



Violence is Preventable:

**A Best Practices Guide
for Launching & Sustaining
a Hospital-based Program
to Break the Cycle of Violence**



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I. Introduction

Chapter I Roadmap:

- What do we mean by youth violence? 2
- For whom is this replication guide intended? 4
- What is the purpose of this replication guide? 5
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Chapter I Objectives

- User understands how we define youth violence and why
- User understands who the replication guide is intended for
- User understands the purpose of this replication guide
- User understands what is meant by the “public health approach” and how it informs the design and implementation of violence intervention programs.

In 1998, the U.S. Department of Justice’s Office for Victims of Crime, referring to an American Academy of Pediatrics’ report on youth violence, “recommended that hospital-based counseling and prevention programs be established in medical facilities that provide services to gang violence victims.”¹ This replication guide was developed to support development of these programs in medical facilities across the country.

1. New Directions From the Field: Victims’ Rights and Services for the 21st Century at the [Office for Victims of Crime](#) site.

What do we mean by youth violence?

As young victims of violence continue to flow through hospital emergency departments across the country, caught in a *cycle of violence*,² the need to provide quality screening, intervention, discharge planning and follow-up for this population remains substantial.

“Jason,” the inspiration for Project UJIMA, a core NNHVIP program, illustrates this cycle of violence. In 1988, when he was just 9 years old, Jason was treated in the Children’s Hospital Emergency Department in Milwaukee for an “accidental” injury. Two years later, the hospital treated him again for multiple

contusions and abrasions resulting from an assault. In 1992, at 13 years of age, he was treated for multiple stab wounds. Then, in early 1994, at age 15, the hospital treated him for a bullet wound in his leg. By the end of that year, he was dead, shot in the chest and killed at the age of 16. While medical staff expertly cared for his physical wounds each time, not once was the disease of violence treated, even as it occurred over and over. Tragically every community across the country

As young victims of violence continue to flow through hospital emergency departments across the country, caught in a cycle of violence, the need to provide quality screening, intervention, discharge planning and follow-up for this population remains substantial.

that has started a hospital-based violence intervention program knows many Jasons, victims of interpersonal violence.

The Centers for Disease Control and Prevention (CDC) defines interpersonal violence, the focus of this replication guide, as follows:

Interpersonal violence is defined as “the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (Dahlberg and Krug 2002). Research and programs addressing youth vio-

2. Though this term is used most commonly in reference to domestic violence including child abuse, it is also used to describe interpersonal violence in which retaliation is often a factor. Also young victims of violence are more likely than others to become perpetrators or repeated victims. (Menard, S., (2002) *Youth Violence Research Bulletin*, Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Dobrin, AL. *The risk of offending on homicide victimization: A public health concern*. Am J Health Behav 2003.)

lence typically include persons between the ages of 10 and 24, although patterns of youth violence can begin in early childhood.

This definition associates intent with committing the act no matter the outcome. In other words, intent to use force does not necessarily mean intent to cause damage. Indeed, there may be a considerable disparity between intended behavior and intended consequence. A perpetrator may commit a seemingly dangerous act that will likely result in adverse health effects, but the perpetrator may not perceive it as such. For example, a youth may get in a physical fight with another youth. The use of a fist against the head or the use of a weapon in the dispute certainly increases the risk of serious injury or death, though neither outcome may be intended.

Other aspects of violence are implied in this definition. For example, it includes all acts of violence, whether public or private, reactive (in response to previous events such as provocation), proactive (instrumental for or anticipating more self-serving outcomes), or criminal or non-criminal. Each of these aspects is important to understanding the causes of violence and in designing prevention programs.³

The CDC explains why it is important to carefully define youth violence when planning interventions strategies that address the drivers of violent behavior:⁴

A consistent definition is needed to:

- Monitor the incidence of youth violence,
- Examine trends over time,
- Determine the magnitude of youth violence, and compare youth violence across jurisdictions.

Such consistency also helps researchers uniformly measure risk and protective factors for victimization and perpetration. Ultimately, these measurements inform prevention and intervention efforts.

In 1996, the American Academy of Pediatrics (AAP) published a report pointing out that, while “it has been routine to treat victims of child abuse, suicide attempts, and

3. Visit the [CDC site](#) for the CDC definition of interpersonal violence.

4. Visit the [CDC site](#) for the CDC definition of interpersonal violence.



Theodore Corbin, M.D. (Healing Hurt People, Philadelphia), Reginald Zachery and Jose Ibarra-Virgen (Office of the Mayor, Gang Reduction and Youth Development, Los Angeles)

sexual assault via multidisciplinary care protocols, . . . no care guidelines exist that address the unique needs of” violently injured adolescents.⁵ Two years later, the U.S. Department of Justice’s Office for Victims of Crime took the next step by recommending that hospital-based counseling and prevention programs be established in communities grappling with gang violence. Since the mid-1990s, these care guidelines have been established in fewer than a 25 medical facilities across the country and they are held in place by passionate advocates who struggle daily to sustain financial support for the

intervention services that give substance to the screening and referral protocols in place.⁶ These care guidelines are still not in place in most hospitals that treat a significant number of violently injured children, youth, and young adults.

For whom is this replication guide intended?

To help address this need, the National Network of Hospital-based Violence Intervention Programs (see Appendix 2), established in 2009, produced this replication guide. The National Network is a partnership of programs across the country. These programs provide intervention services to individuals being treated for violent injuries. They serve violently injured victims who are mostly between ages 15 to 25, though some work with victims as young as 7 and others with victims into middle age.⁷ The philosophy of these programs is that violence is preventable and that trauma centers and emergency rooms offer a unique opportunity at the hospital bedside — the *teachable moment* — to most effectively engage a victim of violence and stop the cycle of violence.

5. American Academy of Pediatrics, “Adolescent Assault Victim Needs: A Review of Issues and a Model Protocol,” *Pediatrics*, Vol.98, No.5, 1996:991-1001.

6. This refers to the programs that make up the National Network of Hospital-Based Intervention Programs. Visit the [Network’s](#) website for details about member programs.

7. NOTE: This replication guide focuses on youth violence prevention and intervention, though most of the information here is applicable to programs serving older victims.

The Network's purpose is to strengthen existing programs and help develop similar programs in communities across the country. It works to achieve sustainability of hospital-based violence intervention programs, develop and disseminate evidence-based resources, and inform public policies related to violent youth victimization.

This replication guide is addressed to two main audiences:

- National Network member programs so that they can draw on the information here to strengthen their programs as they continue to develop.
- Representatives of agencies in both the public and private sectors who are responding to a serious community need and are seeking help in establishing hospital-based or hospital-linked services for victims of intentional violence. These individuals may represent a county hospital or a community-based agency or a city health department or an established partnership involving perhaps a hospital, community-based agency, and other key stakeholders.

While there are several excellent guides already available to help strengthen existing programs or to assist new programs get off the ground,⁸ this guide is for a broader audience and integrates more recent research and case studies to reflect the development of youth violence intervention programs in recent years.

Purpose of this replication guide

The purpose of this replication guide is two fold:

1. To provide the user with information about *best practices* in this field of hospital-based or –linked violence prevention. This replication guide will aid the reader in understanding the *best practices* — evidence-based practice, promising practices, emerging practice, value-based practice, and practice-based evidence — that currently exist.⁹ Unfortunately there is little published research demonstrating, through randomized study, the effectiveness of the programs currently providing hospital-based intervention services for violently injured youth. However, there is substantial information, both published and not, about practices in this area that consistently

8. Most National Network programs have program manuals. Visit the [National Network's](#) website for a copy of several training manuals including *Reinjury Prevention for Youth Presenting with Violence-Related Injuries: A Training Curriculum for Trauma Centers*.

9. Visit the [Oakland County \(Michigan\) Community Mental Health Agency](#) for an excellent definition of *best practices*.

produce positive outcomes. We will use both this research and these promising practices throughout this replication guide to illustrate specific points.

2. To provide a framework for and information needed in conceptualizing, initiating, administrating and evaluating a violence intervention program. Each chapter is intended to convey a key component and is ordered to basically follow the process of developing, implementing, and sustaining the

For readers who are unfamiliar with this perspective and/or may be reluctant, for a variety of reasons, to treat young people who are injured by guns, knives, fists, or other weapons, gaining an understanding of this approach may allay fears and introduce a ray of hope.

best program possible. The steps in this process may vary depending on the unique characteristics of a particular circumstance. For example, if the impetus to establish a program comes from the medical staff or administration of a hospital, then the program design may be somewhat different from one initiated by a community-based agency.

Replication Guide Overview

- I Introduction
- II Selecting the Population to be Served (Focus Population)
- III Establishing Program Goals and Objectives
- IV Securing Hospital Buy-in
- V Partnerships
- VI Identifying Patients, Assessing Risk, and Managing the Crisis
- VII Intervention Services after the Initial Crisis
- VIII Making Informed Direct Service Staff Hiring Decisions
- IX Supporting Direct Service Staff through Training and Supervision
- X Conducting Effective Program Evaluations
- XI Obtaining and Sustaining Program Funding
- XII Engaging in Advocacy or Systems Change
- Appendix 1: Master List of Resources
- Appendix 2: The National Network of Hospital-based Violence Intervention Programs

Each section will begin with an overview and will provide more detail that is illustrated with “case studies” and will include footnotes referring to published supporting material. The “case studies” from National Network programs will be employed to illustrate what has worked and, if an approach hasn’t worked, how challenges were met.

Theoretical underpinning – public health approach

This replication guide and the programs discussed are all based on the public health approach to violence. For readers who are unfamiliar with this perspective and/or may be reluctant, for a variety of reasons, to treat young people who are injured by guns, knives, fists, or other weapons, gaining an understanding of this approach may allay fears and introduce a ray of hope. The Violence Prevention Alliance, a network of World Health Organization Member States, international agencies and civil society organizations working to prevent violence, defines the approach this way:

This public health approach to violence prevention seeks to improve the health and safety of all individuals by addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence.¹⁰

The Alliance explains that the public health approach to violence consists of four steps:

1. To define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
2. To establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.
3. To find out what works to prevent violence by designing, implementing and evaluating interventions.
4. To implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and



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10. Visit the [Violence Prevention Alliance](#) website for more information.

the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.

The information about the magnitude, scope, characteristics and consequences of youth violence across the United States and in many large cities is already well developed. In the next section, we highlight this information and point to additional sources. Similarly, there is substantial research about the causes and correlates of youth violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions. Again, we summarize and provide links to this research in several of the following sections.

Throughout this replication guide, we illustrate points made with case studies from programs participating in the National Network of Hospital-based Violence Intervention Programs, case studies related to the design, implementation, and evaluation of these programs, to show how some promising programs function.

Chapter I resources

An excellent description of the public health approach to violence prevention can be found on the [Centers for Disease Control and Prevention](#) website.

II. Selecting the Population to be Served (Focus Population)¹¹

Chapter II Roadmap:

- Why define the population to be served? 9
- Step 1 – gathering data to determine need 10
- Step 2 – Choosing/Defining the focus population 11
- Chapter II Resources 12

Chapter II Objectives:

- User will understand why it is important to define the focus population
- User will understand how to gather data to determine focus population
- User will understand how to define the focus population

Why define the population to be served?

Selecting a client population to serve helps determine:

1. The kinds of services a program will offer, in a hospital and after discharge,

11. We use “focus population” rather than “target population” because “target” suggests a level of violence not suggested by the word “focus.”

2. If a community-based program is the lead agency, which hospital to link with to ensure that as many clients as possible are reached, and
3. Types of community resources that are needed to serve the clients best.

The majority of existing programs providing intervention services for violently injured patients focus on adolescents and young adults. Some programs serve violently injured patients regardless of age. Many programs also extend services to the violently injured patient's family members and friends.

Step 1 – Gathering data to determine need

Step one in this process is to gather information essential in identifying the level of need. Determining which data are gathered and how they are assessed will be

somewhat different depending on whether the lead agency is a hospital or a community-based agency or a government agency.

Examining local data such as hospital admission data and/or youth violent homicide data can help determine the characteristics of the potential focus population. For community-based agencies that have not established a link to a hospital, these data can also point out which geographical area shows the highest level of need, thereby helping to determine which hospital to reach out to. Common data sources used include the local or state Department of Health, emergency department e-codes, hospital trauma registries, and the local police or probation department. These data may include the number of individuals treated for a violent injury each year at a particular hospital (ideally for the past few years in order to reveal trends), with a breakdown as follows:

- Injury type,
- Age,
- Gender,



Tammy Cloud (Caught in the Crossfire, Oakland), Julie M. Brown (consultant), Sheila Regan (CeaseFire, Chicago)

- Ethnicity,
- Place of residence,
- Place of injury,
- Time and day of admission, and
- Length of hospital stay

One resource that includes a good description of how to assemble these data is the American Medical Association's *Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals*.¹² Though it was published in 2002, it can be very helpful to those trying to figure out where to look for data and how to organize it into an effective presentation. An excellent source of data that requires relatively sophisticated skills, such as knowing which data are needed and how to navigate a complex internet site, is the federally supported socio-economic mapping site called [SMART](#).

Interviewing local leaders can also help determine which part of the city or county is most aware of the need indicated by the data. For community-based agencies in the initial planning stages, this can help to identify which hospital or hospitals to approach to secure hospital buy-in (described in next section). These interviews can also increase understanding of what is already being done in the community and by the community.

Since clients are nested in families and communities, deciding whether to extend services to family members and friends of the primary client and determining the extent to which support will be extended to them is important.

Step 2 – Choosing/Defining the focus population

Step two is to determine screening criteria. In some situations, funding streams define who can and cannot be served. Also the demand often exceeds the available resources.

There are many ways for new programs to limit scope so as not to have too many clients to serve initially. Some programs focus only on patients being treated in an emergency department or admitted to a trauma unit. Some narrow the age range of participants, the geographic area they will serve, or the hours they will recruit from the ED or trauma floor. Many programs exclude potential clients based on offender

12. Lyndee Knox, PhD, (2004) *Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals*. Available for downloading at <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/violence-prevention/youth-violence-prevention-training-outreach-guide.shtml>

status, self-injury, psychiatric diagnosis, or brain injury. Many programs also exclude cases resulting from suicide attempts, sexual assault, and child abuse because there are already mandated protocols for screening and serving those populations.

Since clients are nested in families and communities, deciding whether to extend services to family members and friends of the primary client and determining the extent to which support will be extended to them is important. Programs need to be prepared for the impact of other violence issues within the family, such as domestic violence and child abuse. Social service agencies and community-based organizations that deal specifically with these issues should be part of the resource network to which staff can refer.

The focus population may be modified after program implementation based on changes in the community or in the program capacity to meet the needs of the population.

Chapter II Resources

Resource A: Selected Youth Violence Related Data Sources¹³		
Surveillance System	Data Source	Characteristics
Medical Examiner & Coroner Data	Autopsy & Coroner Reports	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Available for every violent death. • Provides information regarding injury circumstances.
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • Wide variability in report detail and quality. • Presented as narratives & often not computerized
Vital Statistics Mortality Data	Death Certificates	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Uniform death certificate format • Information on every death in a particular location is recorded.
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • Information cannot be linked to specific individuals. • Two to three year delay in reporting.
National Violent Death Reporting System	State-based monitoring system	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Links variety of record types related to each violent incident • Aims to provide timely surveillance combined with circumstantial detail of incident.
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • Violence-related morbidity not captured by system

13. Table provided by co-authors Rebecca Cunningham, M.D. and Lyndee Knox, PhD.

Resource A: Selected Youth Violence Related Data Sources		
Surveillance System	Data Source	Characteristics
Trauma Registries	Hospital Records	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Detailed information on individual cases • Organized in searchable databases
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • Data collected only at referral trauma centers • Data may not be representative of surrounding community • Referral population may be dictated by site's specialty areas • Mechanism of injury often not recorded (e-codes)
National Hospital Discharge Survey (NHDS)	National Sample of Inpatient Records	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Allows comparison of local, regional and national data
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • E-codes (cause of injury) excluded from annual summaries. • N-codes (diagnostic code) alone limit usefulness for determining violence statistics.
National Hospital Ambulatory Care Survey (NHAMCS)	National sample of hospital emergency & outpatient departments	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Includes complete information on injury cause (E-codes)
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • Subject to sampling variability due to voluntary hospital participation
Police & School Incident Reports	Police & School incident/arrest reports	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Very detailed case records
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • No standardized record, very labor intensive to review • Confidentiality laws often limit use of records for research
Youth Risk Behavior Surveillance System	National survey	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • National sample (12,000 students) • Comprehensive analysis of risk & behavior analysis among young people
		<p><i>Limitations</i></p> <ul style="list-style-type: none"> • Relies on self-reports that cannot be verified

Resource B: Sample Data Collection Worksheet¹⁴		
Question	Data	Data source, how collected, etc
In what part of our community are young people experiencing the highest rates of aggravated assaults and homicides?	# aggravated assaults per 100,000 residents in previous year _____	# homicides per 100,000 residents in previous year _____
	# homicides per 100,000 residents in previous year _____	Local police department
		State department of justice
		SMART
Which medical facility(ies) is (are) treating the greatest number of young victims of violence?	Name of facility _____	ADT (admissions/discharge/transfer) data of _____ medical facility
	# of admissions for violent injuries in previous year (& over several years?): <ul style="list-style-type: none"> • Total admissions: _____ • Injury type <ul style="list-style-type: none"> • Gunshot • Stab wound • Physical assault • Age <ul style="list-style-type: none"> • <12 yrs _____ • 12-14 yrs _____ • 15-17 yrs _____ • 18 – 20 yrs _____ • 21-25 yrs _____ • 26-30 yrs _____ • 30 + yrs _____ • Gender <ul style="list-style-type: none"> • Male _____ • Female _____ • Unknown _____ • Race/Ethnicity • Location of residence • Seriousness of injury and response to treatment, e.g. treated and discharged or admitted to Trauma Unit • Time & day of admission • Length of hospital stay 	

14. Table provided by co-authors Rebecca Cunningham, M.D. and Lyndee Knox, PhD.

Things to consider as you incorporate current statistics into your presentation:¹⁵

- Understand the meaning behind the statistics
- Use them appropriately
- Know the source of the numbers, how they were collected, and how recent and reliable they are.

Resource C: SMART for mapping

The Socioeconomic Mapping and Resource Topography (SMART) System is a GIS-based issues management system, developed to support the early identification of emerging local issues and provide resources to assist decision makers with implementing both rapid response and long-term plans. This system allows users to locate

resources and incidents of crime and delinquency and other social indicators, visualize the data, and perform complex location-based analysis that should lead to better decision-making. Visit the [SMART](#) website for more details.



John Torres (Caught in the Crossfire, Oakland), Linda Rich (Healing Hurt People, Philadelphia), David Osman (UMC Trauma Services VIP, Las Vegas)

15. Lyndee Knox, PhD, (2004) *Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals*. Available for downloading through the [American Medical Association's](#) website.

III. Establishing Program Goals and Objectives

Chapter III Roadmap:

- Program goals 17
- Program objectives 18
- Chapter III resources 21

Chapter III Objectives

User understands the value of setting program goals and how to articulate them.

- User understands the value of setting program objectives and how to articulate them.
- Establishing program goals and objectives helps the program’s administration and direct service staff stay on course and measure progress. Well-crafted goals and objectives also form the basis of a strong program evaluation process.

Program goals

Program goals articulate parts or aspects of the program’s vision and mission. They cannot be easily measured yet they are intended to convey the program’s direction in more detail than its mission does. For hospital-based violence intervention programs, goals may include preventing retaliatory violence and re-injury in a community, or breaking the cycle of violence among youth at “high risk” for violence.

When articulating program goals, it is useful to keep in mind that some goals may be impossible to reach, given significant limits in local resources. For example,



Carnell Cooper, M.D. (Violence Intervention Program, Baltimore)

placing violently injured youth in jobs may be an unrealistic goal if the skill levels and employment histories of these young people preclude employment, especially in a community with few available low-skill jobs. It may be more realistic to phrase the goal as preparing the focus population for eventual employment. On the other hand, it may make sense to include finding employment as a goal to remind the program administration and staff to do everything possible for the focus population.

Choosing certain goals can also clarify a program's orientation. For example, articulating goals related to fostering strong individuals and healthy communities and not just preventing re-injury can identify a program as a health promotion model and not only a risk reduction model.

Program objectives

Objectives articulate parts of each goal in a way that *can* be measured. For example, one objective might be to reduce the number of youth admitted to the Emergency Department who had been treated for injury within the previous two years by 10% compared to the numbers in the previous year. Many programs use the "SMART" framework to help shape useful objectives:

- **Specific** – *What exactly are we going to do, with or for whom?*

The program states a specific outcome, or a precise objective to be accomplished. The outcome is stated in numbers, percentages, frequency, reach, scientific outcome, etc. The objective is clearly defined.

- **Measurable** – *Is it measurable & can WE measure it?*

This means that the objective can be measured and the measurement source is identified. If the objective cannot be measured, the question of funding non-measurable activities is discussed and considered relative to the size of the investment. All activities should be measurable at some level.

• **Achievable** – *Can we get it done in the proposed timeframe/in this political climate for this amount of money?*

The objective or expectation of what will be accomplished must be realistic given the market conditions, time period, resources allocated, etc.

• **Relevant** – *Will this objective lead to the desired results?*

This means that the outcome or results of the program directly support the outcomes of the agency's or funder's long-range plan or goal, e.g., youth violence prevention or improving health outcomes.

• **Time-framed** – *When will we accomplish this objective?*

This means stating clearly when the objective will be achieved.

Program objectives can address processes, impacts, and outcomes:

Process objectives use participants and their activities to articulate what the program is going to do, how, and by when, e.g. *By Dec. 31, 2012, outreach workers will provide services for at least 100 violently injured patients.*

Impact objectives (also often called short-term outcome objectives) articulate how the program will change attitudes, knowledge, or behavior in the short term and by how much, e.g. *Within 12 months of admission to the program, 75% of violently injured patients served will have completed all terms of their safety plan.*

Outcome objectives articulate long-term program expectations and are challenging to measure well because unanticipated factors may affect outcomes over the long-term. However, with this caveat in mind, articulating these objectives provides essential markers to help guide and



Sandra Bloom (Healing Hurt People, Philadelphia) and Thea James, M.D. (Massachusetts Violence Intervention Advocacy Program)

sustain the program, e.g. *By Dec. 31, 2012, the re-admission rates for violent injuries will be reduced by 50%.*

Using a logic model helps to map objectives in a way that relates clearly to program resources and activities. For more information about developing logic models, see the manual available through the [Kellogg Foundation's evaluation site](#).

Program goals and objectives should be linked to a program's service goals or benchmarks for individual participants. These are the indicators that are used as part of providing services to the focus population. They might include completing intake assessments, or completing a plan to help the injured youth be safe or enrolling a healing patient in school or helping them secure victim compensation funds. Service objectives are usually used to help measure a participant's progress through available services.

Collecting, analyzing, and sharing these measures of program process is a valuable tool for guiding and supporting line staff and for helping administrators negotiate adjustments in program design. Discovering, for example, that a much lower percentage of violently injured youth are enrolling in school or job training than in previous years may help the program identify (a) a need for additional staff training or (b) a change in the characteristics of the focus population or (c) a sharp reduction in school and job training resources available in the community. Engaging direct service staff in regularly reviewing these data is often a valuable way of pinpointing the cause of changes in measures because they are often most familiar with the factors causing the changes.

Chapter III resources

RESOURCE A: EXAMPLE OF PROJECT GOALS FROM PROJECT UJIMA, MILWAUKEE, WISCONSIN

Project Ujima Goals:

- Reduce the number of youth who are repeat victims of violence.
- Promote positive development and quality of life for youth and families affected by violence.
- Reduce the number of youth with injuries caused through interpersonal violence (firearms, stabbings and assaults).

RESOURCE B: SAMPLE LOGIC MODEL FOR VIOLENCE INTERVENTION PROGRAM

Assumptions: Providing violently injured patients with post-injury intervention and ongoing comprehensive services to address needs/strengths and risks for violence can reduce re-injury rates and retaliation.

Goal(s): Improve the health and well-being of violently injured patients and their family members and friends

Inputs →	Outputs →		Results		
	Activities	Participants	Short Term	Medium Term	Long Term
What we invest	What we do	Who we reach	Result(s) in the short-term	Result(s) over more time	Ultimate impact(s)
Partnerships Staff Money Time Volunteers Equipment Materials Etc.	Assess at bedside Provide crisis intervention Provide case management	Violently injured patients Family members and their friends	Crisis diffused Patients & family members linked to services, e.g. medical, psychological, housing, educational	Clients* make progress in addressing the individual risk factors for violence Family members make progress addressing risk factors	Lower re-injury rates Lower arrest rates Improved sense of well-being

* We refer to violently injured patients after they choose to take part in the intervention services as “clients”.

RESOURCE C: LOGIC MODEL TEMPLATE FOR MEDICAL CLINIC IMPLEMENTATION FROM W.K. KELLOGG FOUNDATION: LOGIC MODEL DEVELOPMENT
PROGRAM IMPLEMENTATION TEMPLATE – EXERCISE 1 & 2

RESOURCES	ACTIVITIES	OUTPUTS	SHORT- AND LONG- TERM OUTCOMES	IMPACT
<p>In order to accomplish our set of activities we will need the following:</p> <ul style="list-style-type: none"> • IRS 501(c)(3) status • Diverse, dedicated board of directors representing potential partners • Endorsement from Memorial Hospital, Mytown Medical Society, and United Way • Donated clinic facility • Job descriptions for board and staff • First year’s funding (\$150,000) • Clinic equipment • Board & staff orientation process • Clinic budget 	<p>In order to address our problem or asset we will conduct the following activities:</p> <ul style="list-style-type: none"> • Launch/complete search for executive director • Board & staff conduct Anywhere Free Clinic site visit • Board & staff conduct planning retreat • Design and implement funding strategy • Design and implement volunteer recruitment and training • Secure facility for clinic • Create an evaluation plan • Design and implement PR campaign • Launch/complete search for executive director 	<p>We expect that once completed or under way these activities will produce the following evidence of service delivery:</p> <ul style="list-style-type: none"> • # of patients referred from ER to the clinic/year • # of qualified patients enrolled in the clinic/year • # of patient visits/year • # of medical volunteers serving/year • # of patient flyers distributed • # of calls/month seeking info about clinic 	<p>We expect that if completed or ongoing these activities will lead to the following changes in 1–3 then 4–6 years:</p> <ul style="list-style-type: none"> • Memorandum of Agreement for free clinic space • Change in patient attitude about need for medical home • Change in # of scheduled annual physicals/ follow-ups • Increased # of ER/ physician referrals • Decreased volume of unreimbursed emergencies treated in Memorial ER 	<p>We expect that if completed these activities will lead to the following changes in 7–10 years:</p> <ul style="list-style-type: none"> • Patient co-payments supply 20% of clinic operating costs • 25% reduction in # of uninsured ER visits/year • 300 medical volunteers serving regularly each year • Clinic is a United Way Agency • Clinic endowment established • 90% patient satisfaction for 5 years. • 900 patients served/year

Developed from these sources:
 Visit the [Kellogg Foundation](#) for more details about their Evaluation Toolkit which can be found in their “knowledge center” under “resources.”
 Visit the [Kellogg Foundation](#) for information about logic model development guide.

IV. Securing Hospital Buy-in

Chapter IV Roadmap:

- Why get hospital buy-in? 23
- Data that can be used to make a compelling argument 24
- Assessing hospital readiness & capacity 26
- Determining who to talk with & finding a “champion” 26
- A Talking Points Framework 27
- Sustaining hospital support 29
- Chapter IV resources 40

Chapter IV Objectives

- User understands how to secure hospital buy-in for the intervention services.
- User has the resources and talking points needed to go to hospital leadership
- User understands how to sustain hospital support for the services.

