loan repayment programs (e.g., National Health Service Corps) to support professional retention.

Explore funding development options through contracts with local state and county programs to support additional personnel needs.

Explore grant funding options relevant to current services and populations served to facilitate additional personnel hiring needs.

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CRFTH Staff

PART 8: MARKETING THE HSSESI

Marketing the HSSESI improves the credibility of the HSSESI by building name recognition. It allows organizations to identify potential assistance and can provide encouragement.

DIRECT E-MAIL

From: kirkann@isu.edu
To: site@organizationl.com
Subject: FW: Potential ISU program

ISU has a program that I thought your Name school district would be interested in. It would be wonderful if you would be kind enough to pass this on to you superintendent.

Idaho State University has a special program to help organizations and schools deal better with child trauma. Schools are very concerned about children and trauma but struggle with finding mental health resources for students. Idaho State University in partnership with the National Child Traumatic Stress Network has created an intervention to assist schools with these problems. In this intervention, ISU Faculty and Staff work collaboratively with you to identify your current needs and relevant resources you may not have known how to access. This intervention is grant supported and available to you at no cost. Teachers or counselors as individuals and schools or districts can participate, based on interest and need.

For more information, go to childtrauma.isu.edu or email HSSESI Coordinator at HSSESI@isu.edu.

I'd appreciate it if you would share this information with your school folks. It was wonderful to see you at train the trainer last week. We should be in contact before you do training. Since you missed a bit, I'd like to come observe if at all possible.

I've also cc'd this to NAME HSSESI Coordinator i so she'll know how to reach you.

Sincerely,

Ann Kirkwood

NEWS PAPER ADS

Insert Logo

Organization Name Presents:

Improving Trauma Informed Care: The Health Services Systems Environmental Scan and Intervention

Join us for a free training seminar on the effects of Child Trauma and how to improve trauma-informed services. The seminar is designed for health professionals, mental health professionals, teachers, faith leaders, and EMS workers. During the seminar, we will discuss an innovative assessment or your organization and ways to access tools for optimal practice management, evidence-based clinical protocols, effective personnel recruiting, up-to-date reimbursement knowledge, and telehealth innovations.

Where: Name of Place
Address 1
Address 2
When: Day, Date
Time: start and finish time

The session is free, but seating is limited.

To register, please email name@domain.xxx or call 999-999-9999.

Certificates for Continuing Education Will Be Available

NCTSN The National Child Traumatic Stress Network

Funding credit.

RADIO ADS

Are you a mental health professional? Are you concerned about children and trauma? There's a national network that can help you. For more information, go to childtrauma.isu.edu. That's childtrauma.isu.edu. This message from Idaho State University in partnership with the National Child Traumatic Stress Network. Remember, it's childtrauma.isu.edu.

Do you work in a school? Are you concerned about children and trauma? There's a national network that can help you. For more information, go to childtrauma.isu.edu. That's childtrauma.isu.edu. This message from Idaho State University in partnership with the National Child Traumatic Stress Network. Remember, it's childtrauma.isu.edu.

Are you a medical professional? Are you concerned about children and trauma? There's a national network that can help you. For more information, go to childtrauma.isu.edu. That's childtrauma.isu.edu. This message from Idaho State University in partnership with the National Child Traumatic Stress Network. Remember, it's childtrauma.isu.edu.

Are you a faith leader in your community? Are you concerned about children and trauma? There's a national network that can help you. For more information, go to childtrauma.isu.edu. That's childtrauma.isu.edu. This message from Idaho State University in partnership with the National Child Traumatic Stress Network. Remember, it's childtrauma.isu.edu.