Why get hospital buy-in?

Securing hospital buy-in ensures that the provider of violence intervention services, whether it is the hospital or a community-based agency, can reach patients during those “teachable moments,” those rare opportunities when a person is most open to addressing the risk factors associated with violence. Several studies have demonstrated the effectiveness of interventions at these moments among both youth and adults with alcohol-related injuries.¹⁶ There is evidence that vio-

16. Monti PM, Colby SM, Barnett NP, et al. Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department. *J Consult Clin Psychol.* Dec 1999;67(6):989-994. Becker B, Woolard RE, Nirenberg TD, et al. Alcohol use among sub-critically injured emergency department patients. *Acad Emerg Med.* 1995; 2:784-790. Dikmen SS, Machamer JE, Donovan DM, et al. Alcohol use before and after traumatic head injury. *Ann Emerg Med.* 1995;26:167-176. Longabough R, Minugh PA, Nirenberg TD, et al. Injury as a motivator to reduce drinking. *Acad Emerg Med.* 1995;2:817-825.

lently injured youth are similarly open to significant change while in the emergency department.¹⁷

Hospital buy-in is essential to ensure access to patients, particularly at that crucial “teachable moment,” and to secure in-kind support such as data, medical and administrative staff attention, and support for program fund raising.

Hospital buy-in is essential to ensure access to patients, particularly at that crucial “teachable moment,” and to secure in-kind support such as data, medical and administrative staff attention, and support for program fund raising. Hospitals may also make intervention services a line item in the hospital budget, thereby strengthening program sustainability. For programs that are operated by a community-based agency (“hospital-linked” rather than “hospital-based”), hos-

pital buy-in is even more important to assure patient access and to effectively address challenges related to privacy of patient health information.

Data that can be used to make a compelling argument

Securing hospital buy-in requires that those advocating the intervention services have at their fingertips information that can be used to make a compelling argument. The kind of information that has proved useful to others in the past includes the following:

- **National data and reports on youth violence:** The data on youth violence nationally are readily available¹⁸ in several easily accessible reports.
- **State and local data:** State and local data may be more difficult to secure, but are perhaps more important in making a compelling argument to hospital administrators than are national data. Local sources include hospital trauma data, homicide data from a local health department, and police data on violent crime.

17. Walton MA, Chermack ST, Shope JT, Bingham CR, Zimmerman MA, Blow FC, Cunningham RM. Effects of a Brief Intervention for Reducing Violence and Alcohol Misuse Among Adolescents: A Randomized Trial. 2010 Aug *JAMA* 304(5):527-535. Widom CS. The cycle of violence. *Science*. 1989; 244(4901):160-166. Spivak HR, Prothrow-Stith D. Addressing violence in the emergency department. *Clin Pediatr Emerg Med*. 2003;4(2):135-140.

18. Visit the [Surgeon General’s website](#) to view the Report on Youth Violence (2001). The [American Academy of Pediatrics](#) website also lists useful data sources.

- **Cost of care:** Estimates of cost of care without effective intervention are available in several published materials.¹⁹ In the 1990s, the average cost of acute care treatment ranged from \$14,850 to \$32,000 per hospital admission and the average medical cost of a non-fatal gunshot injury was \$17,000. Accounting for inflation, \$17,000 balloons to almost \$25,000 in 2010.²⁰ A study of a violence intervention program in Baltimore, published in 2006, found that the program saved \$598,000 in hospital recidivism costs; only 5% of the treatment group recidivated, compared with 36% of the control group. The average cost of hospital care for violent injury was \$46,000.²¹ A study comparing the medical treatment costs of interpersonal violence with the costs of providing violence intervention services through San Francisco's Wraparound Project in 2007 found that providing intervention services is cost neutral if just one re-injury is prevented and saves money if it prevents two or more re-injuries.²² In addition, intervention programs assist with medical care costs by helping clients secure Victims of Crime compensation and supporting follow-up care.

While the numbers are powerful, the human stories bring them to life. An excellent example is the story of "Jason," the inspiration for Project UJIMA, a core NNHVIP program. In 1988, when he was just 9 years old, Jason was treated in the Children's Hospital Emergency Department in Milwaukee for an "accidental" injury. Two years later, the hospital treated him again for multiple contusions and abrasions resulting from an assault. In 1992, at 13 years of age, he was treated for multiple stab wounds. Then, in early 1994, at age 15, the hospital treated him for a bullet wound in his leg. By the end of that year, he was dead, shot in the chest and killed at the age of 16. While medical

19. Cook PJ, Lawrence BA, Ludwig J, Miller TR. The medical costs of gunshot injuries in the United States. *JAMA*. 1999;282:447-454. Kizer, K.W., M.J. Vassar, R.L. Harry, and K.D. Layton, "Hospitalization Charges, Costs, and Income for Firearm Related Injuries at a University Trauma Center," *JAMA*, 1995; 273:1768-1773. Bonderman, J. Working With Victims of Gun Violence, Office for Victims of Crime, July 2001, NCJ 186155. Visit the [U.S. Office of Justice Programs website](#) for a copy of Dr. Bonderman's article.

20. U.S. Bureau of Labor Statistics. <http://data.bls.gov/cgi-bin/cpicalc.pl>

21. Cooper, Carnell MD; Eslinger, Dawn M. MS; Stolley, Paul D. MD. "Hospital-Based Violence Intervention Programs Work." *The Journal of Trauma: Injury, Infection, and Critical Care*: September 2006 - Volume 61 - Issue 3 - pp 534-540. Visit the [Center for Nonviolence and Social Justice](#) resource page for a pdf of this paper. Accessed 5/18/11.

22. Visit the [San Francisco Wraparound Project's website](#) to view *An Ounce of Prevention: Comparing the Cost of Treating Victims of Interpersonal Violence to the Cost of a Violence Prevention Program at an Urban Trauma Center*.



Rochelle Dicker, M.D. (UCSF/San Francisco Wraparound Project)

staff expertly cared for his physical wounds each time, not once was the disease of violence treated, even as it occurred over and over. Tragically every community across the country that has started a hospital-based violence intervention program knows many Jasons, victims of interpersonal violence.

Assessing hospital readiness and capacity

For community-based agencies, it is also important to gather the information needed to assess hospital readiness and capacity to effectively support a hospital-based violence intervention program. This may involve interviews with hospital and non-hospital staff who are familiar with how a hospital operates and its vision and mission.

One National Network program, Project Ujima in Milwaukee, has had success with making participation in the program a competitive process for hospitals within their network. This helped to stimulate interest and identify those hospitals most ready and able to implement a program.

Determining who to talk with & finding a “champion”

Once one has assembled this basic information, the next step is to determine who to talk with at the medical facility and how to talk with them. Everyone from the CEO to the ER staff to trauma doctors and nurses to the medical social workers and the Injury Prevention Coordinators²³ need to understand the program, how it works, what their various roles are in facilitating its success, and why it makes a valuable contribution to their own work. In addition, one or more members of the hospital board of directors may become program “champions.”

Finding a “champion” in the hospital, someone who can serve as the leading voice in the institution for the intervention, is crucial. The “champions” of most National Network programs continue to be emergency department or trauma center

23. All Level I trauma centers in the U.S. are required to have an Injury Prevention Coordinator position to assure optimal care through hospitalization and discharge, including development of intervention strategies, and to monitor and evaluate outcomes. Some Level II trauma centers also maintain an Injury Prevention Coordinator.

doctors because they regularly experience the *cycle of violence*, treating the same patients again and again for violent injuries. And they know how the hospital bureaucracy works.

A Talking Points Framework for talking to hospital leadership:

- **Reducing recidivism:** The program can help reduce trauma recidivism due to violent injury among non-insured patients thereby reducing medical costs. A study of the Violence Intervention Program in Baltimore, Maryland found an 83% decrease in repeat hospitalization rates due to violent re-injury.²⁴

Another positive outcome is reduced subsequent violent criminal behavior. A study of the Caught in the Crossfire program in Oakland, California found that intervention with violently injured youth reduced risk of criminal justice involvement, is more effective with younger patients, and is cost-effective. They concluded that intervention programs can save \$750,000 to \$1.5 million annually in juvenile detention center costs.²⁵

Everyone from the CEO to the ER staff to trauma doctors and nurses to the medical social workers and the Injury Prevention Coordinators need to understand the program, how it works, what their various roles are in facilitating its success, and why it makes a valuable contribution to their own work.

- **Increasing medical care payments and adherence to post-discharge follow-up:** Intervention programs work closely with patients to support medical care cost reimbursement and to ensure that they continue with post-discharge care. In addition, intervention programs provide hospitals with information about patient outcomes, information that is usually difficult, if not impossible, to determine as fully.

24. Carnell Cooper, MD, Dawn M. Eslinger, MS, and Paul D. Stolley, MD, *Hospital-Based Violence Intervention Programs Work*, The Journal of Trauma, Injury, Infection, and Critical Care, 2006; Vol. 61, No. 3: 534-540. Visit the [Center for Nonviolence and Social Justice](#) resource page for a copy of this paper. Accessed 5/18/11.

25. Daniel Shibrú, MD, MPH, Elaine Zahnd, PhD, Marla Becker, MPH, Nic Bekaert, MSW, Deane Calhoun, MA, Gregory P Victorino, MD, *Benefits of a Hospital-Based Peer Intervention Program for Violently Injured Youth*, Journal of the American College of Surgeons 2007;205: 684-689.

• **Building the reputation of the hospital within the community:** As an asset in building the reputation of the hospital within the community, the program can serve as part of the community benefit requirement of nonprofit hospitals or, in the case of a for-profit hospital with a mission to serve the community, create a sense of seamlessness between the hospital and the communities it serves.

Complementing existing services As a complement to existing services, a program can harness new resources and services. As with any work environment, employees can be territorial; it is crucial to understand the roles and responsibilities of existing hospital staff in order to accurately describe how services enhance or work in tandem with those that already exist.

Providing field instruction or clinical supervision opportunities: A program can serve as a provider of field instruction or clinical supervision to medical and/or social work students, if program design and resources permit. This can enhance the hospital's reputation as a place of learning and improve the knowledge and skills of medical and/or social work students.

Meeting professional requirements: The American College of Surgeons requires that Level 1 Trauma Centers have injury prevention and rehabilitation components. For example, at Children's Hospital of Wisconsin, Project Ujima serves as one of the injury prevention components in place to meet the American College of Surgeons requirements.²⁶

Finding a "champion" in the hospital, someone who can serve as the leading voice in the institution for the intervention, is crucial.

One can enhance the effectiveness of discussions with hospital leadership by good timing, by making use of "critical incidents" such as a high profile case that affects the hospital or has impacted the community. Conversely, some "critical incidents" can make it more difficult to convince hospital leadership about the need for an intervention program. For example,

in September 2010, the son of an elderly patient being treated in a Baltimore hospital shot his mother and her doctor before shooting himself. He was reportedly disturbed by his mother's grave health condition and by the doctor's explanation to him about it. As a result, hospital staff became far more anxious than they had been about

²⁶. Email communication with Toni Rivera-Joachin & Marlene Melzer-Lange, M.D. on 5/12/11.

working with emotionally distraught patients and their family members, the kind of situation that violence intervention programs are designed to address. Being aware of these opportunities and challenges is essential.

Sustaining Hospital Support

Once the program has been implemented, there are other steps that can be taken to deepen the commitment of the hospital and other partners to making the screening, assessment, intervention, and transitional services routinely available to violently injured youth. These include the following:



Jennifer Williams (Out of the Crossfire, Cincinnati)

- **Hospital-wide policies and procedures to support the program:** Implementing hospital-wide policies and procedures to support the program such as regular presentations at new staff orientation, monthly in-service trainings for emergency and trauma staff, presenting at Grand Rounds, and scheduling a time/multiple times each day for a particular hospital staff member to check the trauma log for new referrals.
- **Frequent in-services:** Frequent in-services to remind hospital staff about the program and referral protocols. Both new and veteran staff can benefit from in-services that reinforce the program goals and procedures, and offer an opportunity for a dialogue on what is working and areas for improvement. In-services can also provide a good opportunity to discuss staff biases about violently injured young patients.
- **Public relations:** Opportunities for participating staff to hear about the successes of the program in order to reinforce its value. Successes can be illustrated by research showing the impact of the program design as well as testimonials from former patients who complete the program. Optimum forums for updates include regular department staff meetings, such as the Department of Social Services, Trauma Department, Emergency Department, etc.

According to Kyndra Simmons, Program Coordinator of Caught in the Crossfire in Oakland, California:

“The only way to maintain a good working relationship is to continue to tell the hospital workers that the program is here to help them and use examples. Often participants are rude and family members are angry because of the incident and not knowing how to deal with the emotions that come along with the crisis. Point out every chance you get that this is the component that hospitals don’t offer beyond the discharge. Maintaining the relationship with the Administration is often easier because I can point out the cost of an average gunshot victim, point out that most don’t have health insurance, and then tell the hospital how the program works to get Victim of Crime compensation for those who are not covered, or either health insurance for those that qualify. Either way the hospital can be paid for treating most uninsured violently injured people that participate in the program.”

Toni Rivera-Joachin and Marlene Melzer-Lange of Project Ujima in Milwaukee, Wisconsin report that they strengthen hospital support in two primarily ways:²⁷

- “With Project Ujima, we have found that our hospital staff and leadership are interested in volunteering for program functions. By engaging hospital staff as volunteers, the violence intervention program is embraced not only by the direct program staff, but also by the wider community of hospital staff.”
- “Conversely, Project Ujima encourages the volunteerism of our Youth Leadership Council, youth who have participated in our program who have now stabilized, in volunteering in the hospital. Their volunteering at our hospital’s Prom for Patients brought our youth much satisfaction, but also engaged our hospital leadership in the strengths of our program.”

Chapter IV Resources

Resource A: Visit the [San Francisco Wraparound Program’s](#) site for a poster outlining a cost analysis of San Francisco’s Wraparound Program.

Resource B: Report of VIP Cost Effectiveness Research

Visit the R. Adams Cowley Shock Trauma Center — [Violence Intervention Program \(VIP\)](#) website for a report of their cost effectiveness research.

27. Email communication with Toni Rivera-Joachin and Marlene Melzer-Lange, M.D. on 5/12/11.

Resource C: The data below were adapted from the [Wraparound Project at San Francisco General Hospital](#). They can help hospital administrators understand the dire need for a program that can prevent future violence. These data put the local problem in a national context.

The Epidemic of Violence [nationwide]

- According to the Centers for Disease Control reports, homicide was responsible for 18,573 deaths in 2006, up from 18,124 in 2005. This represents nearly 600,000 potential life years lost, giving credence to the concern that interpersonal violence disproportionately affects our young people.
- Fifteen youth per day were killed in the United States in 2005.
- Homicide is the 2nd leading cause of death in people 15-24 years of age and 3rd in those 25-34 years of age overall. Disadvantaged minority populations are disproportionately represented in this devastation.
- Homicide is the #1 cause of death in African Americans aged 10-24 years old and # 2 amongst Hispanics.
- Fatalities from assault represent the tip of the iceberg; non-fatal injuries are believed to outnumber fatal injuries on the order of **100 to one**.
- As a result of the tremendous societal affects of violent injury, violence prevention is considered a fundamental goal of “Healthy People 2010”.

San Francisco has not escaped the horrendous toll of interpersonal violence. The major findings are:

- The number of homicides in San Francisco is on the rise, with 59 in 2000, 70 in 2003, and 89 in 2007.
- San Francisco General Hospital Medical Center (SFGHMC), the only Level I Trauma Center in the city of San Francisco, treated 97% of the firearm victims.
- In San Francisco, adolescents (ages 15-24) have the highest rates of non-fatal violent injury, primarily involving assaults, resulting in hospitalization.
- In 2006, SFGHMC treated 228 gunshot victims and 196 stab victims. There were nearly three times as many gunshot victims in 2006 than

there were only 5 years prior. Over *half* the victims in 2006 were under the age of 25. Final data for 2007 preliminarily appears to be worse than 2006.

- Gun shot wounds are the leading cause of traumatic death at SFGHMC.
- Within 3 years, approximately 35% of assault victims are reinjured from another assault badly enough to require hospitalization.
- Approximately 90% of assault victims between 15 and 30 years old, admitted to SFGHMC for their injuries, have a prior history of criminal activity.
- African Americans in our city make up about 6% of the population but represent about 60% of the gun violence victims.
- In 2001, the last year these data were rigorously compiled in the Profile of Injury, firearm assault victims had the most extensive length of stay at SFGHMC.
- During that same year, health care charges to assault victims exceeded \$23 million dollars. Greater than 60% of these charges are estimated to be covered by public funds.

Resource D: Cost Analysis from the Violence Prevention Program, Baltimore, Maryland²⁸

Background: Homicide is responsible for over 611,000 potential life years lost in the US. An estimate of the long-term costs of gunshot wounds (GSWs) and stabbings in the US is \$264 billion yearly. Our level I trauma center violence prevention program (VPP) is designed to reduce our hospital's preprogram injury recidivism rate of 36.6%. Our purpose is to evaluate VPP recidivism rate and conduct a cost-analysis comparing VPP programmatic costs to the costs associated with treatment of victims of interpersonal violence. We hypothesize that the VPP reduces recidivism and provides a cost-savings in public dollars. Using a cost model, expansion of the VPP would lead to additional savings.

Methods: Using the Microsoft Excel randomization feature, we evaluated medical and financial information on 100 violently injured individuals who met our VPP eligibility criteria. Costs were extrapolated for the entire eligible population in that

28. Carnell Cooper, MD, Dawn M. Eslinger, MS, and Paul D. Stolley, MD, *Hospital-Based Violence Intervention Programs Work*, *The Journal of Trauma, Injury, Infection, and Critical Care*, 2006; Vol. 61, No. 3: 534-540. Visit the [Center for Nonviolence and Social Justice](#) resource page for a copy of this paper. Accessed 5/18/11.

year. We converted hospital charge data to total direct cost (cost to charge ratio). VPP annual budget includes salaries, travel and supplies. The three-year recidivism rate of the VPP was calculated. Extrapolated costs determined potential savings of a fully implemented VPP.

Results: Total hospital cost of the 100 subjects was \$4,860,000. Average cost was \$49,000. Overall VPP recidivism rate was 11%. The VPP served 58 clients in the one-year period at a budget of \$168,000. The table demonstrates current cost savings and expanded cost savings using an extrapolated cost model with an 11% recidivism rate.

Table: VPP Cost-Effectiveness

	VPP current	No VPP	Expanded Cost Savings
Clients per year	58	200	200
Recidivism rate	11%	36.6%	11%
# of recidivists	6	73*	*22
Cost of recidivists	\$291,582	\$3,547,581	*1,069,134
VPP cost savings	\$680,358	0	*2,478,447
Program costs	\$168,135	0	*579,800
Net savings	\$512,223	0	*1,898,647

Resource E: Cost Analysis from Project Ujima, Milwaukee, Wisconsin²⁹

Results: We enrolled 32 clients who gave informed consent to perform the evaluation and who also consented to be enrolled in Project Ujima. The control group consisted of 85 patients violently injured youth during the same time period who refused Project Ujima services. None of the youth receiving program services sustained a repeat violent injury requiring an emergency department visit, while eight non-program youth suffered injuries requiring an emergency department visit.

Outcomes: Costs for program services including direct care services, administrative oversight and mental health services were calculated for the group of youth who participated in the evaluation. The average program cost for each youth-family unit was \$2419 for the duration of Project Ujima involvement, while their hospital charges, not including physician fees, was \$5910 per youth. For the 85 youth who did not receive services, the average initial hospital charges were \$2545. In addition

29. Email communication with Toni Rivera-Joachin and Marlene Melzer-Lange, M.D. 5/12/11

these youth had additional hospital charges of \$1447 per patient for the eight repeat injury visits. Partial indirect cost savings by the program such as lost work on the part of parents, lost school attendance by the youth and other ancillary costs such as physician charges, medications and other social costs were not calculated. On average, clients receiving Project Ujima services received 37 hours of service during their enrollment period. Location of services included the hospital, clinics, patient's home, patient's school, community churches, the youth detention center, a health education center and public libraries.

Table: Comparison of Study and Control Groups

	Project Ujima Services N = 34	Control No services N = 85	P Value
Gender (%male)	85.3	76.5	NS
Age (years)	15.0	13.9	NS
Race (%)			P<.001
African American	91.2	53.5	
Caucasian	5.9	16.8	
Other	2.9	19.7	
Insurance Type(%)			NS
Public	61.9	57.1	
Commercial	23.8	42.9	
Self Pay	14.3	0%	
Initial Injury (%)			P=.003
Gunshot Wound	50	22.6	
Physical Assault	50	77.4	
Inpatient Hospitalization (%)	44.1	11.8	P<.001
Repeat Violent Injury	0	8 (9.4%)	P=.064

Utilizing a base cost-effectiveness analysis model, with Project Ujima costs of \$2,419 per patient and a cost of hospital visits of \$1,466 per recidivism episode, a success rate of 100% for Project Ujima patients and 90.6% for patients not receiving Project Ujima services, we found that Project Ujima is a cost-effective strategy at a “willingness to pay” threshold of the inpatient recidivism cost of \$1,466.

V. Partnerships

Chapter V Roadmap:

- Characteristics of an effective partnership 35
- Examples of National Network members' experiences in developing partnerships 37
- Chapter V resources 44

Chapter V Objectives

- User understands the characteristics of an effective partnership
- User understands the potential challenges involved in building a partnership for violence prevention

Characteristics of an effective partnership

Currently all hospital-based intervention services for violently injured youth are partnerships between a hospital that treats violently injured youth and one or more community-based agencies. In some, the hospital is the lead agency. In others, the lead agency is a community-based provider. In the ideal partnership, all partners exchange information, complement each other's activities, and share resources, thereby enhancing each other's capacity to address a crucial healthcare need. These details are usually formally described in a Memorandum of Understanding (MOU). (Key elements in a Memorandum of Understanding are described in the Resources section at the end of this chapter.) However, each partnership is different in terms of the extent to which resources and/or information are shared.

Common to all partnerships is knowledgeable and passionate leadership as well as a shared understanding of and commitment to the public health approach to youth violence.

The key characteristics of an effective partnership include the following:

- There is a high level of trust among partners.
- Roles and responsibilities among partner organizations and individuals are clearly defined. These are usually defined in writing through memoranda of understanding (MOUs) or letters of agreement.
- Partnership has a written financial plan and a clear strategy for obtaining financial resources with identified responsibilities for implementing it.

Common to all partnerships is knowledgeable and passionate leadership as well as a shared understanding of and commitment to the public health approach to youth violence.

- Leadership includes high-level, visible leaders.
 - Staff is accountable to partnership.
 - Partnership has clearly articulated goals, strategies, and indicators of progress that provide a sense of direction and consensus among members.
 - Learning generated from projects and processes is used to enhance future efforts.
 - Partnership has evidence of progress in affecting desired outcomes.
- Partner organizations have changed the way they operate as a result of this partnership.

As a first step in building a partnership, the partnership planners should list all of the most relevant organizations and hospitals in the area. After making the list, the planners should then brainstorm potential contacts at each institution as well as colleagues who may have contacts. Contacts are crucial doors into any institution.

Once the key partners are committed to forming the partnership, they can begin mapping out a plan to launch the partnership.

To form or strengthen partnerships for hospital-based or –linked violence intervention programs, the following excellent resources stand out:

- Community Partnerships: Improving the Response to Child Mistreatment³⁰

30. Children’s Bureau, Office on Child Abuse and Neglect (2010) *Community Partnerships: Improving the Response to Child Mistreatment*. Visit the Children’s Bureau website for a web version of this manual.

- The Collaboration Primer: Proven Strategies, Considerations, and Tools to Get You Started³¹

These outline the key issues to address in the process. Visit the [Children's Bureau's](#) website to see an adaptation of the partnership checklist from The Collaborative Primer.

Other key elements to consider are:

Effective negotiation skills (See Resource section below)

Communication strategies to convey information about the program among partners and the broader community

Techniques to resolve conflicts³²

Building cultural competence in partner agencies to enhance the partnership, e.g. training for community-based agency staff in hospital culture

Examples of National Network members' experiences in developing partnerships

Building an effective partnership can be done in different ways. Six National Network programs provide good examples:

Partnership Case Study 1: Sacramento Violence Intervention Program: In 2008, Kaiser Permanente South Sacramento Medical Center, a new regional trauma center, decided to implement a violence intervention program for victims of interpersonal violence. They reached out to the City of Sacramento's Office of Youth Development to jointly plan and implement a program. With technical assistance from Caught in the Crossfire, a well-established violence intervention program in the region, they mapped a detailed implementation plan, ran an RFQ process, selected a community-based agency, The Effort, to provide the crisis intervention and case management services that are central to any hospital-based violence intervention program, and selected program

31. From Torres, G.W., Margolin, F.S., *The Collaboration Primer: Proven Strategies, Considerations, and Tools to Get You Started*, Health Research and Education Trust, Chicago, June 8, 2010. Visit the [Health Research and Education Trust](#) website to download this manual.

32. Visit the [Office of Quality Improvement and Office of Human Resource Development](#) at the University of Wisconsin for some useful advice about conflict resolution.

staff. Though The Effort had never done hospital-based intervention before, they were selected because of their stability as an agency and their experience in the community working with similar populations. As the program moved ahead with implementation, Caught in the Crossfire provided intensive technical assistance including weekly phone meetings for the first few months, case conferencing, on-site training, and staff shadowing. By 2010, the Sacramento Violence Intervention Program was successfully launched.

Partnership Case Study 2: Project Ujima, Milwaukee, Wisconsin: In 1994, as youth firearm violence increased significantly in Milwaukee, nurses and physicians at Children’s Hospital of Wisconsin (CHW) treated over 180 children, ages 5 to 18, for firearm injuries. The tragic story of one of these children, a 16-year-old boy, sparked the organization of a multidisciplinary group to plan and implement program to intervene in the escalating cycle of violence affecting so many youth.

In late 1994, this 16-year-old male arrived at CHW’s emergency department with a fatal gunshot wound. A review of his medical record found that he had been treated in the CHW emergency department four times before: first in 1988 at age 9 for an “accidental” injury; then, two years later for multiple contusions and abrasions resulting from an assault; two years later, at age 13, he was treated for multiple stab wounds; and early in 1994, he was treated for a firearm injury to his leg.

The multidisciplinary team, organized by the CHW trauma and injury prevention nurse, engaged nurses, physicians, and hospital social workers with community partners including youth development specialists, youth advocacy workers, law enforcement personnel, mental health professionals, and family advocates. The leading partner agencies included CHW, the Medical College of Wisconsin, the Milwaukee Youth Opportunities Collaborative, Family Services of Milwaukee, the Milwaukee Health Department, and the Social Development Commission.

Drawing on the work of Grundle³³ and others, the team shaped a wrap-around program design to help youth victims of violence and their families break the cycle of violence. The CHW ED was the designated entry

33. Grundle, T.J. (2002) *Wraparound care*. In D.T. Marsh and M.A. Fristad (eds.), *Handbook of Serious Emotional Disturbance in Children and Adolescents*. New York, Wiley: 323-333.



National Network of Hospital-based Violence Intervention Programs (NNHVIP) leadership (left to right): Rochelle Dicker, M.D. (UCSF/San Francisco Wraparound Project), Rose Cheney (Firearm & Injury Center at Penn), Joseph Griffin (NNHVIP Project Manager, Youth ALIVE!), Theodore Corbin, M.D. (Healing Hurt People, Philadelphia), Carnell Cooper, M.D. (Violence Intervention Program, Baltimore), Marla Becker (NNHVIP Founder, Youth ALIVE!), Thea James, M.D. (Massachusetts Violence Intervention Advocacy Program), Anne Marks (Caught in the Crossfire, Oakland), Joel Fein, M.D. (Philadelphia Collaborative Violence Prevention Center), Marlene Melzer-Lange, M.D. (Project Ujima, Milwaukee). Not pictured: Steve Salzman, M.D. (CeaseFire, Chicago).

point for services and included brief bedside intervention and preparation of a discharge plan. The partners designed aftercare services that were family-centered, culturally competent, and developmentally appropriate. They also established a way of periodically evaluating the program, giving administrators and staff the information needed to adjust the design over time to better reach the program's goals: (1) support youth and their families through the recovery process, (2) provide social support to these youth and their families, and (3) prevent retaliation.

Each of the partner agencies provided the initial financial support in the form of in-kind services. Subsequently, the Project Ujima secured funding from the Children's Hospital Foundation, Targeted-Issues funding from the Emergency Medical Services for Children, the Allstate Foun-

dation, and Victims of Crime Assistance through the U.S. Department of Justice. Today, Wisconsin's Victims of Crime Assistance funds about 50% of the work and the hospital and grants from foundations and government sources cover the other 50%.

Partnership Case Study 3: Violence Intervention Advocacy Program (VIAP).

In 2006, a team led by Dr. Thea James and Dr. Benjamin Shelton from Boston University's Department of Emergency Medicine launched the VIAP demonstration project at Boston Medical Center. It was funded by a \$100,000 Shannon Grant award from the Boston Public Health Commission. The following year, in response to the increase in gunshot and stab wounds in cities across Massachusetts, the Brief Negotiated Interview and Active Referral to Treatment (BNI-ART) Institute received a supplemental grant to add a violence intervention component to its state-funded substance abuse intervention programs to expand the VIAP to serve victims of violence across the state, at Brockton Hospital in Brockton, UMASS Memorial in Worcester, Massachusetts General Hospital (MGH) in Boston, BMC in Boston, Lawrence General Hospital and Baystate Medical Center in Springfield. Dr. Edward Bernstein of Boston University's Department of Emergency Medicine and the BNI-ART Institute worked closely with Dr. James and Dr. Shelton and violence intervention advocates Anthony Christian and Leroy Muhammad to adapt this program for conditions in Massachusetts. In 2009, state funding cuts forced the closing of three of the six original sites.

VIAP integrated and piloted an intense self-improvement replication guide to the program for clients called The Reclamation Project (TRP). The program was developed by one of the violence intervention advocates. The first group of clients who enrolled and completed the rigorous ninety-day program are doing well and following through with their self identified goals. The second session of TRP took place in Spring 2010.

To support VIAP, the Boston Medical Center, the flagship site, has received multiple sources of funding from their partner organizations: the Boston Public Health Commission, the Robert Wood Johnson Foundation, a Byrne Grant, and the Boston Foundation.



Valerie Street (Alameda County Emergency Medical Services) & John Rich, M.D. (Healing Hurt People, Philadelphia)

Partnership Case Study 4: Violence Intervention Program (VIP), Baltimore, Maryland. Trauma surgeon Dr. Carnell Cooper started Baltimore, Maryland’s Violence Intervention Program (VIP) in 1998 in the R. Adams Crowley Shock Trauma unit of the University of Maryland Medical Center. In 2008, Dr. Cooper proposed expanding the umbrella of VIP services citywide. Under this plan, partner hospitals would identify eligible patients, obtain VIP consent, and refer recruits for VIP participation. Each hospital could allow personnel the time needed for in-service training, administrative tasks, and record keeping responsibilities as in-kind benefits. As of early 2010, written commitments had been obtained from Bon Secours, Harbor Hospital, Johns Hopkins Bayview, Sinai, Union Memorial, Maryland General, and St. Agnes. The Baltimore City Police Commissioner, the Department of Public Safety and Correctional Services’ Secretary Gary Maynard, the Baltimore City Health Department, and the Baltimore Health Services Cost Review Commission also supported the proposal.

Partnership Case Study 5: Caught in the Crossfire, Oakland, California.

A partnership to implement Caught in the Crossfire between the Alameda County Medical Center (ACMC), located in the heart of Oakland, California, and a community-based public health agency, Youth ALIVE!, was launched in the mid- 1990s after an 18-month planning phase.

An ACMC social worker, Karen West, alarmed at the increasing number of young African-American males who, after being treated for violent injuries, were being discharged back into their communities without a safety plan, asked a Student Services Manager with the Oakland Unified School District for assistance. He referred her to Deane Calhoun, the Director of Youth ALIVE! who had developed and was administering youth violence prevention programs in middle and high schools. She worked from local, state and national data to develop programs to prevent violent injuries and death. She had already met with the local Trauma Coordinator at ACMC to discuss the possibility of initiating a peer intervention program, based on the risk of recidivism to the young people and the benefits of intervention services. Ms. West contacted Ms. Calhoun, who had just been called by the Chief of Trauma at ACMC urging her to set up an intervention program, and referring her to a young man, Sherman Spears, who had been treated at ACMC for a gunshot wound that left him wheelchair bound and who was interested in providing intervention services to other going through similar circumstances. Although there was support from the social worker, the Trauma Coordinator, the Chief of Trauma and other trauma surgeons, they had to work harder to secure support from the Chief Surgeon. He needed time to acknowledge and accept that the prevalence of shootings of urban African-American men was likely to be an ongoing medical problem in his urban hospital. Although he ultimately supported the idea of intervention services, the CEO of ACMC held the power to both approve the program and provide office space in the hospital for the intervention staff to ensure speedy identification and connection with the patients. For several months she refused to support the effort at all. When a local reporter learned of this barrier and began gathering information about the significance of the program and the impact of not having it, Ms. Calhoun initially tried to dissuade him to raise the issue of the program being blocked by the CEO, not wanting to make the situation public. She felt there were other avenues, such as the Alameda County Board of Supervisors, that she could pursue. But the reporter persisted and within a few weeks of publication of the article,

the CEO agreed to allow the intervention specialists access to patients, if they were referred through a clear referral process by the designated ACMC social worker.

Ms. Calhoun then secured support for the program from several local foundations that had supported Youth ALIVE!'s school-based violence prevention work. With their support, Youth ALIVE! and the ACMC developed referral protocols and Youth ALIVE! appointed Sherman Spears as project coordinator and began working with violently injured youth in 1994.

Two years later, Youth ALIVE! successfully secured a four-year U.S. Department of Justice grant as well as private foundation funding. In addition to supporting the direct services to hospitalized youth, the grant supported building a broader partnership of public and private sector agencies to address local youth violence. At the end of the grant period, Youth ALIVE! was able to secure a multi-year, federal Substance Abuse and Mental Health Services Administration grant to continue direct service and community partnership work. Thereafter, the City of Oakland's special tax fund to support youth programs funded the direct services to violently injured youth being treated at the ACMC as well as highly at risk youth referred by the schools. And after 12 years of trying to secure EMS (Emergency Medical Services) support, the county EMS recently allocated funds to support the program. These larger grants allowed the program to expand in ways it could not have if it had relied primarily on private foundation funding.

Partnership Case Study 6: Healing Hurt People, Philadelphia, Pennsylvania³⁴ *Healing Hurt People* was first implemented at a university hospital as a partnership between the university's College of Medicine and School of Public Health. Support to establish the Center from a private behavioral health foundation, combined with the support of *Healing Hurt People* by the public sector, converged to launch this multidisciplinary comprehensive effort. Several core activities were crucial in designing and implementing the program:

34. Corbin, T.J., Rich, J.A., Bloom, S.L., Delgado, D., Rich, L.J., Wilson, A.S. (in press). Developing a Trauma-Informed, Emergency Department-Based Intervention for Victims of Urban Violence. *Journal of Trauma and Dissociation*.

- A literature review on emergency department-based violence interventions;
- Visits to similar model programs in the U.S. (in particular, the *Caught in the Crossfire* program in Oakland, CA);
- Consultation with experts in the field of violence prevention and trauma;
- Focus groups with individuals in the target age range who have experienced intentional violence;
- Focus groups with emergency department personnel;
- Establishment of collaborative relationships with community-based partners to meet the needs of program participants.

Chapter V Resources

Resource A: Memorandum of Understanding

What is a Memorandum of Understanding (MOU)?

An MOU is a written agreement that clarifies the relationships and responsibilities between two or more organizations that share services, clients, and resources.

Why is it important to have an MOU?

MOUs help strengthen community partnerships by outlining clear roles between individuals, agencies, and other groups. Communities with MOUs report that the strengthened partnerships resulted in enhanced services for children and families.

What is actually included in an MOU?

MOUs can address a variety of issues and topics. Content areas to consider including in an MOU are:

- Clarification of agency roles
- Referrals across agencies
- Assessment protocols
- Parameters of confidentiality
- Case management intervention
- Interagency training of staff

- Agency liaison/coordination
- Process for resolving interagency conflicts
- Periodic reviews of the MOU.

Adapted from: Appendix I of Children’s Bureau, Office on Child Abuse and Neglect (2010) *Community Partnerships: Improving the Response to Child Mistreatment*. Visit the [Children’s Bureau, Office on Child Abuse and Neglect](#) website to view the table of contents of their manual.

Resource B: Key Elements to Include in a Memorandum of Understanding or Agreement Between a Hospital or Medical Center and a Community Based Agency that is Providing Hospital-Linked Services for Violently Injured Patients.

- Date the agreement is signed.
- Names of agreeing parties & their acronyms, e.g. hospital and community-based agency.
- Identification of which party is the “Contractor” and what that means, e.g. independent contractors are responsible for all personnel matters such as salaries and benefits of their employees.
- Description of the services that the Contractor will provide called *Scope of Services*.
- Description of how much the Contractor will be compensated for services, if applicable.
- Specification of the beginning and ending dates of the agreement.
- Clear statement of liability, insurance requirements, workers compensation requirements, and conformity with legal requirements and professional standards.
- Clarification about confidentiality of information, specifically related to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-101 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (“the HITECH Act”).
- Clarification of conflict of interest.
- Statement about how the agreement can be terminated.
- Signatures of representative of each party to the agreement.

Resource C: Interest-based negotiations (also known as integrative bargaining, mutual gain bargaining, win-win bargaining, principle-based negotiations, open bargaining). Visit the [Taylor-Nelson](#) website for more information about integrative bargaining.

VI. Identifying Patients, Assessing Risk, & Managing the Crisis

Chapter VI Roadmap:

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- Building trust 51
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Chapter VI Objectives

- User understands who determines patient eligibility, barriers to this process, and how to overcome barriers.
- User understands what is involved in conducting entry assessments.
- User understands the process of linking patients to intervention services.

According to experts in the field,³⁵ “best practices” for promoting successful transition from an institution to the community for youths at high risk for violence involve four steps:

35. Rebecca Cunningham, MD, Lynda Knox, PhD, Joel Fein, MD, MPH, Stephanie Harrison, MPH, PhD, Keri Frisch, MS, Maureen Walton, MPH, PhD, Rochelle Dicker, MD, Deane Calhoun, MA, Marla Becker, MPH, Stephen W. Hargarten, MD, MPH, *Before and After the Trauma Bay: The Prevention of Violent Injury Among Youth*. *Ann Emerg Med*. 2009;53:490-500. Visit the [Annals of Emergency Medicine](#) website to view the abstract of this article.

1. Assessment of the patient's psychosocial needs and the risks they pose to public health and safety, using screening tools;
2. Planning for the treatment and services required to address these needs and risks, especially the risks of retaliation (requires immediate attention);
3. Identifying institutional or local programs responsible for post-discharge services; and
4. Coordinating the plan to ensure appropriate service delivery and mitigate gaps in care.

In many cases, however, before the initial assessment can be conducted, just identifying patients in need of violence intervention services and securing their consent for the risk initial assessment is essential. Also, crisis management is central at this point, primarily to address patient safety and to prevent retaliation. Ideally crisis intervention begins in the emergency room or trauma unit. However, if a patient is treated and released before violence intervention services staff can reach the hospital, crisis intervention may take place at the injured youth's home or another community location, ideally within 24 hours of medical treatment.

This chapter focuses on (1) identifying patients and securing their consent for services and (2) conducting the initial assessment of psychosocial needs and risks. It describes a range of approaches that have been developed to address some of the barriers to identifying and assessing young patients needing violence intervention services that are all too common:³⁶

Although many healthcare providers and nurses recognize the importance of identifying, assessing, and intervening with violent youth, most are not currently providing these youth with services that may prevent them from further injury. From a survey conducted among physicians and nurses in emergency departments, Fein and colleagues identified a number of barriers in assessing violent youth.³⁷ Lack of time, energy, and skills, as well as concern for personal safety and upsetting family members were reasons for not conducting an appropriate risk assessment.

36. Cunningham, R., Knox, L. (Winter 2008) *Reinjury Prevention for Youth Presenting with Violence-Related Injuries: A Training Curriculum for Trauma Centers*. Southern California Center of Academic Excellence on Youth Violence Prevention in Collaboration with the University of Michigan Department of Emergency Medicine Injury Center. Visit the Center for Nonviolence & Social Justice website to access this curriculum.

37. Fein JA, Ginsburg KR, McGrath ME, et al. Violence prevention in the emergency department: clinician attitudes and limitations. *Arch Pediatr Adolesc Med*. May 2000;154(5):495-498

Identifying potentially eligible patients

It is crucial to determine specific staff positions responsible for identifying potentially eligible patients and for conducting the initial risk assessment. Most existing programs utilize hospital medical or social work staff, hospital chaplains, the Community Injury Prevention Coordinator (a mandated position at all Level I Trauma Centers), and/or nurses to identify eligible patients and refer them for assessment and intervention services. The San Francisco Wraparound Program's intervention services staff, as hospital employees, carry pagers that alert them when a potentially eligible victim of violence is admitted to the emergency department. If staff employed by a hospital are responsible for identifying patients, they can access patient information that is unavailable to non-hospital staff under the Health Insurance Portability and Account-

ability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (HITECH) passed in 2009. In Savannah, Georgia's Violence Intervention Program, which is operated by the local prosecutor's office, a lead program staff member is designated as an "unpaid" hospital staff member so that he can readily access patient information to speed the process of identifying potentially eligible patients and linking them more quickly with crisis intervention services.

Several National Network programs have discovered that frequent turnover among medical staff requires frequent trainings to ensure that all potentially eligible patients are identified.

In some communities, program staff members other than healthcare providers identify and conduct the initial screening of youth who might need services, secure their consent for referral to services, and link them to community-based intervention services. In these cases, the non-hospital program formally agrees with the hospital to maintain patient confidentiality as required under HIPAA and HITECH. In some cases, non-hospital program staff complete the hospital's volunteer training program and, as specifically trained hospital volunteers, have access to patient information.

Some programs, particularly those based in academic settings and those evaluating program outcomes, may also need to follow human subject protection guidelines as established by their Institutional Review Boards. In these cases, patients and/or parent(s)/ guardian(s) must sign a release of information form to allow any information from their medical files to be shared. If there is any possibility that there

If a patient is treated and released before violence intervention services staff can reach the hospital, crisis intervention may take place at the injured youth's home or another community location, ideally within 24 hours of medical treatment.



Aiyana Johnson (Beyond Violence, Richmond and Antioch, CA)

will be data collected and shared in venues other than to improve the project for quality assurance purposes, local IRB will likely need to be involved.

Case Study on Identifying Patients 1:

CeaseFire, a community-based intervention program in Chicago, Illinois relies on either trauma surgeons or hospital chaplains to identify, assess, and link the patients at highest risk for violence to their services.³⁸ They gather key background information including the gender and age of the victim, the severity of the wound, the state of the waiting room and visitors related to the case, information related to gang affiliation, and information related to plans for retaliation, and the address of the incident which led to hospitalization of the patient. They then refer the patients to CeaseFire outreach workers.

Case Study on Identifying Patients 2:

At a Level 2 Trauma Center in Oakland, California, the Community Injury Prevention Coordinator regularly reviews all admission data to determine which patients meet the intervention program's basic criteria, e.g. type of injury, age, and location of residence. After describing the services and securing patient consent as required under HIPAA, the Coordinator then immediately refers the patient to the Caught in the Crossfire program and staff conduct the intake or entry assessment within the hour. In addition, Caught in the Crossfire maintains a formal agreement with the medical center to maintain client confidentiality. (See example of agreement between the program and the medical center in the Resources section at the end of this chapter.)

38. Visit the [CeaseFire](#) website for a description of their hospital emergency room intervention.

Case Study on Identifying Patients 3: Project UJIMA in Milwaukee has parents/guardians of violently injured children and youth sign a consent form in the Emergency Department that allows hospital and related agencies to have free access to patient information without jeopardizing youth confidentiality or privacy.³⁹ (For a full account of Project Ujima’s process of identifying and linking with patients, please see the Resource section at the end of this chapter.)

Case Study on Identifying Patients 4: In the Boston area, the community-based Violence Intervention Advocacy Program’s Intervention Specialist was initially denied access to patient information needed to provide intervention services. To meet HIPAA requirements, they arranged for the Intervention Specialist to complete the hospital’s rigorous volunteer training and certification program. As a certified hospital volunteer, the Intervention Specialist became able to access the information needed.

CeaseFire, a community-based intervention program in Chicago, Illinois relies on either trauma surgeons or hospital chaplains to identify, assess, and link the patients at highest risk for violence to their services.

Case Study on Identifying Patients 5: Baltimore’s Violence Intervention Program (VIP) staff, as hospital employees, review the health care information system’s daily admissions roster for the Shock Trauma Center to identify patients who meet VIP eligibility requirements. VIP staff members talk to eligible patients and their families at the bedside to discuss voluntary enrollment into the program. Those who give informed consent for participation complete an intake questionnaire and begin the assessment process for service planning. The VIP team is multidisciplinary. There are representatives from medicine, social work, epidemiology, parole/probation, social services, as well as consultants from other fields as needed to best meet program needs.

Building trust

Building a trusting relationship between the violently injured patient and those providing violence intervention services is absolutely essential, primarily to allow intervention services to respond as quickly as possible to the potential for retaliation. Many

39. Robert D. Ketterlinus, Ed., (2008) *Youth Violence: Interventions for Health Care Providers*, American Public Health Association Press, Washington, DC. P. 41

Building a trusting relationship between the violently injured patient and those providing violence intervention services is absolutely essential, primarily to allow intervention services to respond as quickly as possible to the potential for retaliation. Many violently injured patients are distrustful of professionals and other authority figures and are reluctant to talk about retaliation.

violently injured patients are distrustful of professionals and other authority figures and are reluctant to talk about retaliation. National Network programs are keenly aware of this and make every effort to ensure that those responsible for identifying patients in need of violence intervention and for conducting the initial assessment are culturally competent and can quickly build a trusting relationship. Some programs provide training for hospital staff in developing trusting relationships. One strategy programs use is to employ street savvy paraprofessional staff members who can quickly bridge the cultural gap. (See Chapter IX, Making Informed Direct Service Staff Hiring Decisions, for more details). Although this has the benefit of instant cultural sensitivity, other programs have noted that the staff hired for this reason may occasionally still have ties to street life that compromises confidentiality or be of the opposite group (gang) prior affiliation than the

client in years gone by. Data are lacking to guide these hiring decisions, but clearly hiring staff that have good clinical rapport, and cultural sensitivity is mandatory in maintaining the trust of clients.

Building trust can be threatened if patients confuse violence intervention services with law enforcement. Since violently injured patients are victims of crime, police and other law enforcement personnel often want to get information from patients, even while they are still in the hospital. That is their job, of course. Violence intervention services providers must be clear with law enforcement that our role is not to help them conduct investigations. Instead, it is the safety and health of the victim, and in the prevention of future violence.⁴⁰

While law enforcement and hospital-based violence intervention program roles are very different and can conflict, all programs maintain a cordial working relationship with law enforcement and work together in appropriate situations. For example, police departments regularly provide crime incident reports to hospital-based violence intervention program staff so that they can help clients submit applications for Victims of Crime compensation.

40. Email communication with Anne Marks, 5/18/11.

Mandatory reporting

A key aspect of the public health approach to disease and injury is mandatory reporting of incidences to local, state, national, and/or international data collection centers. This helps identify, control, and prevent these incidences. Most states in the U.S. require that professionals who have regular contact with vulnerable populations such as children and the elderly report abuse to appropriate authorities.⁴¹ These professionals include physicians, medical residents, nurses, social workers, and case managers.

Those providing intervention services are usually mandatory reporters. Giving violently injured patients notice that their injury may be reported is part of the consent process.

Risk assessment

Conducting an initial risk assessment is the essential first step in violence intervention to determine both the risk of retaliation (the possibility that the patient and/or his/her family members or friends may injure someone else) and the vulnerability of the patient to re-injury.

A program that operated at Children’s Hospital of Philadelphia employed a 5-question screening tool for physicians to administer.⁴² The tool was used to identify patients at risk for retaliation and needing referral for a lengthier assessment.

Risk Assessment Tool

1	Do you know the person who hurt you?
2	Do you think the conflict that caused this incident is over?
3	Do you think that you will hurt anyone because of what happened today?
4	Do you think that any of your friends or family will hurt anyone because of what happened today?
5	Have you reported the incident to the police or other authority?

Risk Assessment Case Study 1: Caught in the Crossfire, a violence intervention program in Oakland, California, conducts the risk assessment as part of a hospital bedside visit, following this protocol:

41. Visit the [RAINN](#) (Rape, Abuse, and Incest National Network) website for information about state-by-state mandatory reporting requirements.

42. This tool was provided by its author, Joel A. Fein, M.D., MPH. Dr. Fein is a co-author of this replication guide.

GOALS OF INITIAL BEDSIDE VISIT

- Addressing any immediate needs the patient might have (For example helping them to understand what is going on in the hospital, making them as comfortable as possible, helping them follow-up on contacting family, etc.).

A key aspect of the public health approach to disease and injury is mandatory reporting of incidences to local, state, national, and/or international data collection centers. This helps identify, control, and prevent these incidences.

- Explaining how the program works, what it offers, and what is expected of the youth and his/her family members (Include process of connecting youth and family to community-based services).
- Reviewing the violent incident (When talking about incident, be aware of people in immediate area as information may be part of ongoing police investigation).
- Preventing any retaliation that may be planned by friends or family (Be prepared to explain the cycle of violence as it relates to the youth and his/her friends and family).
- Learning how long the youth expects to be in the hospital and establishing a plan for a follow-up meeting within 3 days.
- Completing an initial needs/strengths assessment (Sometimes this needs to be completed in the next visit or even over the course of the next few visits, depending on the emotional and physical health status of the youth).
- Providing program contact information, including the Intervention Specialist's business card, to the patient and any friend or family member present.
- Obtaining consent to participate in the program from the patient or his/her parent/guardian, if patient is a minor.

Caught in the Crossfire's approach relies on the knowledge of the risks for re-injury and retaliation that its Intervention Specialists bring to the encounter.

Risk Assessment Case Study 2: The San Francisco Wraparound Project case managers, when called to a patient's bedside, focus immediately on assessing risk of retaliation and managing the crisis. They make an assessment and enroll patients they decide are high risk for repeat injury and/or incarceration based on the presence or



Thea James, M.D. (Massachusetts Violence Intervention Advocacy Program), Ted Corbin, M.D. (Healing Hurt People, Philadelphia), Marla Becker (Caught in the Crossfire, Oakland), David Osman (UMC Trauma Services VIP, Las Vegas)

absence of risk factors. Their approach, like Caught in the Crossfire's, is based on the Case Managers' gut understanding of the risk factors. In collaboration with the city's Crisis Response Network, they work hard to prevent retaliation and to do everything possible to ensure the patient's safety.

Chapter VI resources

Resource A: How Project Ujima, Milwaukee, Wisconsin, identifies patients needing violence intervention services

Project Ujima community liaisons come to the emergency department (ED) at Children's Hospital of Wisconsin when a youth is identified with a violent injury at the time of their presentation in triage. Because we want to assure a face-to-face encounter between the injured patient/family and the Project Ujima community liaison, the triage nurse pages the liaison. If a patient comes by ambulance, the primary ED nurse or social worker involved in the case will page early in the ED course. This has now become a matter of nursing and social services practice for the violently injured patient. The ED medical and nursing team considers the Project Ujima part of the ED

“violently-injured” patient team—it’s part of our culture. For patients who come overnight, a referral line is in place and checked daily so that the community liaison makes contact with patients and families soon after their presentation to the emergency department. Some patients are admitted to the inpatient unit and, in those cases, if the patient has not received services in the ED, the trauma advanced practice nurse and surgical team assure that Project Ujima community liaisons provide consultation on the inpatient unit. We post photo placards of our staff on the inpatient units and intensive care units that serve trauma patients. In addition, presentations by Project Ujima program staff to hospital unit nurses, chaplains and social workers provide additional team bonding. It is very important to integrate the violence intervention staff into the hospital care team for the violently injured patient—to provide the best care and outcomes for these patients.

Resource B: A Potential Source of Forms and Advice about Identifying Patients and Assessing Risk: Visit the [National Network of Hospital-based Violence Intervention Programs](#) (NNHVIP) for links to programs across the country that may be able to share their forms and provide advice on these subjects to new and emerging violence intervention programs.

Resource C: Case Studies on Identifying, Risk Assessing, and Managing the Crisis

Case Study I: In 2005, Chicago’s CeaseFire intervention program and Advocate Christ Medical Center emergency room developed a protocol to ensure a consistent approach to each violently injured patient. Through this protocol, either the trauma surgeon or the chaplain can initiate contact. In each case, the trauma surgeon or chaplain on duty, before calling the CeaseFire hospital hotline, gathers background information including gender and age of the victim, the severity of the wound, the state of the waiting room and visitors related to the case, information related to gang affiliation, information related to plans for retaliation, and the address of the incident which led to the patient’s hospitalization. Each call to the CeaseFire hospital hotline prompts a team of CeaseFire outreach workers to go to the hospital to reach out not only to the patient, but also to the friends and family in the waiting room who might be planning to retaliate for the injury to their loved one.

This “reaching out” to the patient and relatives constitutes the beginning of a more in-depth assessment of the patient’s psychosocial needs and the risks they pose to public health and safety and development of a treatment and services plan.

When arriving in the emergency room, outreach workers speak to the chaplain, trauma team, and security personnel to establish an intervention plan. Often one outreach worker stays in the waiting room with family and friends to assess their need for support and potential plans for retaliation. The other outreach worker attempts to meet with the patient, provide program literature, and ask if the patient would like to receive ongoing assistance from CeaseFire. Hospital staff also encourage patients to participate in the program. When possible, the outreach workers are from the same community as the patient and understand the conditions and available services. Their role is to develop a trusting relationship with the youth and guide them to services already available in the community to help them make positive life changes. Outreach workers follow up after the patient is discharged from the hospital using contact information provided by the patient.

Case Study II: Caught in the Crossfire, a partnership between the Alameda County (California) Medical Center’s Trauma Center and a community-based agency, Youth ALIVE!, established a referral protocol in 1994 in which a medical center social worker identified and referred patients to Youth ALIVE! for intervention services. When the social worker left in 2003 for a position at another hospital, the number of eligible patients referred by her successors declined sharply. To remedy the situation, Youth ALIVE! worked with ACMC to ensure that the job description the new Community Injury Prevention Coordinator included identifying and referring eligible patients for intervention services. They were largely successful because the first Coordinator had directed the Caught in the Crossfire program before he was hired as the Community Injury Prevention Coordinator and was deeply committed to the vision and mission of



DeAngelo Mack (Sacramento VIP)

the program. In his new position, he reviewed admissions data daily and contacted all patients likely to make use of the program. Referrals increased substantially and stayed high until he moved out of state. Since screening and referring patients to Caught in the Crossfire was written into the job description, referrals remain high under the new Community Injury Prevention Coordinator.

VII. Intervention Services After the Initial Crisis

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Chapter VII Objectives

- User understands the key elements of the primary models
- User understands the issues related to selecting and using assessment tools.
- User understands what factors to consider in determining duration and dosage of services.
- User understands what factors to consider in determining the service options
- User understands how to work with service benchmarks

Service Model Options

Structuring services to help violently injured youth transition from the hospital to the community should reflect the program’s theoretical framework, its goals and objectives, available resources, and the characteristics of the focus population. While current National Network programs employ somewhat different service models, all follow the four steps “best practices”⁴³ that boost the likelihood of achieving positive outcomes:

- a. Assessment of the patient’s psychosocial needs and the risks they pose to public health and safety, using screening tools;
- b. Planning for the treatment and services required to address these needs;
- c. Identifying institutional or local programs responsible for post-discharge services; and
- d. Coordinating the plan to ensure appropriate service delivery and mitigate gaps in care.

To fill out this four-step process, programs draw on theoretical frameworks and “best practices” to craft a model that is most appropriate given the available resources and the characteristics of the focus population. Below are five examples of theoretical frameworks and “best practices”:

- *Brief intervention* is a service model, used successfully by medical providers to address substance abuse among patients. It is based on three theoretical frameworks: Stages of Change (Proshka & Di Clemente), Cognitive Behavioral Therapy, and Motivational Interviewing (Miller & Rollnick).⁴⁴ It involves a single session or multiple sessions of motivational discussion focused on increasing insight and awareness of the situation. It can be tailored for a variety of populations or settings and can be used as a stand-alone treatment for those at-risk as well as a vehicle for engaging those in need of more extensive levels of care.
- The *mentor implemented violence prevention* approach, pioneered by Tina L. Cheng, MD, MPH, was evaluated in a randomized, control trial

43. Rebecca Cunningham, MD, Lynda Knox, PhD, Joel Fein, MD, MPH, Stephanie Harrison, MPH, PhD, Keri Frisch, MS, Maureen Walton, MPH, PhD, Rochelle Dicker, MD, Deane Calhoun, MA, Marla Becker, MPH, Stephen W. Hargarten, MD, MPH, *Before and After the Trauma Bay: The Prevention of Violent Injury Among Youth*. *Ann Emerg Med*. 2009;53:490-500. Visit the [Annals of Emergency Medicine](#) website for information about this article.

44. Visit the [UCLA Center for Nutrition](#) website for more details about Stages of Change. Visit the [National Alliance on Mental Illness](#) website for more information about cognitive behavioral therapy. Visit the [Motivational Interviewing](#) website for more information about motivational interviewing.

conducted through the emergency departments in two large urban hospitals.⁴⁵ In this approach, patients being treated in the emergency department were identified from ED logs or chart copies and from computer printouts for hospitalized patients based on these criteria: assault victim, excluding sexual assault, child abuse, sibling fights, and legal intervention; ages 10-15; living in the Washington, DC area; and mental, physical, and English-speaking abilities. Patients who agreed, with parental consent, to participate were assigned a mentor who would meet with them at least 6 times over a 2 to 6-month period. Mentors had all received extensive training and were supervised by program staff members through regular telephone contacts, monitoring of mentor logs, feedback from the parents and youths, and occasional observation and retraining sessions. Mentors received a \$240 stipend for their time and activity expenses. The mentors and youths completed a 6-session, violence prevention replication guide focusing on skills building. The replication guide was grounded in social-cognitive theory and included sessions on conflict management and “hot buttons,” problem-solving, weapon safety, decision-making, and goal-setting. The replication guide also included interactive activities, role-playing scenarios, and a pledge to remain nonviolent.

- *Trauma informed treatment*, a framework used by the National Network participating program, Healing Hurt People (HHP), is “care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services.”⁴⁶ This approach, since it significantly changes the way that seriously injured people are served, requires a planning process that incorporates the basic principles right from the start.⁴⁷ These principles are:

45. Cheng, T.L., Haynie, D., Brenner, R., Wright, J.L., Chung, S., Simons-Morton, B.. *Effectiveness of a Mentor-Implemented, Violence Prevention Intervention for Assault-Injured Youths Presenting to the Emergency Department: Results of a Randomized Trial*. PEDIATRICS Vol. 122 No. 5 November 2008, pp. 938-946. Visit the [American Academy of Pediatrics](#) website to view this paper.

46. Visit the [Sanctuary Model](#) © website for more information about trauma informed care.

47. Roger D. Fallot, Ph.D., and Maxine Harris, Ph.D., *Trauma-Informed Systems of Care: An Update* [Fallot & Harris co-edited the referenced book, *Using Trauma Theory to Design Service Systems*], U.S. Department of Health & Human Services, Center for Mental Health Services’ National Center for Trauma-Informed Care, *Trauma Matters*, e-Newsletter, (October 2007). Visit the [National Center for Trauma Informed Care](#) (NCTIC) website for more information. NCTIC is a technical assistance center of the federal Substance Abuse and Mental Health Services Administration.

Safety: Ensuring the physical and emotional safety of consumers and staff.

Trustworthiness: Making the tasks involved in service delivery clear. Ensuring consistency in practice. Maintaining boundaries, especially interpersonal boundaries, that are appropriate for the program.

Choice: Prioritizing consumer experiences of choice and control.

Collaboration: Maximizing collaboration and the sharing of power with consumers.

Empowerment—Prioritizing consumer empowerment. Recognizing consumer strengths. Building skills.

These principles translate into a specific way of providing services:

Rather than asking, “What is your problem?” trauma-informed providers may ask, implicitly or explicitly, “What has happened to you?” and, “How have you tried to deal with it?” Rather than adopting a stance of, “Here is what I can do to help you,” a trauma-informed approach asks, “How can you and I work together to meet your goals for healing and recovery?” In every aspect of the program’s functioning, there is enhanced awareness of the ways in which trauma may have affected people coming for services. There is a corresponding shift in attitude, practice, and setting to welcome, engage, and sustain helpful relationships with consumer-survivors.

- The *case management* approach, employed by the National Network participating programs such as Ceasefire & Caught in the Crossfire, has a long history in the health field. The Case Management Society of America⁴⁸ defines case management as “a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.”

In Chicago’s Ceasefire hospital-based intervention program, the para-professional case managers are called outreach workers. They meet with patients; conduct an assessment; and plan, facilitate and advocate “for options and services to meet the patient’s health needs through communication and available resources to promote quality cost-effective

48. Visit the [Case Management Society of America](#) website for more information.

tive outcomes.” They follow each patient into the community, adjusting the plan as needed and facilitating access to services. The outreach workers often collaborate with Ceasefire Violence Interrupters who have special expertise with street gangs. Their job is to assemble information needed to prevent the retaliation that often follows a violent injury.

In Oakland, California’s Caught in the Crossfire, the paraprofessional case managers are called Intervention Specialists. They meet with patients, provide immediate crisis counseling, and conduct a needs/strengths and risk assessment. Then with the patient and often family members and friends, they develop a safety plan and longer-term plan for life changes to break the cycle of violence. Each Intervention Specialist also continues to work with each patient after discharge, adjusting the plan as needed and facilitating access to services. They contact clients at least weekly, often meeting at the youth’s home, for an average of six months, though they work with some clients for a year or more. Because of their time-consuming, but crucial, case management approach (e.g. home visits, providing transportation for clients to and from appointments), the program keeps caseloads at 14-17 clients per Intervention Specialist.

- A *faith based* approach, launched in late 1997 as the Violence Prevention Initiative (VPI) in Philadelphia but no longer operating, engaged hospital chaplains to conduct bedside assessments with injured youth in the emergency department and referral to community-based services after discharge.⁴⁹ It was rooted in the belief that “optimal health care attends to more than the physical body,” and that chaplains are uniquely suited to address the spiritual issues that often accompany



Les Zun, M.D. (Within Our Reach, Chicago)

49. For an excellent description of this approach, see Robert D. Ketterlinus, Ed., (2008) *Youth Violence: Interventions for Health Care Providers*, American Public Health Association Press, Washington, DC. pp. 133 – 141.

a major physical injury and the associated trauma. The VPI model was based on a similar intervention with victims of intentional violence in the trauma unit at Barnes-Jewish Hospital in St. Louis, MO in which hospital chaplains assessed violently injured youth and linked them with services, including Big Brothers Big Sisters mentors, in the community. In Philadelphia, VPI initially sent chaplains to follow up with *victims of intentional violence* in their communities, but soon ran into problems. Since the chaplains lacked sufficient “street smarts” to navigate safely in these communities, they replaced face-to-face follow up with phone calls. This soon proved ineffective. VPI adjusted its program design further, forming a partnership with the Philadelphia Anti-Violence/Anti-Drug Network (PAAN) to provide trained “street smart” workers to do follow-up. Eventually, VPI added Community Transitional Mentors from Big Brothers Big Sisters to enhance the community-based follow up work.

Needs/Strengths and risk assessments

The instruments that are used by National Network programs to assess needs/strengths that form the basis of ongoing intervention services share many common constructs. Many are based on research that identified three indicators that significantly predict violence-related re-injury among violently injured youth:⁵⁰

1. School enrollment status;
2. Illicit drug use; and
3. History of fighting.

Youth at low risk for re-injury reported attending school and not using illicit drugs or fighting. Moderate risk youth, while in school, reported drug use or a history of fighting. Youth at high risk reported either failing in school or not attending as well as illicit drug use and fighting. Some assessment instruments also screen for stress reaction, depression, and anger expression and attitude to emotional expression.

Risk Assessment Case Study 1: The Violence Intervention Program (VIP) in Baltimore, Maryland assesses risk of re-injury, stress reaction,

50. Robert Sege, Peter Stringham, Sonja Short, John Griffith. *Ten years after: examination of adolescent screening questions that predict future violence-related injury*. Journal of Adolescent Health - June 1999 (Vol. 24, Issue 6, Pages 395-402)

depression, and anger expression and attitude to emotional expression in the 18-page program enrollment form that is administered by a social worker, academic associate, VIP staff member, or other interviewer after a patient has consented to participate in the program.

Risk Assessment Case Study 2: Project UJIMA in Milwaukee’s Children’s Hospital of Wisconsin administers a battery of assessments that include the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) and the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1998) to screen patients ages 6 to 16.

Service duration and dosage considerations

Programs vary the length of time each patient receives services (duration) and the intensity of services (dosage) on a case-by-case basis. The initial risk and needs assessment gives the service provider much of the information they need to know to determine what services the patient needs immediately and over time. Also, programs that develop a violence intervention plan with each patient and coordinate implementation of the plan, usually adjust the duration and dosage of services over time as the patient completes each step or new information is gathered. According to the program design, services can be provided by the program itself or through referral to other providers.

There is no research comparing the effectiveness of short-term and long-term intervention services or comparing different service intensities. Some programs assume that patients with more risk factors for violence may require more intensive resources. However, there is currently no science to determine if brief intervention, for example, produces fewer reports of re-injury than longer-term case management. We also do not know if one approach is more appropriate than another based on the extent of a patient’s needs and strengths.

Defining the tiers of service reflects an assumption that young patients will vary in the service dosage and duration of services needed as they heal from their physical and psychological injuries. The following is an example of three service tiers:

High service dosage & duration of service: Patients at high risk of re-injury and retaliation may require the most intensive services a program

Programs that develop a violence intervention plan with each patient and coordinate implementation of the plan, usually adjust the duration and dosage of services over time as the patient completes each step or new information is gathered.

There is currently no science to determine if brief intervention, for example, produces fewer reports of re-injury than longer-term case management. We also do not know if one approach is more appropriate than another based on the extent of a patient's needs and strengths.

can offer and staff usually work with them most intensively and for a longer period of time than those at lower risk.

Moderate service dosage & duration of service:

Patients at low to medium risk for re-injury or retaliation but with substantial needs for a variety of services such as mental health counseling and educational advocacy may require services over a 3–6 month period.

Low service dosage & duration of service:

Patients at lowest risk of re-injury or retaliation may not require ongoing intensive services, but in light of the risk that even one violent injury has for predicting future violence in youth lives they

should be provided with prevention services, aided in linkage to community resources and receive clear guidance about where they can turn for aid if violence becomes a more critical part of their life, ideally within 24-hours of the injury. Some ED, clinic, or hospital programs may focus on this less severe patient with the goal of preventing progression or trajectory to more risk factors development.

Usually as the client moves through the system, his/her service needs will change, resulting in movement to a lower service tier.

Internal and External Service Options

Determining which services a program provides internally and which client needs require referral to other providers is affected by the characteristics of the focus population, the range and quality of services available in the broader community, and the capacity of the program to fill service gaps.

All National Network programs internally provide the following services:

- Crisis intervention
- Needs/strengths assessment
- Case management
- Referral to other providers.

Since peer support is an important social mechanism for clients, a program may establish opportunities for bonding as a group, such as bringing clients together on a regular basis for discussion of specific topics and “coaching.”

Case Study on Internal Services: Project Ujima in Milwaukee, Wisconsin, offers youth and family development activities as part of services for families.⁵¹ These activities include:

- Male and female adolescent mentoring support groups
- Summer day camp
- Youth Leadership Council
- Co-ed Trauma groups
- “Mom’s Night Out” events
- Annual family events such as Back to School Picnic, Thanksgiving Dinner, and Pancake Breakfast with Santa

Also, opportunities to remain involved in the program post-graduation can be therapeutic for former clients.

Case Study on Internal Services: Project Ujima in Milwaukee, Wisconsin, with a strong youth development model has established several mechanisms for graduate involvement, including:

- A youth advisory group to help new clients, provide input on services, and promote the program;
- A summer camp for current clients where graduates work as counselor mentors; and
- Field trips where current clients and graduates can *hang out* socially.

Project Ujima uses a client bulletin board to mark important events in clients’ lives, such as pictures of their children, snapshots from events, and certificates of achievement. This offers a visual display of clients and their progress that is viewed not only by the program participants but also by hospital staff, providing an opportunity for them to see the clients in a positive light.

51. WISN Channel 12, a local media station, filmed Project Ujima staff and participants over the summer of 2007. Visit the [WISN Channel 12](#) website to view the video.

Case Study on Using Photography in Intervention Services: The Violence Intervention Program (VIP) in Baltimore, Maryland, early in its development, wanted to create an environment in which participants felt, in the words of VIP clinician Melissa Cole, “empowered, inspired, like they belonged, supported, and legitimized. We realized our clients are marginalized in society.” She explained marginalization as follows: “We appreciated the fact that they go through life feeling disrespected, rejected,

minimized, jaded, and mocked. Most live transient lives, moving from one home to another or from one institution to another. Many have multiple adult partners and children for whom they care and with whom they live on occasion. We recognized the main way participants had tangible memories was through tattoos. We saw that the majority did not have any family pictures to help them tell their stories. I also knew that morale would be hard to maintain among staff and students and it would be hard to stay focused on positive accomplishments as a team over time without the help of visual aids.”

Project Ujima uses a client bulletin board to mark important events in clients’ lives, such as pictures of their children, snapshots from events, and certificates of achievement. This offers a visual display of clients and their progress that is viewed not only by the program participants but also by hospital staff, providing an opportunity for them to see the clients in a positive light.

In order to address all of these things, Melissa Cole assumed the role of team photographer. She introduced the idea of taking pictures at times of significant accomplishment, such as when a client earned his or her G.E.D., completed probation, landed a job, or reached another personal

milestone. She would take pictures during ordinary moments, e.g. their baby’s mother in front of their shared dwelling or weekly peer support group sessions. Photos covered an office bulletin board and copies were always given to clients as soon as possible after the event. Soon clients began expecting the photos, looking for them on the bulletin board, talking about them, and then requesting them more and more often. Eventually, they started asking for multiple copies to send to friends and family.

Over the years, individual and group photos served unique clinical purposes for each program participant. They began representing milestones; serving as transitional objects; eliciting memories; sparking imagination or unleashing emotion; and symbolizing growth and identity. The photos helped participants take ownership of the office space, making it a safe place for them to do the clinical work and a comfortable place to bring their

family and friends. The photos offered a natural focus point to start talking with their kids about taboo subjects such as getting into fights or going to jail, as well as a means of being able to interact with them in different ways than they were used to. After a while, the photos took on a life of their own. Clients took pride in being on the bulletin board; they asked about clients in other photos; and they pressed others without recent photos. Clients were also able to process the departure of former interns by pointing them out in the photos and sharing memories of them with other participants or with staff/students.

Melissa Cole made collages of events that lead staff had participated in and hung them around the office as a means of inspiring staff and clients. She also made collages from photos of VIP's peer support groups and collages out of artwork that VIP program participants had made. Subsequently many participants contributed their own artistic creations that now adorn the VIP office space.

The role of law enforcement with hospital-based violence intervention programs varies across the country. Since many clients have histories of involvement in the criminal or juvenile justice system, programs maintain positive relationships with law enforcement agencies, e.g. police, probation, and parole. Most programs maintain a cordial, but distant relationship; others work in partnership. For example, the Violence Intervention Program (VIP) in Baltimore, Maryland, assigns all the VIP clients on probation to a single probation officer so they can work together more effectively to help clients stay safe and finish probation.⁵²

Determining how to handle referrals to other providers, e.g. how to make sure that injured youth and/or others being served actually connect with services, is a very important step in developing a program. Key to establishing the referral protocol is to understand (1) what services each resource provides including dosage and duration, (2) who they serve including age range, gender, ethnicity, if relevant, primary language,



Alicia Romero (Sacramento VIP),
Charles Mack (CeaseFire, Chicago)

52. Email communication with Anne Marks, 5/18/11.

immigration status, and probation status, and (3) how services are paid for, which can affect eligibility. It is also important to know how to determine which clients need “active referral,” or hands on assistance, with the process of connecting and staying with a service.

Linking to external services: protocols

The protocols for linking to services define how the staff member, who initially identifies a patient for services, transfers the information gathered initially to a staff member who provides the direct services. In many violence intervention programs, direct service staff maintain a database of community resources that can address specific

client needs and strengths. This list of resources is usually developed over time and refined as direct service staff learn which services work for which clients.

The actual process of linking clients to additional services as part of the violence intervention program ranges from encouraging clients to link to the services themselves to actually taking the client to an initial appointment and even subsequent ones. For example, Intervention Specialists from the Caught in the Crossfire program in Oakland, California often accompany a youth and/or family member to their first appointment(s) with a mental health counselor and periodically confer with counselors to ensure that they know all the information they need to know to best treat the

client. This procedure helps to overcome the reluctance of clients to utilize mental health services.

Since no hospital or community-based agency working with violently injured youth can provide *all* that a young person needs to heal, identifying an array of potential providers and establishing strong working relationships with them is essential to producing lasting positive outcomes. It is also important to develop relationships with individuals representing other systems such as schools, the juvenile and criminal justice systems, Medicare, local Victims of Crime support, and immigration enforcement. Many clients are already involved with these systems and hospital-based intervention service staff can help clients navigate these complicated systems if the staff are knowledgeable about the systems and, ideally, can call on a trusted contact within them to help resolve client-related issues.

Since no hospital or community-based agency working with violently injured youth can provide *all* that a young person needs to heal, identifying an array of potential providers and establishing strong working relationships with them is essential to producing lasting positive outcomes.

Some commonly used outside resources include:

- Job training and placement,
- Mental health and substance abuse counseling,
- GED preparation,
- School administration offices to help younger patients enroll in an academic program that works for them,
- Legal advocacy,
- Tattoo removal,
- Housing assistance, and
- Victim of Crime compensation.

Most hospital-based intervention programs develop and maintain a database of services, updating the database as they gain more experience with these services and the focus population. Most programs develop relationships with outside agencies before they are needed, assessing their stability and competence. For example, the San Francisco Wraparound Project's community resource list, available online, arranges resources under the following headings:

- **Umbrella Organizations**

Example: Mission Neighborhood Centers, Inc. - Works to improve the quality of life in the greater Mission Community of San Francisco by providing culturally sensitive human services that both support and empower individuals and families

- **Vocational Training and Employment Resources**

Example: Goodwill - "Create solutions to poverty through the businesses we operate"

- **Law Enforcement Services**

Example: Victims of Crime Compensation Program

- **High School Equivalency/General Education**

Example: GED Testing (City College) - Listing of five sites where testing occurs.

- **Mental Health/Anger Management and Family Services**

Example: San Francisco Critical Incidence Response Team - provides first-response counseling to victims and witnesses of violent crimes and their families. In addition, therapists provide long-term individual and family therapy. The team effectively collaborates with community-based organizations in order to effectively reach those who need services.

- **After-School and Social Services**

Example: Peacekeepers - Mentorship program for at-risk youth.

The *Caught in the Crossfire* violence intervention program in Oakland, California organizes information in its *Resource Guide* as follows:

East Bay Conservation Corps

Contact: 1021 3rd Street
Oakland, CA 94607
Ph: (510) 992-7800
Contact Person: Joanna Lennon, Executive Director

Service Description: The EBCC is an educational organization promoting youth development through environmental stewardship, community service, education reform and social change. They link academic learning with service that meets community needs. EBCC offers programs focusing on youth development and education through service-learning and civic engagement. EBCC's flagship program, the Corps-member Program, offers youth ages 17 to 24 education through service-learning programs that focus on environmental stewardship and community service. Project YES (Youth Engaged in Service), provides school-based teacher training, classroom, after school, weekend, and summer service learning programming. Ameri-Corps Literacy Initiative provides one-on-one literacy tutoring in-class and after school.

Fees: None

Eligibility: Requirements vary with program. EBCC's programs serve youth, ages 5-24.

Enrollment Process: Varies according to program.

In Philadelphia, violence intervention services often make use of resources found through the **Philadelphia Collaborative Violence Prevention Center** website.

Many Network programs establish a contact person at each agency so that there is an individual with whom to work and exchange information. Furthermore,

program staff visit these agencies periodically to continually assess quality and appropriateness to clients.

After referring a violently injured youth to an outside agency, program staff follow-up with providers to make sure the referral has worked. In cases where a violently injured youth appears unable to connect with an outside agency, program staff may provide transportation to the first few appointments until the client is able to manage keeping their own appointments. In order to assess client readiness to manage making and keeping appointments, one program offered the conceptual frame of “functional independence measures,” commonly used in rehabilitation practice. Establishing relative independence for clients can be used to quantify client progress.

Working with service benchmarks

Most National Network programs use service benchmarks to mark patients’ progress. The medical director from one program said that even “getting the client out of the house for the first time after an event might be an important benchmark.”

Benchmarks used during the early stages of care usually include the following:

- Receiving injury follow-up medical care,
- Obtaining Victims of Crime financial support,
- Getting medical bills paid,
- Securing safe housing, and
- For younger patients, getting back into school.

During the later stages of care, benchmarks may include the following:

- Improving school performance or getting a G.E.D.,
- Enrolling in and completing job training,
- Enrolling in a substance abuse and/or mental health treatment program, and
- Building a sustainable support network.

Chapter VII resources

Resource A:

Visit the [Wraparound Project – San Francisco General Hospital](#) website to view their list of services and risk reduction resources.

VIII. Making Informed Direct Service Staff Hiring Decisions

Chapter VIII Roadmap:

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Chapter VIII Objectives

- User understands how to find, select, and prepare new direct service staff.
- User understands the challenges of finding staff who can work in both hospital and community settings.

Though all staff hiring decisions are important in creating a productive workforce, particular attention should be paid to the hiring of direct service staff since they have the most interaction with and influence on clients the program serves.

The program's "organizational home" is also an important consideration. In violence intervention programs that are operated by a hospital, the staff are hospital employees. This facilitates access to patient information. It also reflects a higher level of commitment by the hospital to the service than if the "organizational home" is a local nonprofit or community-based program other than the hospital or is a local university. Every "organizational home" defines characteristics and qualities of those they can

and cannot hire. For example, some institutions cannot hire people who have been convicted of a felony, whereas other institutions do not have that barrier to employment.

Who are the direct service staff?

In hospital-based or hospital-linked violence intervention programs, **direct service or line staff** are called case managers, peer counselors, outreach staff, violence interrupters, or intervention specialists. They may be paraprofessionals who can quickly develop and sustain trusting relationships with violently injured patients and their family members and friends. Most grew up in the same or similar communities as those communities served by the programs and bring to their work a solid understanding of street culture.

This reflects the public health approach to violence preventing that underlies hospital-based or –linked violence intervention programs. It adds a valuable dimension to promoting public health. Health care providers (doctors, nurses, etc) focus primarily on healing the physical wounds; outreach workers or peer counselors primary focus on healing the psychosocial wounds. Engaging paraprofessionals as health outreach workers or peer counselors was originally developed to encourage sex workers to use condoms. Most sex workers had little or no contact with professional health care providers and, when they did, rarely followed their advice on condom use because “they just didn’t understand the sex business.” By hiring, training, and supporting sex workers to convey crucial health information, public health systems found that the effort produced far better outcomes; sex workers shared common experience and ways of communicating with those they were trying to reach and they were able to function as role models, demonstrating that sex workers who regularly used condoms did not damage their business. Another example of this approach that developed was training and supporting high school students to provide information to other teens about safe sex practices.

As previously described, a Philadelphia-based program that is no longer operating initially sent hospital chaplains to follow up with *victims of intentional violence* in their communities, but soon ran into problems. Since the chaplains lacked sufficient “street smarts” to navigate safely in these communities, they began calling clients rather than meeting face-to-face. This did not work. So the program formed a partnership with the Philadelphia Anti-Violence/Anti-Drug Network (PAAN) to provide trained “street smart” workers to do follow-up. Eventually, they added Community Transitional Mentors from Big Brothers Big Sisters to enhance the community-based follow up work.⁵³ This produced far better outcomes.

53. For a good description of this approach, see Robert D. Ketterlinus, Ed., (2008) *Youth Violence: Interventions for Health Care Providers*, American Public Health Association Press, Washington, DC. pp. 133 – 141.

Finding job applicants

Finding job applicants with the qualifications needed to be effective case managers or intervention specialists for the focus population requires creativity, getting the word out through a variety of channels such as religious institutions, the local Workforce Investment Board, community colleges, and community-based nonprofits. Most National Network programs have found that word-of-mouth “advertising” works best. This means going to all the key stakeholders in the high violence areas that are in or adjacent to where most clients live to explain what type or types of applicants are needed.

One program posts job announcements in small local papers (distribution of 10,000 or less), health fairs, church bulletins, and online sites, if appropriate.

Developing a job announcement that accurately reflects the most important skills or qualifications required for each position is essential. Youth ALIVE!, the Oakland, California agency that operates the first hospital-based violence intervention program in the country, reported discovering surprises when they recently updated their job descriptions. When they reviewed the required skills and qualifications and assessed their importance based on years of experience, they found that education and case management experience were relatively less important, whereas passion, commitment, and flexibility were essential.⁵⁴ (Examples of job descriptions can be found in the resource section at the end of this chapter.)

Setting a competitive salary range and good benefits for the position helps to draw in the best candidates. Contacting other community-based agencies in the area is a good way to research salary ranges for case manager positions with similar qualification requirements. In one Network program (Oakland, California) salaries range from \$37,000 to \$43,000. In another (Cincinnati, Ohio) salaries range from \$30,000 to \$40,000.

In addition to salary, advertised benefits may include the following:

- Health benefits (physical, mental health, and dental)
- Training stipends – professional development
- Cell phones
- Mileage reimbursement, if personal vehicle is used for work

Health care providers (doctors, nurses, etc) focus primarily on healing the physical wounds; outreach workers or peer counselors primary focus on healing the psychosocial wounds.

54. Email communication with Anne Marks, Executive Director of Youth ALIVE! on 5/11/11.

Selection process

As part of the selection process, it is important to consider the demographics of the focus population to ensure that **staff demographics** reflect the focus population's age, race/ ethnicity, language skills, and gender as much as possible. One National Network program gives priority to hiring direct service staff who are at least 3 years



Anne Marks (Youth ALIVE!/Caught in the Crossfire, Oakland), Thea James, M.D. (Massachusetts Violence Intervention Advocacy Program)

older than the oldest patient they serve; they set no maximum age. Direct service staff who are close in age to clients are often better able to guide them while also being able to relate well, though this varies based on whether a client relates best to a peer or a parental figure. This often varies by where the client may be in the process of change. Also, since the risk factors for violence among older people such as patients' family members in their 40s and 50s are different than those for youth, staff members need to be familiar with assets and risk factors for older adults.

Another important consideration in selecting direct service staff is to make sure that they have **matured sufficiently**, especially if they have prior substance abuse issues and/or gang involvement and/or contact with the juvenile or criminal

justice systems. Those who are not sufficiently mature are highly vulnerable to relapse under the challenges of providing violence intervention services. As one administrator noted, "It is important that the staff members have their lives organized, are not 'players', and are dedicated to the cause."⁵⁵ Another emphasized that it is "important to hire local staff from the community, but it is not necessary for them to have had the violence or street experience of the clients in order to be very good at their job and for clients to trust and relate to them. They need to be culturally sensitive and have very good people skills. Some of our best staff are great people, people easy to talk to, develop instant rapport with young men, and have never had the life they have. In the same way, some of our best staff are not of the same ethnicity of the client, but perhaps they did grow up there on the street.

55. Joel Fein, M.D. in communication 8/29/10.

So [keeping] an open mind and eye to really good people skills, street smarts, and cultural sensitivity is mandatory. Prior history of violence I would say is not mandatory and is less important than maturity, ethnicity and gender and the other traits. And we have had problems with hiring people who were not as far out of street life as they say they may be. The therapy literature on case management supports this.”⁵⁶

During the interview process, interviewers can mention that substance use, current involvement in risky activity, and other behaviors that indicate “insufficient maturity” is problematic. According to Dr. Thea James of the Violence Intervention Advocacy Program in Boston, Massachusetts, raising this during the interview stage can be a powerful tool for interviewers and interviewees. It gives interviewees the opportunity to reflect and to de-select themselves and gives interviewers the opportunity to provide crucial information and to observe an interviewee’s response.⁵⁷

Including one or more current direct service staff members on the **interview team** in the experience of National Network programs enhances the candidate interview. Most programs have found that body language and overall demeanor during the interview can say a lot. One seasoned National Network program manager says she can tell whether someone is right for the position within 5 minutes of completing the interview. Other factors include how long it takes an applicant to return a call and how well information in their application matches that provided by references.

Caught in the Crossfire in Oakland, California often includes role playing exercises as part of the selection process for staff that are going to be working directly with participants.⁵⁸ This helps the interview team see how a potential staff member is likely to act under specific circumstances such as calming a frightened and angry parent or friend of an injured patient.

Those who are not sufficiently mature are highly vulnerable to relapse under the challenges of providing violence intervention services. As one administrator noted, “It is important that the staff members have their lives organized, are not ‘players’, and are dedicated to the cause.”

56. Rebecca Cunningham, M.D. in communication 9/3/10.

57. Thea James, M.D. in email communication 5/15/11.

58. Email communication with Kyndra Simmons on 5/11/11.



Elizabeth Duggan and Jumaane Kendrick (Massachusetts Violence Intervention Advocacy Program)

Staff selection criteria

Selection criteria for these direct service staff reflect each program's commitment to providing culturally competent care or a "means of addressing interpersonal and institutional sources of racial [and ethnic] disparities in health care."⁵⁹ Since hospital-based violence intervention is designed to seize the opportunities of the "teachable moment" when a patient is grappling with the trauma of serious injury, **ensuring that direct service staff can quickly bridge the cultural gaps** that persist between most patients and medical institutions is essential. However, for many reasons, including language and cultural barriers, small subpopulations may need to be "outsourced" to another agency, with which the program can establish a relationship.

National Network programs usually develop criteria in the following areas to help select staff. However, the specific criteria vary based on factors such as the

59. Visit the U.S. Department of Health and Human Services' [Health Resources and Services Administration](#) website for helpful references addressing cultural competency.

program's theoretical approach, the characteristics of a specific community, or the hospital's and the program's cultures. All relate to producing the most positive program outcomes possible. The main criteria are as follows:

Age: Can vary. Programs, however, ideally need both peer role models and parental figures to best address the range of client needs. Another dimension to consider here is that younger direct service staff generally require more training and ongoing support than more mature staff, though level of maturity is not always measured by years.

Gender: Many National Network programs are not specific in this area. Standard cultural competency criteria assume that the ratio of male and female staff should reflect the gender ratio of the focus population. However, some programs have found that gender diversity is important not to mirror the gender ratio of the focus population, but to ensure that staff can respond best to client needs. For example, CeaseFire in Chicago found that both male and female clients focusing on addressing highly personal and emotional issues usually responded best to female outreach workers, whereas both male and female clients focusing on addressing more *nuts and bolts* issues tended to do better with male outreach workers.

Ethnicity & language skills: If possible, the staff should mirror the racial/ ethnic diversity and languages of the focus population.

Life experience: Staff should be able to bring to their work a solid understanding of street culture, but in a way that clients are comfortable with. They should bring *street cred* or the capacity — based on experience, communication style, and demeanor — to quickly inspire respect. For example, though a former police officer might understand street culture well, clients generally distrust police. Building trust between a former police officer and patient is likely to take an inordinate amount of time. Another factor to consider here is that direct service workers who were involved in the negative aspects of street culture should have left that behind at least several years in the past to minimize the possibility of relapse.⁶⁰

60. To make sure that staff understand the seriousness of relapse, the CeaseFire program in Chicago augments its training and staff support efforts with drug/alcohol testing when needed. Staff agree to be tested when they accept employment with the program.

Preparing newly hired staff

After selecting and hiring a new direct service staff member, National Network programs have found that they must follow several steps. These are:

- **Setting clear expectations** from the start about what doing the job entails;
- Establishing a **probationary period** and ensuring the staff member understands what it means and that it includes a formal evaluation at the end of the period;
- Identifying **skills that need to be developed** and making sure that sufficient training is provided to develop them;
- Conducting **orientation training** (this is discussed in Chapter IX)

As a program hires a strong direct service team, the next step is to strengthen that staff to ensure the most productive work environment possible. This is discussed in the following chapter and includes self-care and other strategies for reducing burnout as well as strategies to protect safety of staff.

Chapter VIII resources

JOB DESCRIPTION EXAMPLE 1: CHILDREN’S HEALTH SYSTEM JOB DESCRIPTION

Job Title: Project UJIMA - Community Liaison	Job Code: 227100	OSHA II
Department: Emergency Services	Salary Plan: CHW	Orig. Date: 10/96
Immediate Supervisor: Program Manager Project Ujima	Cost Center: 7763	Last Revised: 8/2004
Division: Patient Care Services	FLSA: Exempt	

GENERAL SUMMARY:

Links Project UJIMA clients to ongoing violence intervention and prevention services. Responding to the EDTC when a youth is violently injured, provides crisis intervention, comfort and education about the emotional consequences following violent injury. Schedules and conducts home visit(s) and provides ongoing case management in

collaboration with the mental health and medical team, particularly accountable for helping youth establish linkages to appropriate youth development activities. Works as part of the Project UJIMA team in ongoing program improvements and tracking project outcomes.

ESSENTIAL FUNCTIONS:

- Demonstrates behaviors outlined in the Core Competencies the Blue Kids Way to provide service excellence as a committed partner to children, families and co-workers.
- Responds promptly to EDTC pages, works with Peer Liaison to immediately provide client comfort, crisis support and education following violent injury. Visits daily if admitted. Keeps Peer Liaison involved and informed.
- Works closely with EDTC staff and all social workers to obtain consent for release information and to assess victim/family needs and establish appropriate plan of care, including home visits.
- Completes follow-up calls to all clients within 48 hours of event (or discharge) to reinforce the plan of care. Prepares for home visit, including identifying significant issues.
- In collaboration with Nurse and Mental Health Provider, conducts home visit to develop an individualized plan and goals to address social, recreational, educational, and personal development needs.
- Consults and works closely with Project Staff, particularly the community-based staff, to identify the best programmatic options and community resources for youth and family. Makes the appropriate referral to community-based services/programs. Accompanies youth on initial visits to new programs, services or centers. Assures that the youth is oriented and successfully integrated.
- Works with staff from the youth's school to identify academic strengths/deficits. Develops a collaborative plan to support the youth's progress.
- Maintains ongoing contact with youth and family until identified goals are met. Identifies new issues and evaluates progress toward goals.

- Modifies plan as needed and prepares family for discharge from program.
- Facilitates youth in achieving goals. Works with youth/family to address significant barriers to follow-up plan. Functions as case manager. Conducts monthly family meetings in collaboration with Project UJIMA team in order to evaluate and document progress toward goals and effectiveness of youth/family development plan.
- Compiles monthly progress report on each client and submits to designated project staff. Participates in weekly case conferences and monthly Project Steering Committee meetings and is active in the quality improvement process.
- Maintains an open line of communication with Project Coordinator, Manager, Director of Emergency Services and Medical Director of Project regarding progress of clients, issues, or deficits in the available services required by clients.
- Participates in the development, implementation, analysis and dissemination of findings for the Program

MINIMUM KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:

- Knowledge usually acquired through Associates Degree in related field or acceptable experience in violence intervention and prevention. Bachelors Degree in social sciences preferred.
- Professional demeanor and excellent communication skills, written and verbal, to relate to people of varying socioeconomic class with differing lifestyles or cultural values and to interact with community based service organization professionals. Bilingual skills preferred.
- Two years work experience with youth-serving programs, particularly adolescent work experience, and familiarity with community programs and services available in Southeastern Wisconsin.
- Working knowledge with crisis interventions strategies.
- Strong time management and organizational skills to maintain project tracking activities and manage multiple priorities.
- Strong analytical ability to assess various crisis situations and recommend appropriate plan of care.

- Ability to work independently with limited supervision.
- Requires personal computer and word processing knowledge in order to enter and retrieve related information for effective reporting and correspondence.
- Bilingual ability (Spanish/English) both verbal and written preferred

WORKING CONDITIONS:

- Must maintain a flexible schedule to meet requirements of caseload.
- Travel throughout greater Milwaukee area for home visits and community based organizations.
- Normal office environment where there is no reasonable potential for exposure to blood or other high risk body fluids.

JOB DESCRIPTION EXAMPLE 2: CHILDREN'S HEALTH SYSTEM JOB DESCRIPTION

Job Title: Project Ujima Youth Intervention Specialist	Job Code: 227340	OSHA II
Department: Surgical Services	Salary Plan: CHP/009	Orig. Date: 8/02
Immediate Supervisor: Project Ujima Program Manager	Cost Center:	Last Revised: 8/04
Division: Patient Care Services	FLSA: -Exempt	

GENERAL SUMMARY:

Provides supportive youth and family programs including support groups and youth development. Under the direction of the Medical Director and Project Manager of Project Ujima, works with Community Liaisons and partner agencies to provide youth and family support groups, recreational activities, youth development program and schedules transportation.

ESSENTIAL FUNCTIONS:

- Demonstrates behaviors outlined in the Core Competencies the Blue Kids Way to provide service excellence as a committed partner to children, families and co-workers.
- Serves as lead staff for youth development activities by assisting in the development and implementation of Project Ujima youth development programming including but not limited to youth development meetings, recreational activities, educational activities, retreats and picnic.
- Coordinates program activity schedule, including setting up meetings, scheduling speakers, and informing clients.
- Develops the youth development program goals for each year and works with Community Liaisons and Peer Liaisons to ensure program goals are met.
- Serves as lead contact person for PR for Project Ujima activities in partner newsletters
- Serves as lead staff for youth and parent support groups, coordinating the planning and implementation of those groups, arranging speakers, meeting space, curriculum and transportation as required to implement a successful program.
- Assists in recruiting, training and placing volunteers into the program activities.
- Identifies trends or issues that need to be brought to the attention of the Medical Director or Project Coordinator.
- Participates in the development, implementation, analysis and dissemination of findings for the Program.
- Attends appropriate project meetings, community meetings and in-services and educational opportunities.
- Performs other duties as assigned to support injury prevention.

MINIMUM KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:

- Knowledge usually acquired through Associates Degree in related field or acceptable experience in violence intervention, prevention and/or youth development programming.
- Ability to analyze and act to solve problems in the context of the goals of Project Ujima.
- Values diversity.
- Professional demeanor and excellent communication skills, written and verbal, to relate to people of varying socioeconomic class with differing lifestyles or cultural values and to interact with community based service organization professionals.
- Two years work or volunteer experience with youth-serving programs, particular young adolescent work experiences, and familiarity with community programs and services available in Southeastern Wisconsin.
- Strong time management and organizational skills to maintain project tracking, data collection and database activities and manage multiple priorities.
- Ability to work with others on a team.
- Computer skills in spreadsheets, word processing, database and graphics.
- Possess flexibility and adaptability to meet project needs.
- Ability to work independently with self-direction.

WORKING CONDITIONS:

- Work requires flexibility to accommodate fluctuating schedule (days, weekends, evenings,).
- Ability to travel to off-site locations (homes, clinics and other agencies) locations, which requires coordinating own transportation and adaptability to unpredictable work-space environments.
- Normal office environment where there is no reasonable potential for exposure to blood or other high risk body fluids.

**JOB DESCRIPTION EXAMPLE 3:
INTERVENTION SPECIALIST/CASE MANAGER
CAUGHT IN THE CROSSFIRE (A PROGRAM OF YOUTH ALIVE!)
JOB ANNOUNCEMENT**

Job Description:

This position is responsible for the provision of intensive case management and mentoring services provided by *Caught in the Crossfire*, a youth violence prevention/intervention program of Youth ALIVE! that provides peer-based bedside visits and intensive follow-up services to youth who have been hospitalized for violent injuries. Youth ALIVE! is a non-profit organization dedicated to preventing violence and generating youth leaders in California communities.

Job Responsibilities:

- Provide intensive case management, mentoring and advocacy to youth involved in violence (youth who are hospitalized for gunshot wounds and other forms of violent injuries);
- Provide support to family and friends of youth;
- Provide client referrals to community service providers;
- Maintain intensive follow-up contact with clients, family, friends and service providers through home visits and telephone contact;
- Document consistently and accurately in records all contacts with clients;
- Attend weekly staff meetings;
- Represent Youth ALIVE! to the media, public officials, community leaders, etc. on strategies to prevent gun violence and improve services to youth;
- Participate in violence prevention efforts with other providers as assigned;
- Facilitate youth support groups;
- Other responsibilities as assigned by supervisor.

Qualifications:

- Demonstrated commitment to working with youth (ages 14-24);

- Knowledge of urban youth issues, specifically youth violence;
- Demonstrated ability to work independently and as part of a team;
- Must have strong communication and organizational skills, and possess the ability to communicate effectively with staff members, clients, vendors and the public;
- Ability to work well with diverse populations;
- Punctual and extremely reliable;
- Highly organized and detail-oriented;
- Candidate must be computer literate;
- Must be able to present self and program in a professional manner;
- Flexibility to work some evenings & weekends;
- Ability to work in stressful situations;
- High School Diploma or GED required; B.A. or B.S. preferred;
- Must have reliable car and DMV clearance;
- Applicants with personal experience in overcoming violence/ violence-related injuries/ the criminal justice system are especially encouraged to apply.
- A minimum of 2-3 years experience working with at risk youth (ages 14- 24) is required. A minimum of 1 year case management experience is strongly preferred.
- Candidate must be fluent in English and Spanish

Salary and Benefits:

- Competitive salary (starting salary dependent upon experience). Full-time (40 hours per week) non-exempt position. Benefits include: Medical/ Dental/ Vision/ Vacation/ Sick Leave/ Retirement/ Educational Reimbursement

To Apply: Send cover letter and resume to: casemanager@youthalive.org

- No phone calls or visits please.
- Youth ALIVE! is an equal opportunity employer.

JOB DESCRIPTION EXAMPLE 4:**Violence Intervention Program (VIP):****JOB DESCRIPTION & JOB RESPONSIBILITIES: CASE MANAGER****Job Description**

The Violence Intervention Program Case Manager's role is to work closely with the rest of the multidisciplinary team to ensure that all program participants are receiving the services best suited to meet their needs. The case manager interfaces with the client, in the office and the community, on a regular basis to help him/her practice new skill sets while he/she pursues community referrals and personal goals. The case manager keeps the team informed and advocates for VIP participants across many systems. Additionally, the case manager strengthens the program model by participating in community events, task forces, research components of the intervention, and other supportive aspects of service delivery.

Background & Experience Required

Bachelors degree preferred in Sociology, Psychology, Social Work or related field plus one year of experience in clinical counseling and / or research. Background in substance abuse, traumatic stress and violence preferred.

Equivalent combination of education and experience may be considered.

Drug free / Sobriety is an essential component to this job

Criminal history is acceptable. Current criminal justice involvement is not acceptable.

While employed by VPP, the case manager will be encouraged by the VPP team to pursue his/her own professional growth. Discussions about what this means for each case manager will take place at the time of hire and during each performance review.

General Responsibilities

The primary responsibility of the case manager is to carry himself/herself in a professional manner. He/she needs to approach daily responsibilities according to best practice standards. He/she is obligated to use his/her clinical supervision sessions responsibly and to implement the concepts, techniques, and assignments discussed in supervision into daily work responsibilities.

Recruitment Responsibilities

Assist with active recruitment on the STC floors each week. Coordinate schedules & tasks with other team members. Review census. Visit patients. Discuss eligibility and patient status with VIP Clinical Director. Accept case assignments from VIP Clini-

cal Director. Check office voice mail & return recruitment related phone calls. Input computer documentation/ data as needed.

Follow the recruitment protocol for pre/post discharge & keep this documentation up to date. Communicate with the *VIP* team on the status of outreach efforts. Once consent is signed, administer Part I & Part II of the *VIP* questionnaire & complete other recruitment paperwork. Turn all of this paperwork in once it is done. For patients who are still in the STC after they sign consent, place a copy of the consent form in the patient chart at the nursing station & visit regularly to establish a working rapport

Ask questions and/or alert team members to any problems you see regarding recruitment

Case Management Responsibilities

Maintain an individual caseload of 10-25 clients.

This includes:

- Developing /reviewing service plans *at least* every two months
- Making *at least* one face to face contact/attempt every month
- Making referrals & accompanying clients to agencies
- Working with the *VIP* team regarding client goals
- Role modeling appropriate behavior & skill development in the office and in the community
- Maintaining professionalism in & out of the office
- Visiting clients in the community (i.e.: home, court, school, jail, etc...)
- Updating *VIP* team members on case developments
- Maintaining case file documentation as directed. This includes computer documentation.
- Discussing cases & case management in supervision (scheduled & ad hoc sessions)
- Completing assignments per supervision
- Observing the limits of confidentiality & privacy issues, adhering to best practice standards
- Notifying the *VIP* team of personal / public safety issues
- Nominating clients for “success story of the month” / Notifying the *VIP* team of client successes

Co-facilitate a weekly peer support group with another team member.

This includes:

- Designing the group / marketing the group
- Developing service plans & group rules
- Identifying topics for discussion
- Selecting & using activities for the group sessions
- Handling group logistics (place, time, setting, etc...)
- Involving volunteers
- Updating the *VIP* team on group developments
- Completing group related documentation

Program Development & Evaluation Responsibilities

Help maintain a Community Resource Manual by sharing new community resource information with the *VIP* team & assembling data in computer form or in hard copy format

Participate in community events as a *VIP* representative i.e. health fairs, task force mtgs, etc

Perform administrative duties as assigned re: writing grants; responding to requests and questions from individuals, institutions, government agencies, and the media; participating in the design /implementation of research; and the expansion or replication of the *VIP* model

Assist with the training and orientation of new employees / students
Role model *VIP* protocols

Assist with the annual Holiday Food & Gift Drives for *VIP* clients. Help collect, sort, & deliver the donations

**JOB DESCRIPTION EXAMPLE 5:
UNIVERSITY OF MD JOB CLASS SPECIFICATION:
COMMUNITY OUTREACH WORKER I**

Job Description

The Violence Prevention Program Community Outreach Worker is a vital member of the team. The outreach worker is on the front line everyday representing the program in the community and offering supportive services to individuals who have been victims of violence/violent crime. Each VIP participant is paired with an outreach worker who assists him/her with identifying personal goals, mapping out an action plan to reach those goals, and carrying out the necessary steps to achieving those tasks. The outreach worker / VPP client bond begins at the time of recruitment in the Shock Trauma Center and builds as the worker gains the trust of the client and his/her family. The outreach worker serves as a role model for the client, acts as an advocate on his/her behalf, and provides crisis intervention and/or conflict mediation when needed to help the client stay on track. The outreach worker also keeps the VPP team up to date on the client's status which ensures that the team is doing everything possible to support the client in reaching his/her goals. Additional roles for the outreach worker include bringing VPP clients together each week for peer support groups, talking to youth about his/her own life experiences re: judgment and risk taking behavior, and attending community meetings as a representative of the VPP.

Background & Experience Required

Life experience is the best experience for this position. A successful outreach worker will have the following qualities: a) self-knowledge, b) ability and willingness to follow directions, c) self-discipline, d) empathy, e) tolerance, f) interest in and willingness to learn, g) flexibility, h) writing and typing skills to keep case documentation, i) common sense judgment regarding personal and public safety issues, j) willingness to share case related information with team members, k) ability and willingness to maintain client privacy & respect professional boundaries, l) the capacity to be proactive rather than reactive, and m) organizational skills.

Minimum Qualifications: High School Diploma / GED / GED Equivalency required
Some college classes and/or certifications a plus

Conditions for Employment: State Drivers License Non-Commercial Class C
Use of personal automobile may be required for official business
Being Drug free / Sober
Criminal history is acceptable (depending on the circumstances)
Completion of work duties in the community and in the hospital

While employed by VPP, the outreach worker is expected to pursue his/her own professional growth. Discussions about what this means for each outreach worker will take place at the time of hire and during each performance review. VPP is willing to help each outreach worker enroll in college classes, vocational training, or other professional certification processes to advance skill development.

Required Knowledge / Skills / Abilities

The VPP outreach worker interfaces with all different kinds of people, in a variety of settings, during all kinds of emotional situations. This necessitates that the outreach worker possess a wide array of innate abilities, honed skills, and specific skill sets for successful interventions to take place.

- Communicates effectively orally and in writing; including writing reports, maintaining records, giving verbal case updates, and advocating for clients
- Establishes and maintains effective working relationships
- Operates computers and other office equipment
- Works in extreme weather conditions; perform extensive standing and walking
- Completes client visits in community jails, courts, homes, schools, other places as needed
- Handles sensitive and confidential matters with discretion and tact
- Interacts with the public, health care providers, community organizations, social service agencies, and other stakeholders
- Maintains poise and professional courtesy under pressure

General Responsibilities / Duties

Be professional: This means, but is not limited to:

- Being on time and prepared for meetings & supervision sessions
- Participating in team discussions & communicating regularly with staff
- Keeping timely documentation & submitting paperwork for review within timelines
- Keeping a clean & organized office space
- Advocating for his/her own needs as required

- Completing job duties as expected & observing program protocols
- Refraining from giving peers orders
- Using appropriate/acceptable language & tone of voice
- Following a set work schedule & keeping his/her supervisor informed of daily plans
- Balancing office & field hours responsibly
- Managing anger/stress in acceptable ways / maintaining a positive & constructive attitude
- Participating in performance reviews
- Keeping appropriate boundaries with clients & other staff
- Deferring to supervisor(s) / following authority
- Dressing appropriately for the job as discussed with your supervisor
- Completing other duties as they are assigned

Recruitment Responsibilities

Assist with the active recruitment of VPP clients This means, but is not limited to:

- Coordinating schedules & tasks with other team members
- Checking office voice mail & returning recruitment related phone calls
- Checking hospital databases and visiting eligible patients at the bedside
- Serving as a liaison by providing general information and answering questions

Follow the VPP recruitment protocol for pre/post discharge & keep this documentation up to date

- Communicating with team members on the status of outreach efforts.
- Obtaining informed consent and documenting this consent
- Administering Part I & Part II of the *VIP* questionnaire & documenting this paperwork
- Documenting all other related VPP paperwork filing documentation accordingly

Case Management Responsibilities

Maintain an individual caseload of at least 10-15 clients. This includes, but is not limited to:

- Developing /reviewing service plans at least every two months
- Making *at least* one face to face contact every month –in the office or in the community
- Making referrals & accompanying clients to agencies
- Working with the *VPP* team regarding client goals
- Role modeling appropriate behavior & skill development
- Maintaining professionalism in & out of the office
- Being accessible to clients in the evening / on weekends as needed
- Updating *VPP* team members on case developments
- Maintaining case file documentation as directed
- Discussing cases & case management in supervision
- Completing assignments re: clients per supervision
- Observing the limits of confidentiality & privacy issues
- Notifying the *VPP* team of personal / public safety issues
- Nominating clients for “success story of the month”
- Asking for clarification and/or assistance as needed

Co-facilitate a weekly peer support group This includes, but is not limited to:

- Designing the group / marketing the group
- Developing service plans & group rules
- Identifying topics for discussion
- Selecting & using activities for the group sessions
- Handling group logistics (place, time, setting, etc...)
- Involving volunteers
- Updating the *VPP* team on group developments
- Completing documentation

Program Development & Evaluation Responsibilities

Help maintain a Community Resource Manual

Sharing new community resource information with the VPP team

Participate in community events as a VPP representative

- i.e.) health fairs, focus groups, media requests, task force meetings, etc...

Put ideas on paper and submit these ideas to the VPP team for discussion

- i.e.) for improving outreach services

Assist with the annual Holiday Food & Gift Drives for VPP clients.

- Helping with the collection, sorting, & delivering of donations

Promoting Healthy Alternatives for Teens (PHAT) Responsibilities

Participate in meetings with the PHAT coordinator

- Planning upcoming events & related calendar items

Take part in PHAT events. This includes, but is not limited to:

- Identifying activities & topics for discussion
- Collaborating with other staff on plans for the events
- Completing select tasks for the PHAT STC tours
- Completing select tasks for the community groups
- Attending the PHAT events (hospital & community)
- Speaking to youth & facilitating group discussions
- Role modeling for the youth during the events
- Providing support to the youth at the events, as needed
- Sharing ideas on ways to improve PHAT services
- Listening to feedback & offering his/her opinions

IX. Supporting Direct Service Staff through Training and Supervision

Chapter IX Roadmap:

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- Encouraging cultural competence 107
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Chapter IX Objective

- User understands how to train, supervise, and support direct service staff.

Recognizing that work with violently injured youth and their family members and friends demands such extraordinary human relations, institutional navigation, day-to-day record keeping, and emotional self-care skills from direct service staff, hospital-based and hospital-linked programs have developed ways to train and supervise them to minimize staff turnover and improve client outcomes.

Employees in this field need tremendous support, both in terms of professional development and therapeutic supervision. Working with violently injured youth, particularly for staff members who have experienced violence in their own lives, can lead to significant emotional stress and sometimes burnout. This emotional stress is often called “vicarious trauma.” The federal **Office for Victims of Crime** on its website describes “vicarious trauma” symptoms as “similar to, but usually not as severe

Employees in this field need tremendous support, both in terms of professional development and therapeutic supervision. Working with violently injured youth, particularly for staff members who have experienced violence in their own lives, can lead to significant emotional stress and sometimes burnout. This emotional stress is often called “vicarious trauma.”

as, those of posttraumatic stress disorder, and can affect the lives and careers of even clergy with considerable training and experience in working with disaster and trauma survivors.”

Service plans, or self-evaluation tools, can be useful for staff professional development and ongoing supervisory support around cases. Other components such as job shadowing, new employee buddy systems, updated policies and procedures manuals, and case management manuals can reinforce training for new employees as well.

Training new staff

Training for new staff who work directly with patients typically includes initial orientation to the agency, the program, and the hospital. Hospital-linked program staff usually complete the hospital’s

volunteer training program. Thereafter programs provide opportunities for professional development and skills building.

During the first three months, new direct service staff at most hospital-based and hospital-linked programs receive training on hospital protocols, program-specific policies and procedures, confidentiality and privacy, ethics, case management, safety issues, trauma, stress disorders such as Post-Traumatic Stress Disorder (PTSD), self-care, victims’ compensation, substance abuse screening and intervention, mandated reporting, and cultural competency.

Staff Training Case Study 1: CeaseFire’s (Chicago, Illinois) initial training process includes:

- Ensuring that new staff understand the program goals and objectives so that they know, right from the start, the focus of every activity.
- Learning how to work in the physical space of the hospital. Since office space is non-existent, direct service staff work in and around the emergency department and trauma unit. This is a significant challenge for all programs.
- Integrating the team of hospital staff and outreach workers. At the medical center where CeaseFire provides services, CeaseFire outreach workers are considered part of the trauma team. This approach is grounded in the concept that the intervention services CeaseFire

provides are part of the trauma practice, not a separate program. (This concept ultimately helps support sustainability of the program over the long term. Sustainability is discussed in Chapter XII.)

Team building training involves key hospital workers including the hospital chaplains who screen and initially assess patients for CeaseFire services and CeaseFire staff. The training is comprised mostly of role-playing activities and observations. These team integration trainings are a regular part of ongoing staff training.

The two outreach workers who respond to the hospital patients complete the same 40-50 hour training as the other 140 field staff who work in other CeaseFire program areas. This is augmented with a 2-day training made up primarily of highly interactive role playing exercises that are unique to the hospital setting. [See the schedule of a 2-day training in the Resources section of this chapter.] Using highly interactive role-playing exercises is the best way that staff learn the skills and knowledge they need. CeaseFire also conducts booster trainings and encourages staff to attend conferences and secure certification in areas to build their skills. Many are also supported to take college classes to strengthen expand their knowledge in areas related to their work.

This commitment to training fosters a culture among the agency of self-improvement. It also helps outreach workers serve more fully as positive role models for clients; they not only verbally encourage clients to change their lives and build positive skills, but also model that behavior.⁶¹

Staff Training Case Study 2: Caught in the Crossfire's (Oakland, California) initial training process includes:

- Orientation to agency policy and procedures.
- Field training in which a seasoned Intervention Specialist takes the new staff to visit new and older clients at home or in the hospital. This step includes exposing new staff to the most difficult clients. As Kyn-dra Simmons, the Program Coordinator, explains, "If he or she is going to leave, we'd rather have them leave in the beginning."⁶² The agency uses this phase to gather feedback from the new staff to better understand how he or she would respond to different clients.
- Hospital trainings concerning safety and confidentiality and Child Protective Services trainings depending on the new staff member's experience with youth and families.

61. From communication with Sheila Regan of CeaseFire in mid-January 2010 and late May 2010.

62. Email communication with Kyn-dra Simmons, 5/11/11.

- Violence Prevention course (one semester) at the local community college. The agency pays for tuition and books and counts class time as work hours. Caught in the Crossfire used to require new staff to complete *Introduction to Counseling for Paraprofessionals* and *Introduction to Case Management for Paraprofessionals* community college courses during their first year of employment. However, due to budget cuts at the community colleges, this course is no longer available.

Additional training for new employees includes shadowing a more experienced case manager or outreach worker. Case managers typically do not transition from shadowing to managing their own caseload for 1-2 months.

Staff Training Case Study 3: Project Ujima (Milwaukee, Wisconsin) utilizes a coach mentoring component in training new staff or seasoned staff members that need additional training. The “coach,” a seasoned

Field training in which a seasoned Intervention Specialist takes the new staff to visit new and older clients at home or in the hospital. This step includes exposing new staff to the most difficult clients. As Kyndra Simmons, the Program Coordinator, explains, “If he or she is going to leave, we’d rather have them leave in the beginning.”

Project Ujima staff member, trains and mentors new staff members. Following a power point presentation, the coach explains all components necessary to be successful in the job. Then the coach reviews all forms staff must complete. These forms cover case management, home visitation, Project Ujima’s database, hospital patient systems, and monthly reports. In addition, the manager reviews this information with new staff and explains the policies and procedures of the organization.

The coach works alongside the staff member at the hospital, teaching the required processes. The coach also models the appropriate manner to conduct business at the hospital. When the new staff member is ready to start on-call responsibilities, the coach and the new staff member respond to the calls together. The new staff member interacts with families and observes the seasoned staff explain Project Ujima. This helps the new staff member gain insight about ways to deliver the program and develop their own style of work. Once the staff member is comfortable, the coach steps back, but continues to check in at least weekly with the new staff member for three months to give support and encouragement and assist with challenges that arise.

At times, seasoned staff need to review processes. In those cases, the coach works with the individual staff members as above.

Project Ujima's system has online education capabilities. They utilize online education for annual safety requirements, HIPAA training, and first aid/CPR training. Project Ujima also videotaped presentation about the Project and made it available online for new hires within and outside of the emergency department that are within the health system.

As a Department of Justice funded program, Project Ujima is able to utilize trainings offered by the Office of Crime Victims for program staff. Each year, Project staff complete trainings for crime victim compensation and victim services.

Staff Training Case Study 4: The Healing Hurt People program (Philadelphia, Pennsylvania), which operates within the Sanctuary Model's *trauma informed care* framework, applies the Model's seven commitments to every part of the program including staff training and supervision:⁶³

- Commitment to nonviolence: Development of safety skills
- Commitment to emotional intelligence: Development of emotional management skills
- Commitment to social learning: Development of cognitive skills
- Commitment to democracy: Development of social/political skills
- Commitment to open communication: Development of trust, of flexible but firm boundaries
- Commitment to social responsibility: Development of relationship skills
- Commitment to growth and change: Ability to cope positively with change

As a relatively new program, HHP is still developing training protocols, particularly in building interviewing skills, setting boundaries, preventing burnout, producing case notes,



Toni Rivera-Joachin (Project Ujima, Milwaukee)

and effectively managing time. Training currently focuses on teaching staff (both new and continuing) about the Trauma Informed Care framework that helps all participants (clients, staff, administrators) care for themselves and each other. HHP is exploring ways to enroll staff in continuing education at Drexel University with which HHP is affiliated. Key issues are keeping staff accountable as they work independently and helping them to be able to assure their supervisors and co-workers that they are being accountable.⁶³

Staff Training Case Study 5: The Violence Intervention Program (Baltimore, Maryland) follows no formal curricula as a part of their training. New staff complete a hospital human resources 3-day orientation. The VIP model for staff supervision supports professional development via weekly one-on-one supervision sessions, weekly team meetings, ad hoc peer support supervision, and continuing education classes on topics to

Key issues are keeping staff accountable as they work independently and helping them to be able to assure their supervisors and co-workers that they are being accountable.

support each staff person's area of need regarding job performance. The VIP model also has multiple tools in place to support staff in the clinical work they do (i.e. visual learning aids on crisis intervention, case documentation, conducting home visits, etc.) to support continuity and accountability. The VIP model calls for a clinical trainer to be on staff to work with the clinical supervisor to create need specific in-service training sessions. Outside specialists are also consulted whenever possible to bolster the professional development of all VIP

staff. The VIP model provides for keeping records of training methods, sessions, and general outcomes.⁶⁴

Staff supervision and support

Supervision and support of direct service staff in most of the National Network's participating programs is, in a sense, ongoing training.

Underlying supervision and support is the understanding that, since the majority of those who apply for staff positions are drawn to the work because they understand profoundly the need for violence intervention from their own life experiences, some program staff may experience similar challenges as the patients, e.g. drug/alcohol abuse relapse or PTSD or other stress-related symptoms. Therefore, they require a special type of support and supervision that is extremely different from the type that is typically provided in professional settings. As one National Network member

63. From conversation with Linda Rich of Healing Hurt People via phone late January 2010.

64. From communication with Melissa Cole of VIP via email, 1/15/10.

noted, “Nothing kills a good program faster than a supervisor who does traditional corporate supervision/management of the community workers.”

Since most direct service staff work “in the field,” they produce time sheets to account for hours spent on specific activities. In many National Network programs, direct service staff check with their supervisor via cell phone many times during each day to report developments and to ask for advice. This is also done to ensure staff safety; their supervisor knows where they were last, if they fail to check-in again. Also, direct service staff and their supervisor typically meet weekly to review all cases and monthly to review case documentation; this process supports accountability. Many programs also conduct regular case review sessions, as often as weekly, that include direct staff and supervisors and, in some cases, other key players such as a probation officer, school district representative, the hospital’s Community Injury Prevention Coordinator, or social worker. These sessions help direct service staff air concerns, learn problem-solving techniques, and discover new resources.

As one National Network member noted, “Nothing kills a good program faster than a supervisor who does traditional corporate supervision/management of the community workers.”

Some programs, such as Caught in the Crossfire in Oakland, California, make sure that direct service staff have time during the workweek to informally vent their frustrations and “re-fuel.” Staff may take a walk or just hang out with co-workers when they need to relax briefly.

Staff supervisors need to help direct service staff understand and maintain clear emotional and physical boundaries between themselves and their clients. Also, staff need clear, ongoing guidance about maintaining appropriate boundaries between themselves, especially in programs with male and female staff.

Periodic and frequent formal evaluation of direct service staff by their supervisors provides not only feedback on performance (every 3 months for the first year and every 6 months or annually thereafter), but also support for additional training that can improve skills and enhance performance.

Team morale is an issue when a staff member is not held accountable; there must be a balance between employee support/development and accountability to the program. Procedures for handling poor performance, violations, and other employee issues should be clearly defined and explained to employees. If intervention services staff are employees of the hospital, the hospital’s Human Resources Department guidelines and policies probably cover these employees. There may be additional policies specific to the program.

Building staff morale and camaraderie and trust between staff is essential. This may involve formal activities, such as staff retreats, as well as more informal activities, such as serving food at staff meetings and ensuring a regular supply of good coffee.

Also gathering feedback from staff to incorporate into program evaluations and other program improvement tools can help build their morale.

Building Staff Morale Case Study: For many years, Project Ujima, Milwaukee, Wisconsin, which was started in 1995, has organized an annual staff retreat. Project Ujima leadership believes that is necessary for staff to have a time away from work dedicated to self-care and team building. Each year, the Project Ujima team is away from the office for 2 days at a remote location out of the city, totally disconnected from work responsibilities. During the time away, the manager plans activities aimed at rejuvenation of the spirit, building morale, team building skills and strategic planning. A sample of past activities include: massage and relaxation techniques, “getting to know me” icebreakers and games, new staff-driven initiatives, and shared meals where the staff cook together.⁶⁶

Ongoing training

Ongoing training of participating program staff includes weekly staff meetings, in-services on topics such as PTSD, burnout, mandated reporting, sexual abuse, Victims of Crime procedures, book clubs, and outside conferences and symposia. Most National Network programs also provide diversity and cultural competency trainings that address issues related to not only the provider/client relationship, but also relationships between staff members. Gender issues and clarity about personal and professional boundaries are key to these trainings. Part of training and supervision for the intervention services staff should include small group support including exchange of ideas and feelings. This functions both as an emotional support experience and a learning collaboration among the case managers where they learn from each other.

Ongoing Training Case Study: CeaseFire, Chicago, Illinois, periodically conducts booster trainings that address specific deficits that are shared by many staff. CeaseFire can do this fairly readily because they have enough staff in their more than 20 program sites to make it financially and logistically feasible. One training they provide is in motivational interviewing skills, a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.⁶⁷ Many programs also encourage staff to pursue certifications through training (e.g. conflict mediation, substance abuse coun-

66. Email communication with Toni Rivera-Joachin and Marlene Melzer-Lange, M.D. on 5/12/11

67. Visit the [Motivational Learning](#) website for more information.

seling) and pay tuition and for materials. Workforce Investment Boards may offer funds for certification trainings.

Providing training for hospital staff, especially those that have most frequent contact with violently injured patients, can support the integration of direct intervention service staff and hospital staff. The Wraparound Project in San Francisco reported that when direct intervention service staff were part of the training team for training of hospital staff, the training process not only increasing the hospital staff's knowledge of the program's purpose and process, but also their appreciation of the direct service staff's skills and abilities. This strengthened their working relationship. Through these trainings, participants learn not only more about the details of each other's work, but also learn about them as individuals. This contributes ultimately to building a collegial working relationship.

A major incentive for hospital staff to attend these trainings is offering continuing education units (CEU). The criteria that certify that a training session or series can offer CEUs usually include preparing a formal replication guide and securing a clinical staff member's signature. These criteria vary from state-to-state and information about the criteria can usually be found at the online sites of each profession's governing board, e.g. the California Board of Registered Nursing.



Sandra Bloom (Healing Hurt People, Philadelphia) and Marla Becker (Caught in the Crossfire, Oakland)

Encouraging cultural competence

Programs encourage cultural competency in a variety of ways. For example, by hiring direct service staff from the same or similar communities as those communities

served by the programs and with a solid understanding of street culture, it becomes easier for case managers to develop and sustain trusting relationships with violently injured patients and their family members and friends. Another example is by having the intervention services direct service staff collaborate with hospital staff, many of whom are afraid of violently injured patients and their family members, to demonstrate ways of working effectively and safely with patients and their family members. Since most direct service staff are from similar backgrounds as patients and their family members, they serve as positive role models. A third example is to have direct service staff attend several initial sessions that patients have with mental health or employment counselors to ensure that these professionals fully understand the cultural issues that affect patients.

Chapter IX resources

RESOURCE A:

INITIAL TRAINING SCHEDULE EXAMPLE: The Chicago Project for Violence Prevention CeaseFire Hospital Response Training	
Introduction to the Emergency Department	Building Hospital Response Skills
Thursday, 10:00 a.m. - 12:00 p.m. Location: Hospital CeaseFire Staff + Chaplain/Social Work Staff 10 – 12 pm- Introduction to Hospital Response 10: 15 – 11:30 pm—Observation in the Emergency Department Thursday, 6 p.m. - 10:15 p.m. Location: CeaseFire Office CeaseFire Staff 6 – 7 pm—Welcome and Dinner 7 – 7:45 pm —Hospital Response Pre-Test 7:45 – 8:30 pm—Hospital Response Basics 8:30 – 8:45 pm Break 8:45 – 10 pm—Trauma and Crisis 10 – 10:15 pm—Wrap-up and Evaluation	Friday, 8:30 p.m. - 11:30 p.m. Location: Hospital CeaseFire Staff 8:30 – 11:30 pm—Intervention in the Emergency Department Friday, 3:00 pm – 11:30 pm Location: CeaseFire Office 3 – 3:15 pm—Recap, Debrief, Overview 3:15 – 5 pm—Grief 5 – 6 pm—Dinner 6 – 7:30 pm—Follow-up and Victim Assistance 7:30 –7:45 pm—Break 7:45 – 8:30 pm—Hospital Response Post-Test and Evaluation

RESOURCE B:

Self-Care Problem Statement –

[Draft produced by the National Network of Hospital-based Violence Intervention Program’s Workforce Development group 8/31/10]

Violence intervention program front-line staff and direct service providers come into contact with immense amounts of trauma. Common in peer intervention

work, staff members may be attracted to this line of work because of similar personal experiences and trauma. While their empathy is an asset to relationship development with clients, it also indicates potential psychological and emotional vulnerability to continued vicarious traumatization.

The Workforce Development Working Group of the National Network of Hospital-based Violence Intervention Programs recognizes the importance of addressing stress and trauma amongst violence prevention and intervention direct care providers. The group identified practices across sites that have explored and mitigated the impact of stress and vicarious trauma on the workforce, including addressing stress and trauma within supervision and encouraging peer support. However, those workers who have considerable stress reactions or develop post-traumatic stress disorder may have considerable challenges coping with these stress reactions within the work place. A stigma can be attached to the process for seeking treatment as well as the perception or reality that one's job may be in jeopardy if one is unable to perform due to stress.

Further exploration is needed to examine the scope of this issue and to address associated challenges, in order to best ensure that line staff are capable of coping with the trauma they are exposed to in a constructive way and are able to lead healthy personal lives. Some questions to consider include:

1. What is the effect of enduring stress on this population of workers?
2. How does this stress impact personal lives of direct care workers and what can be done to minimize negative effects?
3. Can workers recognize the elevated stress levels in themselves?
4. Is it possible to gauge existing stress/trauma levels during an interview process with prospective staff members?
5. How does elevated stress levels in workers affect their ability to be and feel safe in the work place? How can this be mitigated?
6. How does pre-morbid trauma compound trauma exposure occurring within the work itself?
7. How can colleagues and supervisors best respond to individuals experiencing heightened stress reactions while continuing to maintain appropriate boundaries?

X. Conducting Effective Program Evaluations

Chapter X Roadmap:

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Chapter X Objectives

- User understands why an evaluation of an intervention program is critical.
- User understands the various types of evaluation.

- User understands the steps involved in conducting a public health evaluation.

Why evaluate?

Evaluating hospital-based or hospital-linked violence intervention programs is essential. Ultimately, evaluations of these programs are crucial in sustaining them and advancing the field of violence prevention. They clarify how specific approaches prevent violence and expand the base of knowledge in the field, thereby improving the quality of future efforts to produce even better results.

- Well-crafted program evaluations are essential in determining what is producing desired outcomes and what is not so that programs can do a better job.

Ultimately, evaluations of these programs are crucial in sustaining them and advancing the field of violence prevention.

They clarify how specific approaches prevent violence and expand the base of knowledge in the field, thereby improving the quality of future efforts to produce even better results.

- Strong evaluation helps protect the integrity of the program and can be a powerful tool for program sustainability.

- The best evaluations engage program staff, volunteers, clients, and other major stakeholders in the design and implementation.

Existing National Network programs have used evaluations in a number of ways that include the following:

- Promoting their model of service delivery to funders, hospital administrators, and other stakeholders;
- Making changes in the program design; standardizing service provision; identifying and examining intermediate outcomes;

- Identifying areas for professional development of staff such as in-service trainings to build capacity;
- Determining new partners needed to strengthen the partnership and improve service outcomes;
- Presenting results to funders (e.g. hospital, foundations, government) and leveraging results to obtain, retain, or expand funding; and
- Estimating the cost of the program for cost-benefit analysis.

National Network programs that have conducted formative, process and/or outcome evaluations (See definitions of these three evaluation types below) have encountered challenges, all of which can be overcome. (See a list of three published evaluations in the Resources section below.) A major challenge is being able to gather information from clients after they have completed services.

Rebecca Cunningham, M.D. reports that, in a current research project, they achieved an 80% follow-up rate for violently injured youth (ages 14-24) treated in the Emergency Department. This is remarkable because this population is generally a transient one. She emphasizes that, though achieving a follow-up rate of 80% is expensive and time consuming, she and her colleagues have been able to reach this rate with very challenging populations over the past ten years.⁶⁸ A list of key literature addressing research methods to achieve high follow up rates is in the Resources section at the end of this chapter. Below are some examples:

Examples of Key Evaluation Challenges and Remedies

Possible Challenges	Remedies
<p>Balancing data collection with intervention work: Initially, line staff felt burdened by the greater than expected amount of time required to gather and record data, recruit participants for interviews, and transport them to and from interviews</p>	<p>The Program Director can schedule a series of staff trainings to engage staff in (1) learning about how the evaluation could help them do their work better and (2) figuring out ways of most efficiently integrating data collection into their day-to-day work, e.g. allocating data collection time as part of the workload.</p>
<p>Adhering to the evaluation design: Ensuring no cross-contamination when trying to conduct a case/control study, e.g. control group members receive services that should have only been available to the treatment group.</p>	<p>The Program Director can review with line staff the evaluation design and brainstorm & prioritize ways of eliminating cross-contamination. They can explore, for example, why a case control design is important and envision how, even though some clients may not receive services in the short term, positive results from the evaluation could expand the number of clients receiving services in the long term.</p>
<p>Maintaining contact with clients to enable gathering outcome data over time: Given the transient nature of the client population, maintaining contact can be a significant challenge.</p>	<p>Encouraging clients by providing incentives to notify the program when there is a change of address can help keep records current for needed follow-up. Offering a monetary stipend for completing follow-up interviews is another important tool to consider. Calling monthly to update contact information.</p>

68. Email communication from Rebecca Cunningham, M.D., to Naneen Karraker, 10/6/10.

Types of evaluations

People often think of program evaluation as only measuring long-term impact. However there are several types of evaluation, each useful during different stages of program design and implementation.

- **Formative Evaluation.** Formative evaluation allows a program to refine its implementation before a full-scale rollout. Formative evaluation can also be thought of as pre-testing or pilot-testing a program on a small scale. In formative evaluation, information is collected through focus groups and in-depth interviews to determine whether the program and its materials are appropriate, acceptable and appeal to the intended audience. Program developers use this information to help make corrections or enhance the program prior to full implementation. Formative evaluation is important and increases the chances for greater impact. For example, if the intended audience does not respond to the program, favorable outcomes over time are unlikely.

- **Process Evaluation.** Process evaluation helps determine whether a program is being implemented as planned, including whether the program is serving the expected number of clients and providing the expected range and amount of services. It is an ongoing part of regular program maintenance. Process evaluation can focus on the amount of services delivered, to whom services are delivered, consistency of delivery of services, and quality of interaction between staff and clients including *acceptability* and *likability* of the intervention. Process evaluation is conducted through careful record keeping and usually regular data analysis that ensures an information feedback loop for program administration and line staff. For example, monthly feedback about the percentage of clients linked to treatment for PTSD may help the program identify and address changes in clients' mental health status, changes in staff attention to the issue of PTSD, and/ or changes in available PTSD treatment options. It can also provide valuable information about why a program did or did not have the outcomes or anticipated intermediate or long-term impacts.

- **Outcome Evaluation.** Outcome evaluations measure the ultimate effectiveness of a program, specifically whether the program changes the main behavior of the focus population. Outcomes for violence prevention programs often measure change in violence-related knowledge, attitudes and behaviors based upon the intervention. This is often measured through self-reports, pre- and post-service surveys, observed



Stefania Kaplanes (Alameda County Medical Center, Oakland), Christine Graham (Eden Medical Center, Castro Valley, CA), Julie Rossie (Regional Medical Center of San Jose)

behavior or other objective measures such as criminal justice records, hospital records and mortality rates.⁶⁹

The W.K. Kellogg Foundation's Evaluation Toolkit defines another way of looking at evaluation approaches as follows:⁷⁰

Different approaches to evaluation are based upon different theories and are practiced differently. In reality, many evaluations combine different approaches, and different approaches might be most helpful

69. A good example of an outcome evaluation conducted by a National Network member agency was published in 2006. See Carnell Cooper, MD, Dawn M. Eslinger, MS, Paul D. Stolley, MD. *Hospital-Based Violence Intervention Programs Work*. *Journal of Trauma Injury Infection, and Critical Care* 2006; 61:534-540. Visit the [Center for Nonviolence and Social Justice](#) resource page for a pdf of this paper.

70. Visit the [W.K. Kellogg Foundation's](#) website to see their Toolkit chapter titled Major Approaches to Evaluation.

at different stages of the project. Below is a simple classification of approaches:

Objectives-oriented approaches: *the focus is on making clear the goals and objectives and measuring how the project has done in reaching them. This might be the approach to choose if measuring outcomes is a major purpose of your evaluation.*

Management-oriented approaches: *the purpose is to identify and provide the information needed by project directors. This type of approach is helpful if a major purpose of your evaluation is program development.*

Consumer-oriented approaches: *the goal is to provide information for use by consumers of products or services. This type of approach can be used both to improve products or services and to help users choose among different services.*

Expertise-oriented approaches: *the judgment of experts is the main source of information. These approaches can provide a simple way to evaluate something that is complex if the stakeholders are satisfied with expert opinion.*

Adversary-oriented approaches: the arguments for and against an action or proposal are laid out, as in a trial. These approaches can help if determining whether or not to continue a project is a purpose.

Participant-oriented approaches: program participants and stakeholders are the key sources of both questions and the information to answer the questions. These approaches are helpful for program improvement purposes.

The Centers for Disease Control and Prevention (CDC) published a classic six-step framework for conducting evaluation of public health programs in 1999 that still serves as a useful model.⁷¹ The Framework designers suggested using it as follows:

The framework is composed of six steps that must be taken in any evaluation. They are starting points for tailoring an evaluation to a particular public health effort at a particular time. Because the steps are all interdependent, they might be encountered in a nonlinear sequence; however,

71. Centers for Disease Control and Prevention, *Framework for Evaluation in Public Health*. September 17, 1999 / 48(RR11);1-40. Visit the [Centers for Disease Control and Prevention](https://www.cdc.gov/epidemiology/prevention/pubs/rr11-140/) website for their Framework for Program Evaluation in Public Health.

an order exists for fulfilling each—earlier steps provide the foundation for subsequent progress. Thus, decisions regarding how to execute a step are iterative and should not be finalized until previous steps have been thoroughly addressed.

They outlined the steps as follows:

Step 1: Engage stakeholders. Stakeholders are those persons involved in or affected by the program and primary users of the evaluation.

Step 2: Describe the program. Need, expected effects, activities, resources, stage, context, logic model.

Step 3: Focus the evaluation design. Purpose, users, uses, questions, methods, agreements.

Step 4: Gather credible evidence. Indicators, sources, quality, quantity, logistics.

Step 5: Justify conclusions. Standards, analysis/synthesis, interpretation, judgment, recommendations.

Step 6: Ensure use and share lessons learned. Design, preparation, feedback, follow-up, dissemination.

Table Comparing W.K. Kellogg Foundation and CDC Evaluation Steps

From Kellogg Foundation toolkit – evaluation plan (2004)	From CDC - evaluation steps (1999)
<p>1. Background and Logic Model: A brief description of the history and current status of the program as well as of the logic model, which is a simple description of how the activities carried out within the program are related to the expected outcomes. This information will show the extent to which the evaluation team understands the context, logic, and purposes of the program.</p>	<p><i>Step 2: Describe the program.</i> Need for program, expected effects, activities, resources, program's stage of development, context of program such as environment, logic model.</p>
<p>2. Purpose of the Evaluation: Clear indication of the need for the evaluation, its audience, and purpose.</p> <p>3. Evaluation Questions: The specific questions the evaluation will answer. Such questions should be closely aligned with the evaluation purposes, covering all major concerns of project stakeholders (staff, participants, funders), and also should be feasible to answer.</p> <p>4. Evaluation Methods: Overall design strategy to answer the evaluation questions, including a plan to collect and analyze data. Includes identifying the existence and availability of relevant information sources to answer the questions.</p> <p>5. Team Composition and Participation: Identification of the approximate team size, the qualifications and skills team members should have, as well as any requirements for participation.</p>	<p><i>Step 1: Engage stakeholders.</i> Stakeholders are those persons involved in or affected by the program and primary users of the evaluation.</p> <p><i>Step 3: Focus the evaluation design.</i> Purpose, users, uses, questions, methods, agreements among those who will execute the evaluation plan.</p>

From Kellogg Foundation toolkit – evaluation plan (2004)	From CDC - evaluation steps (1999)
<p>6. Procedures and Logistics: Specify the various procedural requirements of evaluation, including evaluation activities at the project level, the general schedule - duration, phasing and timing considerations - as well as work hours, preparatory work, availability and provision of services and space, and procedures for arranging meetings.</p>	<p><i>Step 4: Gather credible evidence.</i> Indicators, sources of data, quality, quantity, logistics for gathering & handling data. <i>Step 5: Justify conclusions.</i> Standards, analysis/synthesis, interpretation, judgment, recommendations.</p>
<p>7. Reporting and Assuring Use: A brief plan indicating how the evaluation team will report and assure the use of the evaluation findings. The plan should point out the format (oral, written, visual, etc.), content, and frequency of interim and final reports. It should also specify how the different stakeholders would use the findings.</p>	<p><i>Step 6: Ensure use and share lessons learned.</i> Design, preparation, feedback, follow-up, dissemination.</p>
<p>8. Budget: A general budget estimating evaluation costs and identifying the sources of funds.</p>	

Visit the [W.K. Kellogg Foundation website](#) to view their outline of an evaluation plan.

Visit the [Centers for Disease Control and Prevention website](#) for their Framework for Program Evaluation in Public Health, published in September 1999.

Walking through the steps involved in public health evaluation

Step 1: Engage stakeholders.

Engaging stakeholders, or those persons involved in or affected by the program and primary users of the evaluation, relates to each of the following steps. For example, conducting an evaluation requires a commitment from all levels of program staff in data collection. When an evaluation design requires an Internal Review Board (IRB) review, the IRB must reflect the key stakeholders. Also, ensuring that data are gathered on the largest number of clients may require that clients be given a stipend as an incentive to participate in interviews or to stay in contact with the program for evaluation purposes long after they no longer are making use of the services.

In order to demonstrate long-term success of an established hospital-based violence intervention program, evaluations need to measure the extent to which effects persist years after program involvement. In other words, it is important to be able to track down clients, even years after they left the program. This is true for clients who successfully completed the program, as well as those who self-terminated before program completion. (See Resource B below for a list of literature about following up with challenging populations for research and evaluation purposes.)

National Network programs have also learned the importance of ensuring that staff understand that evaluation processes are beneficial to them, the injured youth and family members they work with, and the broader community. Staff also need to understand that evaluation can identify ways of improving the program design and can ultimately strengthen the potential for replication and expansion to serve more youth, especially if results are positive. Examples of ways to engage staff in the evaluation process are as follows:

- Build accountability and set high expectations for reporting and data entry requirements for all levels of staff.
- Incorporate evaluation into program materials and staff training.
- Engage staff early in the evaluation process to secure their buy-in. This should include incorporating line staff's experience with data collection into the evaluation design.

Case Study on Data Collection Expectations: The medical director of Project Ujima in Milwaukee, Wisconsin became concerned that staff were not completing intake and assessment forms on the first visit with clients. After accompanying staff on a few initial visits, she realized that they had to focus on fostering trust and on immediate crisis intervention during the first visit. Thereafter she expected that forms would be completed within 3-4 visits.

Since the evaluation process is circular, not linear, stakeholders, and especially funders, will want to see results of an evaluation followed up on, expanded, and replicated.

Step 2: Describe the program.

Need for the program, expected effects, activities, resources, program's stage of development, program context including environmental factors, logic model.

Logic models are useful tools to help integrate program design and evaluation and to help engage all stakeholders in the evaluation process. By providing a birds-eye view of key program elements, they encourage stakeholders to better understand how those elements should work together.

National Network programs have also learned the importance of ensuring that staff understand that evaluation processes are beneficial to them, the injured youth and family members they work with, and the broader community.



Anne Marks (Caught in the Crossfire/Youth ALIVE!)

Sample Logic Model for a Process Evaluation

Assumptions: Providing high quality crisis intervention and post-discharge services can reduce re-injury rates among youth at highest risk for violence.

Goal(s): Prevent recurring violent injury among youth at risk for violence.

INPUTS	OUTPUTS		RESULTS		
	Activities	Participants	Short Term	Medium Term	Long Term
<i>What we invest</i>	<i>What we do</i>	<i>Who we reach</i>	<i>Result(s) in the short-term</i>	<i>Result(s) over more time</i>	<i>Ultimate impact(s)</i>
Partnerships Staff Money Time Volunteers Equipment Materials etc.	Assess at bedside Provide crisis intervention Provide case management	Violently injured patients Family members and their friends	Diffuse crisis Link to services, e.g. medical, psychological, housing, educational	Patients make progress in addressing the individual risk factors for violence Family members make progress	Lower re-injury rates Lower arrest rates Improved sense of well-being

An example of a logic model for a formative or process evaluation is as follows:

Logic Model Development

Program Implementation Template – Exercise 1 & 2

RESOURCES	ACTIVITIES	OUTPUTS	SHORT- AND LONG- TERM OUTCOMES	IMPACT
<p>In order to accomplish our set of activities we will need the following:</p>	<p>In order to address our problem or asset we will conduct the following activities:</p>	<p>We expect that once completed or under way these activities will produce the following evidence of service delivery:</p>	<p>We expect that if completed or ongoing these activities will lead to the following changes in 1–3 then 4–6 years:</p>	<p>We expect that if completed these activities will lead to the following changes in 7–10 years:</p>
<ul style="list-style-type: none"> • IRS 501(c)(3) status • Diverse, dedicated board of directors representing potential partners • Endorsement from Memorial Hospital, Mytown Medical Society, and United Way • Donated clinic facility • Job descriptions for board and staff • First year’s funding (\$150,000) • Clinic equipment • Board & staff orientation process • Clinic budget 	<ul style="list-style-type: none"> • Launch/complete search for executive director • Board & staff conduct Anywhere Free Clinic site visit • Board & staff conduct planning retreat • Design and implement funding strategy • Design and implement volunteer recruitment and training • Secure facility for clinic • Create an evaluation plan • Design and implement PR campaign 	<ul style="list-style-type: none"> • # of patients referred from ER to the clinic/year • # of qualified patients enrolled in the clinic/year • # of patient visits/year • # of medical volunteers serving/year • # of patient flyers distributed • # of calls/month seeking info about clinic 	<ul style="list-style-type: none"> • Memorandum of Agreement for free clinic space • Change in patient attitude about need for medical home • Change in # of scheduled annual physicals/follow-ups • Increased # of ER/physician referrals • Decreased volume of un-reimbursed emergencies treated in Memorial ER 	<ul style="list-style-type: none"> • Patient co-payments supply 20% of clinic operating costs • 25% reduction in # of uninsured ER visits/year • 300 medical volunteers serving regularly each year • Clinic is a United Way Agency • Clinic endowment established • 90% patient satisfaction for 5 years. • 900 patients served/year

Step 3: Focus the evaluation design. Purpose, users, uses, questions to be addressed, methods to be used, and agreements among those who will execute the evaluation plan.

Purpose: Public health evaluations can be used to (1) gain insight into, for example, the feasibility of a specific approach to help determine next steps in program development, (2) refine or change practice to better reach program goals, (3) assess impact of the program, and/or (4) stimulate change among key stakeholders through their involvement in shaping and being subjects of the evaluation (also known as *action research*).

However, most commonly, program evaluation is a tool used to assess and improve programs. Almost routinely funders now require a formative, process, or outcome evaluation be a part of applications. Also, a strong evaluation can support dissemination of the program model as a “best practice.” Program evaluation is concerned with five broad questions:

- Is the intervention reaching the intended population?
- Is the intervention being implemented in the ways specified?
- Is the intervention effective at modifying the outcomes (e.g. violence, linkage to services) of interest?
- How much does the intervention cost?
- What are the costs relative to the intervention’s effectiveness?

Users and uses: Engaging the potential users, the people who will receive the evaluation findings, in the design phase helps to ensure that the evaluation meets the expectations of these stakeholders. Additionally, clearly articulating potential uses

of the evaluation increases the chances that it will be relevant to the intended users. Some funders understand the value of evaluation well enough to ensure that a percentage of each grant be allocated to support it. Some estimate that 30% of personnel and operating costs should be added to a grant to pay for evaluation. The federal Substance Abuse and Mental Health Administration has estimated the cost at a minimum of 10% of a total program grant.

Questions to be addressed by the evaluation: These questions are essential in shaping the boundaries of the evaluation.

Methods to be used: National Network programs have found that evaluation designs need to be creative and methodologically sophisticated to most effectively serve the evaluation purpose. An example of sophisticated methodology is to incorporate strategies such as triangulating data (e.g., obtaining data from more than one source) to strengthen the results of the evaluation. More broadly, each design type (e.g. experimental, quasi-experimental, observational) often defines the methods to be employed, e.g. an experimental design-type requires defining control and treatment groups.

As with many health and human service interventions, there are some methodological challenges associated with evaluating their effectiveness:

Engaging the potential users, the people who will receive the evaluation findings, in the design phase helps to ensure that the evaluation meets the expectations of these stakeholders.

- The dose of the intervention can be difficult to measure accurately because, when clients consent to participating in the research, their choice to participate can cause selection bias;
- Measuring a program's effectiveness at *preventing* retaliation is very difficult to measure;
- Sample sizes are often small;
- The impact of powerful factors affecting clients' behavior and beyond the control of the program (e.g. changing socio-economic conditions) are especially difficult to identify, much less measure;
- Threats to validity are common and include diffusion, regression to the mean, selection bias, and loss to follow-up. These are all challenges that apply primarily to evidence-based evaluation but can be overcome with some imagination, careful planning, and understanding of the crucial role that evaluation plays in providing the very best violence prevention and intervention services possible.

Agreements: Agreements describe how and by whom the evaluation plan will be implemented. They clarify roles and responsibilities. Engaging graduate students and university-based research departments in program evaluations can help share the burden of evaluation and bring additional expertise to the process. Many undergraduate and graduate students are required or encouraged to complete internships, and it may be possible to utilize this resource for evaluation activities. However, staff may see these people as *outsiders* and will need to have an understanding of the utility of evaluation for them, their clients and the program in order to facilitate trust and compliance between the evaluator and staff.

When considering hiring an outside evaluator for an outcome evaluation, find an evaluator who will work well with the program and its staff, as well as the clients. This population can be difficult to follow-up with for many reasons, and the evaluator needs to fully understand this difficulty, be persistent, and be culturally competent. Including direct service staff in the hiring process of an outside evaluator is helpful because they have a good sense of who would work well with the clients. Also including them in this process can increase their buy-in to the entire evaluation. Since case managers often assist evaluators by helping to set up interviews and accompanying the evaluator on follow-up visits, trust and accountability needs to be fostered between staff and the evaluator. Outside evaluators should have what one clinical director termed *arrogant*

When considering hiring an outside evaluator for an outcome evaluation, find an evaluator who will work well with the program and its staff, as well as the clients.

humility—the ability to be sensitive, a good listener, competent, and open to learning from staff and clients as much as being open to sharing expertise. Outside evaluators are contractors who are engaged specifically for evaluating programs.

Step 4: Gather credible evidence. Indicators, sources, quality, quantity, logistics.

Indicators: Indicators translate general program concepts, context, and expected outcomes into measurable increments. They are directly connected to the evaluation’s purpose and questions.

Example: Some National Network programs are looking at whether dosage/ duration of services affects outcomes. Stratifying the data to determine what dosage/ duration was most effective and for whom may be one way to fine-tune this analysis. It may also be a way to learn whether dosage/ duration of services is a factor in positive or negative outcomes. However, as noted above, when clients consent to participate in the program, including the research, their consent can cause selection bias. Those who agree to receive services are usually different in many ways from those who refuse.

Measuring intermediate outcomes can capture some significant behavioral change such as an increase in the number or percentage of clients showing symptoms of PTSD who begin and continue with treatment, the percentage of school dropouts who enroll in school, or the percentage of unemployed clients secure employment.

Sources of evidence or data: Sources of evidence or data include people, documents, and observations. It is important to articulate why specific sources were chosen so that users of the evaluation can better interpret the data. It is also important to differentiate between “obtrusive” and “unobtrusive” data; the former requires some interaction with the subjects and the latter can be obtained as “secondary data” from sources such as notes in case files or existing databases. See table in the Resources section below for potential sources and their strengths and limitations.

Quality and quantity of data: Quality means the appropriateness and integrity of the information used in an evaluation. High quality data are reliable, valid, and are most likely to effectively answer the evaluation questions.

Point about small sample size: Creative research designs are necessary for addressing data limitations inherent in studies with small sample sizes. Programs should always be engaged in refining evaluation and research methodologies to capture successes of program in order to build the evidence base.

Another factor to consider is that some concrete client goals may not always be reached. For example, when gathering data about whether clients have secured employment, gathering data about how much client’ attitudes and behaviors change as they progress toward securing a job may be very useful.

Logistics: These are the details about the methods, timing and physical infrastructure of gathering and handling the data. Cultural competency is an important

element here to ensure that enough high quality data are gathered. This may require that the evaluation team include data gatherers whom the subjects can readily trust. This is particularly important, since capturing personal stories to convey qualitative aspects of the program is so crucial to providing a full picture about a program.

Step 5: Justify conclusions. Standards, analysis/synthesis, interpretation, judgment, recommendations.

Standards: It is important to explicitly state the standards or values on which an evaluation is based. For example, a central standard of hospital-based violence intervention programs is to, at a minimum, “do no harm.” Beyond that they must do as much good as possible.

Analysis/synthesis: Analyzing and synthesizing the data requires combing through the data, and looking for patterns that can help answer the evaluation questions.

Interpretation: Figuring out what the data patterns mean helps to determine their practical significance.

Judgment: This part of justifying conclusions refers to the “spin” that the evaluation authors place on the findings. For example, program managers might view a 10% increase in clients reached positively, whereas community members might view it as insufficient.

Recommendations: These are suggested actions that are informed not only by the findings, interpretation of the findings, and judgments about them, but also by a broader understanding of the context (organizational, political, social & economic) in which the program operates.

Step 6: Ensure use and share lessons learned. Design, preparation, feedback, follow-up, dissemination.

Design: This refers to the format in which the evaluation is presented.

Preparation: This refers to the process of testing the release of the evaluation on smaller audiences to ensure that it is complete when officially released.

Feedback: This refers to an ongoing process of encouraging stakeholder involvement in the evaluation process to improve its quality and ensure that it will be used.

Follow-up: This refers to the process of ensuring that the evaluation report does not “sit on a shelf,” but gets used and used well.

Dissemination: This refers to the release of the evaluation report to a broader audience.

Chapter X Resources

Resource A: Selected Youth Violence Related Data Sources¹

Surveillance System	Data Source	Characteristics
Medical Examiner & Coroner Data	Autopsy & Coroner Reports	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Available for every violent death. • Provides information regarding injury circumstances. <p><i>Limitations</i></p> <ul style="list-style-type: none"> • Wide variability in report detail and quality. • Presented as narratives & often not computerized
Vital Statistics Mortality Data	Death Certificates	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Uniform death certificate format • Information on every death in a particular location is recorded. <p><i>Limitations</i></p> <ul style="list-style-type: none"> • Information cannot be linked to specific individuals. • Two to three year delay in reporting.
National Violent Death Reporting System	State-based monitoring system	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Links variety of record types related to each violent incident • Aims to provide timely surveillance combined with circumstantial detail of incident. <p><i>Limitations</i></p> <ul style="list-style-type: none"> • Violence-related morbidity not captured by system
Trauma Registries	Hospital Records	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Detailed information on individual cases • Organized in searchable databases <p><i>Limitations</i></p> <ul style="list-style-type: none"> • Data collected only at referral trauma centers • Data may not be representative of surrounding community • Referral population may be dictated by site's specialty areas • Mechanism of injury often not recorded (e-codes)
National Hospital Discharge Survey (NHDS)	National Sample of Inpatient Records	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Allows comparison of local, regional and national data <p><i>Limitations</i></p> <ul style="list-style-type: none"> • E-codes (cause of injury) excluded from annual summaries. • N-codes (diagnostic code) alone limit usefulness for determining violence statistics.

72. Table provided by Rebecca Cunningham, M.D. and Lyndee Knox, PhD. Dr. Cunningham and Dr. Knox are co-authors of this replication guide.

Surveillance System	Data Source	Characteristics
National Hospital Ambulatory Care Survey (NHAMCS)	National sample of hospital emergency & outpatient departments	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Includes complete information on injury cause (E-codes) <p><i>Limitations</i></p> <ul style="list-style-type: none"> • Subject to sampling variability due to voluntary hospital participation
Police & School Incident Reports	Police & School incident/arrest reports	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • Very detailed case records <p><i>Limitations</i></p> <ul style="list-style-type: none"> • No standardized record, very labor intensive to review • Confidentiality laws often limit use of records for research
Youth Risk Behavior Surveillance System	National survey	<p><i>Strengths</i></p> <ul style="list-style-type: none"> • National sample (12,000 students) • Comprehensive analysis of risk & behavior analysis among young people <p><i>Limitations</i></p> <ul style="list-style-type: none"> • Relies on self-reports that cannot be verified

Resource B: Lyndee Knox, Ph.D., a co-author of this replication guide, raised the following issues for hospital-based violence intervention programs to seriously consider when planning evaluations:

1. Real outcome evaluation is unlikely in these contexts because it is too expensive unless done in partnership with a university.
2. If engaging a university in evaluation, make sure the hospital is involved in shaping the research design to ensure that the hospital gets information it needs.
3. Hospital-based violence intervention programs should focus primarily on quality indicators and use patient surveys and some follow-up interviews aimed at improving program.
4. Picking useful outcome indicators is very important and requires great care. For example, some of these, such as death rates, measure rare events and are therefore unlikely to show much change over any time period that is less than 5 or more years.

Resource C: Literature addressing achieving high follow up rates with very challenging populations (A bibliography provided by Rebecca Cunningham, M.D., a co-author of this replication guide.)

1. Isaacman DJ, Khine H, Losek JD. A simple intervention for improving telephone contact of patients discharged from the emergency department. *Pediatr Emerg Care*. 1997;13:256-258.

2. S.L. Janson, M.E. Alioto and H.A. Boushey, Attrition and retention of ethnically diverse subjects in a multicenter randomized controlled research trial. *Control Clin Trials*, 2001;22: 236S-243S.
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4. J.S. Smith and H.G. Watts, Methods for locating missing patients for the purpose of long-term clinical studies. *J Bone Joint Surg Am*, 1998;80A:431-438.
5. Woolard RH, Carty K, Wirtz P, Longabaugh R, Nerenberg T, Minugh A, Becker B, Clifford PR. Research Fundamentals: Follow-up of Subjects in Clinical Trials: Addressing Subject Attrition. *Acad Emerg Med*, 2004; 11:859-866.
6. MacLachlan, M. Never Say Lost! National Surgical Adjuvant Breast and Bowel Project, 3rd edition. Pittsburgh, PA, 2004.
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8. Fewtrell MS, Kennedy K, Singhal A, Martin RM, Ness A, Hadders-Algra M, Koletzko B, Lucas A. How much loss to follow up is acceptable in long-term randomized and prospective clinical studies? *Arch. Dis. Child*. 2008;93:458-461.
9. Cottler LB, Compton WM, Ben-Abdallah A. Achieving a 96.6 percent follow-up rate in a longitudinal study of drug abusers. *Drug and Alcohol Dependence*. 1996;41:209-217
10. Cunningham R, Walton MA, Tripathi SP, Outman R, Murray R, Booth BM. Tracking Inner City Substance Users from the ED: How Many Contacts Does It Take? *Acad Emerg Med* 2008 15(2) 136-143.
11. Ribsil, K., Walton, M.A., Mowbray, C.T., Luke, D.A., Davidson III, W., & Boots-Miller, BJ. (1996). Minimizing participant attrition in panel studies through the use of effective retention and tracking strategies: Review and recommendations. *Journal of Adolescent Health*, 21, 203-214.

Resource D: W.K. Kellogg Foundation on Evaluation and Logic Models

Visit the W.K. [Kellogg Foundation](#) website to view their Evaluation Toolkit.

Visit the W.K. [Kellogg Foundation](#) website to view their Logic Model Development Guide.

Resource E: Published Evaluations of Hospital-based Violence Intervention Programs

- Becker MG et al (2004) “Caught in the Crossfire: the Effects of a Peer-based Intervention Program for Violently Injured Youth.” *Journal of Adolescent Health*: 2004; 34:177-183.
- Cooper, Carnell MD; Eslinger, Dawn M. MS; Stolley, Paul D. MD. “Hospital-Based Violence Intervention Programs Work.” *The Journal of Trauma: Injury, Infection, and Critical Care*: September 2006 - Volume 61 - Issue 3 - pp 534-540.
- Shibru, Daniel MD, MPH, Elaine Zahnd, PhD, Marla Becker, MPH, Nic Bekaert, MSW, Deane Calhoun, MA, Gregory P Victorino, MD, *Benefits of a Hospital-Based Peer Intervention Program for Violently Injured Youth*, *Journal of the American College of Surgeons* 2007;205: 684–689.

XI. Obtaining and Sustaining Program Funding

Chapter XI Roadmap:

- Fundraising 101 132
- Initial funding 133
- Ongoing funding 135
- Chapter XI resources 137

Chapter XI Objectives

- User understands the options and process of securing initial resources.
- User understands ways to secure ongoing resources to support the program.

In this tenuous economic environment, securing program funding can be particularly challenging. However, there are still many avenues to pursue for initial and ongoing funding for hospital-based or hospital-linked violence intervention programs.

Types of financial and related resources include the following:

- **Public funding:** This includes grants and contracts for service from local, state, and federal sources such as departments of public health or departments of justice.

- **Private funding:** This includes United Way, insurance foundations such as Blue Cross/ Blue Shield, and private foundations.

- **Hospital funding:** This includes grants from hospital foundations such as the Kaiser Permanente East Bay Area Community Benefit Grants Program or contracts

with a local hospital for violence intervention services. Being incorporated into the hospital budget is one way that many violence intervention programs are sustained.

- **Fee-for-service or reimbursement:** This includes state victims of crime reimbursement for expenses on a case-by-case basis or contracted fee-for-services with Medicaid for adults or EPSDT (Early Periodic Screening, Diagnosis, and Treatment) for children.

- **In-Kind:** While cash is crucial, it is important to think of funding not just as cash, but also as in-kind or contributed resources.

Fundraising 101

Developing and implementing a fundraising plan is the best way to make sure this important part of any organization is realistic and manageable over time. This applies both to initial and ongoing funding. It involves the following steps:⁷³

1. *Develop fundraising goals:* These goals should cover the amount of money to be raised for specific purposes such as startup costs, overhead, or a new service. It is most effective if the program leadership define the goals, both to ensure they are comprehensive and to engage leadership from the start in raising funds. A plan should be developed for each goal.
2. *Write down the fundraising plans:* This will make it easier to stay on track and to intentionally change plans as conditions change. Initially, one-year plans work best. More established programs usually make multi-year plans. A fundraising plan should include:
 - a. How much money is needed;
 - b. Potential sources of funding;
 - c. Who will be responsible for completing specific tasks.
3. *Estimate fundraising costs:* Most fundraising and overhead costs are not supposed to exceed 25% of a program's overall operating budget.⁷⁴ Fundraising costs include postage, website development and maintenance, special events, and dedicated staff time for grant writing, locating and contacting potential funding sources, organizing events, and managing volunteers involved in fundraising. How-

73. Adapted from Fritz, Joanne. *6 Steps to a Fundraising Plan for a New Nonprofit: How to Develop a Fundraising Plan That Works, an About.com Guide*. Visit the [About.com](https://www.about.com) website to view Joanne Fritz's article.

74. Stephen J. Smallwood and Wilson C. Levis. The Realities of Fund-Raising Costs and Accountability. Reprinted from *The Philanthropy Monthly*, September 1977. Visit the Urban Institute's [National Center for Charitable Statistics](https://www.urbaninstitute.org/national-center-for-charitable-statistics) to view this article. Visit the Urban Institute's [web site](https://www.urbaninstitute.org) for additional information about fundraising and administrative costs.

ever, there is much discussion about how realistic the 25% figure is since fundraising costs vary depending on how long the program has been operating, the current economic climate, and other factors; also building and sustaining a solid infrastructure to support direct services requires substantial funding.⁷⁵

4. *Develop a timeline:* Lay out a calendar for each fundraising activity. These usually include submitting grant applications, conducting a direct mail campaign, and/or producing a regular newsletter for donors.
5. *Identify sources of support:* Think creatively about potential sources. In addition to private foundations, search for opportunities to earn income by providing trainings to health care providers or untapped funding streams such as the state crime victims fund or Medicaid. Private foundations and government entities periodically release requests for proposals (RFPs) or requests for qualifications (RFQs) throughout the year. Public sources often contract for services with established non-profit providers.
6. *Evaluate the plan regularly:* Every few months, make time to evaluate the fundraising process. Figure out which approaches are working best and which ones are not working at all. Some approaches may change. New opportunities may push others aside. Also the timeline may need to be altered based on changes in available staffing, new deadlines, or unanticipated program demands.

Initial Funding

Securing the financial resources needed to launch a program requires:

- Assembling a group of knowledgeable individuals to develop a plan, including a program budget, for designing the program and securing the startup resources and to implement that plan;
- Learning about the potential sources of start-up funding, both financial and in-kind;
- Negotiating agreements for in-kind support;
- Getting grants.

75. Ann Goggins Gregory & Don Howard. *The Nonprofit Starvation Cycle*. Stanford Social Innovation Review. Fall 2009. Visit the [Stanford Social Innovation Review](#) to view the article.

An excellent resource for this process is the University of Kansas-based Community Tool Box:

Visit the **University of Kansas-based Community Tool Box** website to see their Getting Grants and Financial Resources chapter.

Initially or over the long-term, collaborations with more established agencies can include sharing staff to complete important functions in the program.

In-Kind Resources Case Study 1: The CeaseFire hospital-linked services has relied since the beginning on both medical doctors and hospital chaplains to identify patients who need intervention services. Chaplains then secure their consent to participate in these services and conduct the initial assessment before referring patients to the outreach workers who are employed by the community-based agency that operates the program.

All programs rely on a “champion” in the hospital to advocate for establishing and continuing services and help the program administrators and staff navigate the hospital culture. This is an in-kind resource.

In-Kind Resources Case Study 2: The Caught in the Crossfire program in its work with the Alameda County (California) Medical Center receives substantial in-kind support primarily in the form of ongoing program support from the Medical Center’s Injury Prevention Coordinator. She searches admissions records daily to find patients who meet the program’s criteria, meets with patients who are still in the hospital to explain the program and seek their consent to participate. She then alerts the program’s intake person when a patient agrees to participate. Every two weeks, she also participates in the program’s case conferencing.

All programs rely on a “champion” in the hospital to advocate for establishing and continuing services and help the program administrators and staff navigate the hospital culture. This is an in-kind resource. Another is that sometimes hospitals provide office space where the intervention workers can complete paperwork and contact outside resources.

Financial resources are the dollars and cents needed to support day-to-day intervention services personnel and operations. They are invariably pieced together from multiple sources including private foundations and local, state, and/or federal government sources.

Diversified Funding Case Study:⁷⁶ One National Network program, Project Ujima in Milwaukee began in 1995 as a partnership between Children’s Hospital of Wisconsin, the Medical College of Wisconsin, the Milwaukee Youth Opportunities Collaborative, Family Services of Milwaukee, the Milwaukee Health Department, and the Social Development Commission. To operate the program during the first years, each partner contributed materials and services including staff time, office space, and computer access. After the first years, Project Ujima in Milwaukee secured funding from the Children’s Hospital Foundation, Emergency Medical Services for Children, the Allstate Foundation, and federal Victims of Crime Assistance through Wisconsin’s Department of Justice.⁷⁷

Ongoing Funding

Ongoing funding invariably requires as much hard work as assembling startup support. The Executive Director of Youth ALIVE!, an agency in Oakland, California that developed the first hospital-based violence intervention program in the country, reports that “sustainability is about framing your work.”⁷⁸ To articulate that framing, she searches every federal department website, defining ways in which the program could fit with each department’s mission. For example, a hospital-based intervention program can be framed to fit the mission of the Department of Health and Human Services by emphasizing the health care aspects and framed to fit the mission of the Department of Justice by emphasizing its crime



John Rich, M.D. (Healing Hurt People, Philadelphia)

76. Adapted from description of Project Ujima in: Robert D. Ketterlinus, Ed., (2008) *Youth Violence: Interventions for Health Care Providers*, American Public Health Association Press, Washington, DC. p. 144

77. Visit the [OVC website](#) for the Crime Victims Fund Fact Sheet that explains how Victims of Crime Assistance funds are allocated to the states.

78. Email communication with Anne Marks, Executive Director of Youth ALIVE! on 5/11/11.



David Ross (Violence Intervention Program, Baltimore)

intervention dimension. She then takes these different articulations and explores a wide variety of private and public funding sources.

National Network programs have continued over the years to diversify their funding sources.

Hospital and Other Funding Case Study: The Wraparound Program in San Francisco not only is partially supported as a line item in San Francisco General Hospital's budget, but also has secured funding over the years from the Centers for Disease Control & Prevention, San Francisco's Department of Children, Youth, & Families, and several private & community foundations. However, all sources require frequent renewal and

the project is constantly searching for other sources of funding, in some cases to replace expired grants and in others to increase funding to meet new demands.

Once a program has been launched, the range of potential sources of funding expands to include public and private sources that require funding recipients have a strong track record. Also established programs are more likely to have the capacity to handle fee-for-service streams such as Medicaid for adults or EPSDT for children. Robert Bennett, an expert in strategic funding who has consulted extensively for NIMH, the Department of Housing and Urban Development, US Justice Department, and SAMHSA, prepared a briefing paper in 2010 emphasizing fee-for-service funding opportunities for the violence intervention programs. Visit the National Network of Hospital-based Violence Intervention Programs (NNHVIP) to find a link to his paper.

Resources:

RESOURCE A:

TABLE FROM THE CAUGHT IN THE CROSSFIRE PROGRAM MANUAL

Figure 6: Sources of Initial and Ongoing Funding		
Initial Funding		
<p>Private Funds Insurance foundations State foundations Community-based foundations Hospital foundations</p>	<p>Public Funds City and State Departments of Public Health Monies diverted from police / criminal justice system</p>	<p>In-Kind Contributions ER staff time Volunteers Donations</p>
Ongoing Funding		
<p>Private Funds United Way local funding Insurance foundations, such as Blue Cross / Blue Shield Robert Wood Johnson Foundation State foundations Community-based foundations Hospital foundations Hospital funds Events Hospital seasonal giving campaigns Reimbursement for services</p>	<p>Public Funds Local: City funding, such as the General Fund; Local tax initiative funds; Department of Public Health; Department of Behavioral Health; budget earmarks State: Department of Public Health; Department of Commerce; Governor’s Office Federal: Victims of Crime Assistance; Office of Juvenile Justice and Delinquency Prevention (OJJDP); Department of Justice; Department of Education; Bureau of Substance Abuse; Substance Abuse and Mental Health Services Administration (SAMHSA); Health Resources and Services Administration (HRSA); National Institutes of Health (NIH); National Institute of Mental Health (NIMH) Medicaid/Medicare billing codes</p>	<p>In-Kind Contributions Individual donations Donations from religious organizations Volunteers</p>

Visit [Youth ALIVE!](#)'s website to see a copy of the Caught in the Crossfire Program Manual.

XII. Engaging in Advocacy or Systems Change to Prevent Youth Violence

Chapter XII Roadmap:

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- Types of advocacy 143
- Conducting advocacy 144
- Defining an advocacy strategy to address youth violence 145
- Chapter XII resources 147

Chapter XII Objectives

- User understands why and how health care providers can engage in advocacy
- User understands the different types of advocacy
- User understands how to do advocacy.
- User understands how to define an advocacy strategy to address youth violence.

Health care providers and advocacy

“...Advocacy seeks to increase power of people and groups and to make institutions more responsive to human needs. It attempts to enlarge the range of choices that



Femi Lawal (Violence Prevention Program, Baltimore)

people can have by increasing their power to define problems and solutions and participate in the broader social and policy arena.”⁷⁹

— Lawrence Wallack, DrPH,
Dean, College of Urban and Public Affairs Professor of Community Health,
Portland State University

While those involved in hospital-based intervention services (e.g. physicians, nurses, social workers) are primarily advocates for their individual patients or clients, they also can bring their professional expertise to the process of advocating on other levels. Individuals may choose to advocate on behalf of the following:

- All patients or clients served.
- A health care institution such as a hospital.

79. Wallack, L., Dorfman, L., Jernigan, D.H., Themba-Nixon, M. (1993) *Media Advocacy and Public Health: Power for Prevention*, Sage Publications, Newbury Park, California p. 28

- The broader community where patients or clients live, which may be viewed as a city or county or state or country or even the whole world.

Advocating for changes in broader public awareness and changes in public policies can significantly improve individual health outcomes. According to the Centers for Disease Control and Prevention, the **ten greatest public health achievements of the 20th century**⁸⁰ have been largely responsible for increasing the lifespan of populations by 30 years; over 25 of these can be attributed to public health initiatives that expanded public awareness and/or changed public policies, while medical advances account for less than 4 years.⁸¹

This chapter on advocacy is intended to provide the basic information needed to help the reader think about how to engage in advocacy for violence prevention beyond working on a case-by-case basis.

In the case of hospital-based violence intervention programs, the public health approach and the medical treatment approach complement each other. The medical staff identify patients and link those patients with services that address the risk factors associated with the presenting injury and help strengthen the protective factors to prevent repeated injury. The programs often engage in advocacy to change policies and practices that will help reduce intentional injury. In cases where a local government provides all or part of the funds to operate a hospital-based violence intervention program, staff may advocate for policy changes that increase the funds available to serve the focus population.

Advocacy Case Study 1: San Francisco's Wraparound Project, which is funded in part through the city's Department of Children, Youth, & Families, advocates annually for full DCYF funding, but in concert with other funded programs. This collaboration grew out of an understanding that the Wraparound Project needs their collaborators to be funded so that the patients the Wraparound Project works with can get the help they need to heal.

Advocacy Case Study 2: After Project Ujima, Milwaukee, Wisconsin, argued for violence prevention education — primary violence preven-

Advocating for changes in broader public awareness and changes in public policies can significantly improve individual health outcomes.

80. Visit the [Centers for Disease Control and Prevention](#) website for the list of public health achievements.

81. Visit the [Centers for Disease Control and Prevention](#) website for an explanation of the impact of the list of public health achievements and a reference to the source of the list.

tion —, Project Ujima, the Milwaukee Public Schools, the Milwaukee Fire Department, and the Medical College of Wisconsin’s Department of Pediatrics partnered to develop a violence prevention program for grade school aged children in 2005. “Healthy Youth: Strong and Connected” provides a five-part, interactive curriculum to sixth grade students in Milwaukee Schools. In its first five years, the partnership reached over 10,000 students, teaching about the roots of violence, conflict resolution, and healthy relationships, and role-playing violence prevention skills. Students showed improved knowledge and attitudes towards violence and many students, teachers, and school administrators expressed their appreciation. Project Ujima staff involved in the partnership gained relief from the everyday stresses of caring for violently injured patients. The curriculum has been integrated into the Safe Schools, Healthy Students program in Milwaukee Public Schools.⁸²

In addition to the school program, Project Ujima collaborated with the Milwaukee Homicide Review Commission, to establish a new police procedure through which Project Ujima receives the names of homicide victims’ next-of-kin. Project Ujima staff can then serve these crime victims at their most vulnerable time through home visitation, case management, assistance with Crime Victims Services Compensation paperwork, and participation in Project Ujima’s Homicide Support Group.

Hospital-based intervention programs can also join coalitions that are working to pass laws to limit access to firearms.

The model below of emergency room personnel’s role in advocacy clarifies some distinctions between patient advocacy and policy advocacy.⁸³ In this model, social and economic factors influencing an individual patient’s health are shown in increasingly broad domains while continuing to relate to the emergency room personnel’s core responsibility for patient care.

82. Visit the [Medical College of Wisconsin’s](#) website to read a more detailed account of the story.

83. Gruen RL, Pearson SD, Brennan TA. Physician-Citizen – Public Roles and Professional Obligations. *JAMA*. 2004;291:94-98.

Comparing Patient Advocacy with Policy Advocacy

Case	Patient Advocacy	Policy Advocacy
A child presents to the emergency room a victim of abuse and neglect	Emergency room personnel treat child and contact Child Protective Services	Emergency room staff join with child welfare advocates in support of increased funding for Child Protective Service caseworkers
A young man presents to the emergency room with a gun shot wound	Emergency room personnel treat the violently injured youth and contact law enforcement if necessary	Emergency room staff organize or join a coalition of medical providers focused on limiting access to handguns in the state
A young mother presents to the emergency room a victim of domestic violence	Emergency room personnel treat woman and make referrals to domestic violence programs and shelters	Emergency room staff join with other organizations interested in stronger enforcement of laws governing restraining orders

Types of advocacy

There are basically three types of policy advocacy:⁸⁴

- **Legislative:** This involves working with local, state, and/or federal legislators by proposing, endorsing, or opposing legislation and/or by providing information to legislators.
- **Judicial:** This involves filing lawsuits to change policy or supporting a lawsuit by filing an amicus brief, a legal document that provides information to help the court decide.
- **Electoral:** This involves ballot initiatives, voter education, and get-out-the-vote drives.

Most employers have guidelines about the type and extent of advocacy efforts that employees can engage in during work time. There are laws that govern this as well. For instance, public charities designated as 501(c)3 organizations are not allowed to engage in electioneering, campaigning on behalf of or voicing opposition to a particular candidate. However social welfare organizations designated as 501(c) 4 can. Due to the confusion about these laws, many people assume that they cannot participate in any advocacy efforts. However, advocacy may be a perfectly appropriate strategy to improve health outcomes.⁸⁵

84. Adapted from Chandler, Arnold. (2007) *Click Here for Change: Your Guide to the E-Advocacy Revolution*. PolicyLink and the Community Technology Foundation of California. Visit the [PolicyLink](#) website to see a copy. A condensed version prepared for The California Endowment is called *Communicating for Change: Targeting Audiences with New Communication Tools*. Visit [The California Endowment](#) website to download a describing the training modules.

85. Adapted from: Vernick JS. *Lobbying and Advocacy for the Public's Health: What are the limits for Non-Profit Organizations?* Am J Public Health. 1999;89:1425-1429.

One way to envision advocacy is to think about it in terms of working inside or outside the legislative process as follows:

Inside the legislative process

- Meeting with legislators
- Providing information to legislative offices
- Testifying in committees
- Negotiating with policymakers and lobbyists

Outside the legislative process

- Media advocacy (e.g. monitoring the news, getting to know reporters, producing news releases)
- Coalition-building
- Letter writing
- Organizing and grassroots activities (e.g. rallies, house parties)
- Research and analysis
- Electronic advocacy (e.g. disseminating information and gathering feedback from constituency)



Gerardo Gomez, M.D. (Prescription for Hope, Indianapolis)

Visit the **American Association of Community Theater** website's section on e-advocacy for a link to e-advocacy resources.

Conducting Advocacy

Most advocacy efforts focus on changing public policy through the local, state, or federal legislative process. Whatever type of advocacy is chosen, most advocates

follow steps like those outlined in *The Community Toolbox*, a guide to community organizing. Visit the [Work Group for Community Health and Development at the University of Kansas](#) website to view this guide.

Remember that significant change does not happen overnight. Be prepared and prepare your allies to keep at it for a long time. If you are successful, remember to stay vigilant to ensure that the legislation is being implemented in the way it was intended and advocate for evaluation of its impact.

Defining an advocacy strategy to address youth violence

To develop an overall advocacy strategy to address youth violence, the five important questions to consider and develop approaches for are as follows:

- *What is the problem you are highlighting?*

Though youth violence is the overarching problem, breaking down the problem into pieces that can be addressed with specific actions is essential.

Examples of Approaches to Reducing Youth Gun Violence

	If you define the problem as...	The action becomes...	The audience is...	And the group mobilized is...
Example 1	Lack of information about the lethality of guns	Increase education campaigns about risks of guns	Youth	Parents, physicians, law enforcement and media to deliver and reinforce messages
Example 2	Lack of alternatives for youth	Increase social resources (after school programs, mentors)	Policymakers and others who control resources	Anyone interested in promoting policy change

(Adapted from: Lawrence Wallack, Katie Woodruff, Lori Dorfman, and Iris Dia (1999) *News for Change: An Advocates Guide to Working with the Media*. Sage Publications, Inc.)

- *What is the action?*

Often so much emphasis is placed on defining the problem that the action gets lost. Public health issues in general and youth violence in particular are complex with a complex set of long-term approaches. However, it is important to define a specific goal that you would like to advance. Defining a specific goal is more effective than calling for broad societal changes.

- *Who has the power to complete the action?*

In the case of changing laws or ordinances, those with the power to make the changes are usually elected officials. However, it is useful to remember that their constituents have the power to influence their decisions.

Remember that significant change does not happen overnight. Be prepared and prepare your allies to keep at it for a long time. If you are successful, remember to stay vigilant to ensure that the legislation is being implemented in the way it was intended and advocate for evaluation of its impact.

Also, once laws or ordinances are changed, those responsible for implementing the changes have the power to make the changes in practice.

- *Who must be mobilized to apply pressure to make the needed change?*

It is important to build a strong partnership or coalition with groups and/or individuals that are committed to applying the pressure necessary to make those in power effect change. Identify the key individuals or organizations that can contribute to your overall strategy (e.g. community organizers, researchers or general citizens). Applying consistent pressure to decision makers for change is the only way to counter the entrenched response of the status quo.

- *What to do/say to get attention of those who can make the change real?*

Formulating a message that is persuasive and compelling requires keeping in mind a few basic principles:

- First, different messages appeal to different audiences.
- Second, the message can change over time depending on the evaluation of the problem and solution.
- Third, carefully select the spokesperson(s) to deliver the message.

Understanding how the general public and decision makers think about the issues right now is an important part of developing the message. In the case of youth violence, if the audience does not think guns are a problem, they will not think that restricting gun ownership will reduce youth violence.

For a more in-depth treatment of message development and other aspects of advocacy refer to the resources listed at the end of this module.

Chapter XII resources

American College of Emergency Physicians. Visit the [American College of Emergency Physicians](#) for information about advocacy on the state level.

American Public Health Association's Advocacy Tips and Media Advocacy Manual. Visit the [American Public Health Association](#) website to see their *advocacy tips* and *Advocacy Manual*.

Christoffel KK. Public health advocacy: Process and product. *Am J Public Health* 2000;90:722-726.

Community Tool Box (2010). Organizing for Effective Advocacy. Visit the University of Kansas' *Work Group for Community Health and Development* to see their Tool Box.

Media Advocacy Action Pack, The Marin Institute. Visit [The Marin Institute](#) website to see a copy of their Media Advocacy Action Pack.

National Association of Counties. Visit the [National Association of Counties](#) website for information about advocacy on the county level.

Appendix I:

Master List of Resources

Publications

- American Academy of Pediatrics, "Adolescent Assault Victim Needs: A Review of Issues and a Model Protocol," *Pediatrics*, Vol.98, No.5, 1996:991- 1001.
- Becker MG et al (2004) "Caught in the Crossfire: the Effects of a Peer-based Intervention Program for Violently Injured Youth." *Journal of Adolescent Health*: 2004; 34:177-183.
- Becker B, Woolard RE, Nirenberg TD, et al. Alcohol use among sub-critically injured emergency department patients. *Acad Emerg Med*. 1995;2:784-790.
- Bonderman, J. Working With Victims of Gun Violence, Office for Victims of Crime, July 2001, NCJ 186155. <http://www.ojp.usdoj.gov/ovc/publications/infores/gun.htm>
- Centers for Disease Control and Prevention, *Framework for Evaluation in Public Health*. September 17, 1999 / 48(RR11);1-40. Accessed 6/1/10 at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>
- Chandler, Arnold. (2007) *Click Here for Change: Your Guide to the E-Advocacy Revolution*. PolicyLink and the Community Technology Foundation of California. Available in hardcopy from PolicyLink at: <http://www.policylink.org/site/apps/ka/ec/product.asp?c=klXlLbMNJrE&b=5158897&en=deJBIJNqHeKFIKMoE3LAKNMpFgINJRMvGgIMIVPCKoKZH&ProductID=580703>.
- Cheng, T.L., Haynie, D., Brenner, R., Wright, J.L., Chung, S., Simons-Morton, B.. *Effectiveness of a Mentor-Implemented, Violence Prevention Intervention for Assault-Injured Youths Presenting to the Emergency Department: Results of a Randomized Trial*. PEDIATRICS Vol. 122 No. 5 November 2008, pp. 938-946. Accessed 5/15/10 at <http://pediatrics.aappublications.org/cgi/content/abstract/122/5/938>

- Children's Bureau, Office on Child Abuse and Neglect (2010) *Community Partnerships: Improving the Response to Child Mistreatment*. Access at: <http://www.childwelfare.gov/pubs/usermanuals/partners/index.cfm> Accessed 10/5/10
- Christoffel KK. Public health advocacy: Process and product. *Am J Public Health* 2000;90:722-726.
- Cook PJ, Lawrence BA, Ludwig J, Miller TR. The medical costs of gunshot injuries in the United States. *JAMA*. 1999;282:447-454.
- Cooper, Carnell MD; Eslinger, Dawn M. MS; Stolley, Paul D. MD. "Hospital-Based Violence Intervention Programs Work." *The Journal of Trauma: Injury, Infection, and Critical Care*: September 2006 - Volume 61 - Issue 3 - pp 534-540. Accessed through <http://www.nonviolenceandsocialjustice.org/Resources/26/> (11/1/10)
- Corbin, T.J., Rich, J.A., Bloom, S.L., Delgado, D., Rich, L.J., Wilson, A.S. **(in press)**. Developing a Trauma-Informed, Emergency Department-Based Intervention for Victims of Urban Violence. *Journal of Trauma and Dissociation*.
- Cunningham, R., Knox, L. (Winter 2008) *Reinjury Prevention for Youth Presenting with Violence-Related Injuries: A Training Curriculum for Trauma Centers*. Southern California Center of Academic Excellence on Youth Violence Prevention in Collaboration with the University of Michigan Department of Emergency Medicine Injury Center. Accessed 3/5/10 at <http://www.nonviolenceandsocialjustice.org/Resources/26/>.
- Cunningham, Rebecca MD, Lynda Knox, PhD, Joel Fein, MD, MPH, Stephanie Harrison, MPH, PhD, Keri Frisch, MS, Maureen Walton, MPH, PhD, Rochelle Dicker, MD, Deane Calhoun, MA, Marla Becker, MPH, Stephen W. Hargarten, MD, MPH, *Before and After the Trauma Bay: The Prevention of Violent Injury Among Youth*. *Ann Emerg Med*. 2009;53:490-500. <http://www.annemergmed.com/article/S0196-0644%2808%2902019-2/abstract>
- Shibru, Daniel MD, MPH, Elaine Zahnd, PhD, Marla Becker, MPH, Nic Bekaert, MSW, Deane Calhoun, MA, Gregory P Victorino, MD, *Benefits of a Hospital-Based Peer Intervention Program for Violently Injured Youth*, *Journal of the American College of Surgeons* 2007;205: 684-689.
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- Dobrin, AL. *The risk of offending on homicide victimization: A public health concern*. *Am J Health Behav* 2003.

- Fein JA, Ginsburg KR, McGrath ME, et al. Violence prevention in the emergency department: clinician attitudes and limitations. *Arch Pediatr Adolesc Med*. May 2000;154(5):495-498.
- Fallot, R.D. and Harris, M., *Trauma-Informed Systems of Care: An Update* [Fallot & Harris co-edited the reference book, *Using Trauma Theory to Design Service Systems*], U.S. Department of Health & Human Services, Center for Mental Health Services' National Center for Trauma-Informed Care, Trauma Matters, e-Newsletter, (October 2007). Accessed 3/24/10 at http://mentalhealth.samhsa.gov/nctic/newsletter_10-2007.asp
- Fritz, Joanne. *6 Steps to a Fundraising Plan for a New Nonprofit: How to Develop a Fundraising Plan That Works, an About.com Guide*. Accessed 5/24/11 at: <http://nonprofit.about.com/od/fundraisingbasics/tp/basicfundraisingtips.htm>
- Gregory, A.G. & Howard, D.. *The Nonprofit Starvation Cycle*. Stanford Social Innovation Review. Fall 2009. Accessed 5/24/11 at: http://www.ssireview.org/articles/entry/the_nonprofit_starvation_cycle/
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- Jennings, A. (2004) Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services. Prepared for the National Association of State Mental Health Program Directors. Accessed 5/15/10 at: www.annafoundation.org/MDT.pdf
- Ketterlinus, Robert D. Ed., (2008) *Youth Violence: Interventions for Health Care Providers*, American Public Health Association Press, Washington, DC. pp. 133 – 141.
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- Knox, Lyndee PhD, (2004) *Connecting the Dots to Prevent Youth Violence: A Training and Outreach Guide for Physicians and Other Health Professionals*. Accessed 5/24/11 at <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/violence-prevention/youth-violence-prevention-training-outreach-guide.shtml>

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Online resource sites

- American Academy of Pediatrics' Adolescent Assault Victim Needs at <http://aap-policy.aappublications.org/cgi/content/abstract/pediatrics;98/5/991>
- American Public Health Association, Advocacy Tips at: <http://www.apha.org/advocacy/tips/>

American Public Health Association's Media Advocacy Manual at: www.apha.org/about/news/mediaadvocacy.htm.

Case Management Society of America, definition of case manager at: <http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx>

Caught in the Crossfire Peer Intervention Training Manual at: <http://youthalive.org/resources/>

Centers for Disease Control and Prevention, Public Health Approach to Violence Prevention at: http://www.cdc.gov/ncipc/dvp/PublicHealthApproachTo_ViolencePrevention.htm

Centers for Disease Control and Prevention, the *ten greatest public health achievements of the 20th century* at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm>.

W.K. Kellogg Foundation Evaluation Toolkit at: <http://ww2.wkkf.org/Default.aspx?tabid=90&CID=281&ItemID=2810002&NID=2820002&LanguageID=0>

W.K. Kellogg Foundation logic model handbook: <http://ww2.wkkf.org/default.aspx?tabid=101&CID=281&CatID=281&ItemID=2813669&NID=20&LanguageID=0>

The Marin Institute's Media Advocacy Action Pack. Available at http://www.marininstitute.org/action_packs/media_advocacy.htm Accessed 5/24/11.

Motivational Interviewing at: <http://www.motivationalinterview.org/clinical/whatismi.html> (Accessed 5/24/11)

National Association of Counties at <http://www.naco.org>

National Network of Hospital-Based Intervention Programs at: <http://www.nnhvip.org/>

New Directions From the Field: Victims' Rights and Services for the 21st Century <http://www.ojp.usdoj.gov/ovc/new/directions/>

Office of Quality Improvement and Office of Human Resource Development at the University of Wisconsin for information about conflict resolution at: <http://www.ohrd.wisc.edu/onlinetraining/resolution/index.asp>

Physician's Guide to State Legislation. American College of Emergency Physicians at: <http://www.acep.org/advocacy.aspx?id=22254>. Accessed 5/24/11.

Rape, Abuse and Incest National Network (RAINN) mandatory reporting requirements at: <http://www.rainn.org/public-policy/legal-resources/mandatory-reporting-database>

Sanctuary Project, Trauma Informed Care at <http://www.sanctuaryweb.com/commitments.php>

Socioeconomic Mapping and Resource Topography (SMART) System at: <http://smart.gismapping.info/smart/UserLogin.aspx?ReturnUrl=%2fsmart%2fdefault.aspx>

Texas Public Health Association Legislative Advocacy Guide. Guidelines for Effective Public Health Advocacy. December 2005 at: <http://www.texaspha.org/Content/Documents/Document.ashx?DocId=83500>

UCLA's Center for Nutrition on Stages of Change see: http://www.cellinteractive.com/ucla/phycian_ed/stages_change.html.

University of Kansas' Work Group for Health and Development, Community Tool Box at <http://ctb.ku.edu/en/>

Urban Institute's National Center for Charitable Statistics at: <http://nccsdataweb.urban.org/FAQ/index.php?category=40>

U.S. Department of Health & Human Services' National Center for Trauma Informed Care at: <http://mentalhealth.samhsa.gov/nctic/> (accessed 5/24/11)

Appendix 2:

The National Network of Hospital-based Violence Intervention Programs

Founded in Oakland in 2009, the National Network of Hospital-based Violence Intervention Programs is a partnership of 19 and counting programs across the country that provide intervention services to individuals being treated for violent injuries. Our mission is to strengthen existing hospital-based violence intervention programs and help develop similar programs in communities across the country.

National Network members collaborate on and participate in: joint trainings, site visits, research proposals/projects, e-bulletins and other publications, training/travel scholarships, policy initiatives, sharing of best practices, and an annual conference. Our goal is to continue to strengthen the National Network by achieving program sustainability, developing and disseminating more evidence-based resources, and informing public policies related to violent youth victimization.

Member Programs, as of October 2011 (* indicates a founding member):

- Beyond Violence (Antioch/Richmond, CA)
- Bridging the Gap (Richmond, VA)
- Camden GPS (Camden, NJ)
- Caught in the Crossfire (Oakland, CA)*
- Caught in the Crossfire (Los Angeles, CA)
- CeaseFire (Chicago, IL)*
- Healing Hurt People (Philadelphia, PA)*
- Massachusetts Violence Intervention Advocacy Program*

- Out of the Crossfire, Inc. (Cincinnati, OH)*
- Prescription for Hope (Indianapolis, IN)
- Project Ujima (Milwaukee, WI)*
- Rochester Youth Violence Partnership (Rochester, NY)
- Sacramento Violence Intervention Program (Sacramento, CA)
- UC Davis Wraparound (Sacramento, CA)
- UMC Trauma Services VIP (Las Vegas, NV)
- Violence Intervention Program (Baltimore, MD)*
- Violence Intervention Program (Savannah, GA)
- Within Our Reach (Chicago, IL)
- Wraparound Project (San Francisco, CA)*

To learn more, or to join the National Network, visit www.NNHVIP.org.