Rochester Youth Violence Partnership Final Report

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Executive Summary

The Rochester Youth Violence Partnership (RYVP) is a hospital-based violence intervention program that was implemented in 2005. In order to consider the appropriateness of program replication, The New York State Division of Criminal Justice Services funded an evaluation of the program. The evaluation sought to answer questions about who received the intervention, what intervention components were utilized more than others, and what impact did the intervention have on behavior change, amongst other questions. While the evaluation consisted of interviews, surveys, document review and observations, the core of the evaluation was to be the quantitative data analysis. The data analysis would look at victims treated for penetrating injuries at University of Rochester Medical Center. A variety of information would be captured, including criminal history, school data, family court data, gang membership, and mental health services accessed. We would also examine the extent of repeat victimization among program participants. Although the research design had been agreed upon by program staff, numerous and substantial limitations with data sharing were encountered. Without access to case-specific data we were unable to effectively answer the original, agreed upon questions about the impact of this intervention. Instead, the evaluation was limited to examining the history of the program, program development, and the partnership role, all of which are included in this report. This report also discusses the challenges to evaluation incurred and a preliminary analysis of the limited aggregate data shared by URMC.

RYVP is a theoretically sound, and promising hospital based anti-violence program. It is our hope that this evaluation report will shed light on the work that has been done to develop this program and to institutionalize it, and that this will also make clear the importance of collecting and analyzing data for the purpose of evaluation. In this case, it is unfortunate that data were not collected in order to assess for program effectiveness and replication.

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Introduction

The following is an evaluation report of the Rochester Youth Violence Partnership. This is a hospital-based violence intervention program housed in a trauma center in upstate New York. The hospital-based program has been in existence in some form or another since 2005. In 2011, the Center for Public Safety Initiatives was approached by the New York State Division of Criminal Justice Services to conduct an evaluation of the program as well as the creation of a manual on how to implement a hospital-based violence intervention program. This report is the culmination of interviews, observations, surveys, document review, and data analysis for the hospital program. The handbook can be seen in Attachment 1 (p.65) of this Report, and it can also be viewed by visiting the CPSI website at http://www.rit.edu/cla/cpsi/.

The report begins with a review of the existing literature on hospital-based violence interventions across the country, as there are a number of programs that serve as interventions for victims of violent injuries treated at the hospital. The report then describes the proposed evaluation plan. Next, a program description, along with a flow chart of the process is included. This was developed in conjunction with RYVP during the evaluation. Evaluation results are then shared, which include the analysis of the limited data provided to us by URMC. Included in this section is an explanation of the significant change in the evaluation plan specifically as it relates to the quantitative data. Finally, conclusions and recommendations are described and discussed.

Expected Outcomes

In order to have a program deemed successful, specific outcome measures must be identified, collected, and analyzed. Only then is it possible to determine the impact of a program. For RYVP, according to its program developers, the expected outcome is that the victim will not be treated at URMC for a repeat violent injury. While this is the expected outcome of the intervention, there is reason to believe that this intervention could play a role in future criminal justice outcomes, school outcomes, Court outcomes, mental health outcomes, and service connection for the treated victim. For this reason, we sought to answer the first question but to also assess whether the intervention impacted other areas of the victims' lives.

Literature Review

There is a handful, but growing number, of hospital-based violence intervention programs across the nation. The oldest ones include Caught in the Crossfire implemented in Oakland in 1994, Project Ujima implemented in Milwaukee, and the Violence Intervention Program out of Baltimore. In more recent years, more hospitals have implemented, or begun the steps towards implementation, of violence intervention programs. With the increase in programs, the National

Network of Hospital-based Violence Intervention Programs (NNHVIP; http://nnhvip.org/) was formed as a resource for the various programs.

NNHVIP is run through University of Pennsylvania's Firearm and Injury Prevention Center and has a steering committee with national membership. As explained on NNHVIP's website, the programs that are part of the network incorporate the use of the window of opportunity for victims of violent injuries recovering in the hospital, with a goal of reducing retaliation and future violence.   With such a general description of hospital-based violence intervention programs, the programs identifying themselves as such have varying program structure, measures, and outcomes. This section will shed light on some of the programs and current research state of these programs.

Before describing a select number of programs, the first point to be made is that *all* of the programs, except for RYVP, have a dedicated program budget. RYVP is unique in that its program is run without an identified budget. The intervention is run through the hospital, with hospital staff that are trained in the process. RYVP staff argue that they have found a way to integrate the intervention into the regular way of doing business. As one will imagine, there are both drawbacks and benefits to running a no budget program, which will be discussed further in this report.

Hospital-based intervention programs use various intervention strategies, from mentoring to case management, to referral coordination, to home visitation, to service planning, and brief, directed behavior change counseling (Aboutonos, 2001; Cheng, Haynie et al, 2008; Cheng, Wrught, et al, 2008; Cooper et al, 2006; Cunningham et al, 2012; Johnston at al, 2002; Shibru et al, 2007; and Zun et al, 2006). The interventions are mostly focused on young people who are victims of violence, often between the ages of 13 and 20. Further, participation in the programs may last anywhere from one day to one year. While these intervention programs have varying elements, some of the programs have undergone evaluation.

Caught in the Crossfire (Oakland) has been evaluated twice, once in 2004 and again in 2006. Through the use of Crisis Intervention Specialists, youth who have been hospitalized for violent injuries are introduced to the program. The Specialists are young adults who are from the same community. Many have been incarcerated in the past or are disabled due to violent injury. They meet with the youth and the youth's friends and family immediately after the youth has been hospitalized and then they conduct visits throughout the duration of the hospitalization as well as post-discharge. The specialists assist with referrals, job placement, probation hearings, and other related issues.   The first evaluation study looked at a 6-month follow-up period post-hospitalization. The treated cases were those who had successfully completed the program, while the control group members were those who were similar but were somehow left out of the program (i.e. moved, overlooked at the hospital, wrong identifying information, etc). The results showed that youth who were treated, were 70% less likely to be arrested for any offense 6 months post injury than the control group. Regarding violence-related arrest rates and probation

rates, the results were not statistically significant; however none of the treated group participants were arrested for violence-related offenses 6 months post injury (Becker, 2004).

Using data spanning 6 years, from 1998-2003, Caught in the Crossfire was again evaluated. This study was similar to the previous study, but it looked at 18 months post injury and it also examined the cost-effectiveness of the program. While the results found similarities between risk of physical re-injury and death for both groups, there were differences found in future involvement in the criminal justice system. It was discovered that those who participated in the intervention were less likely to be involved in the criminal justice system than those who did not participate. When controlling for ethnicity and gender, the program's effect on reducing criminal justice involvement was more effective with younger participants. Data were also gathered on cost and it was determined that the program's annual cost was $60,000 less per patient than the cost of incarceration (Shibru, 2007).

CeaseFire (now Cure Violence) in Chicago has a hospital approach to violence reduction as well. The Advocate Christ Hospital in Oak Lawn, Illinois collaborated with Ceasefire three years ago, and committed substantial funding to have chaplain staff available 24/7 for those who are treated for a violence-related injury. The hospital surgeons were getting frustrated at the number of repeat victims of violence showing up to be treated. So, the doctors approached Ceasefire to ask if their street violence interrupters could do some outreach at the hospital as well. In 2007, Ceasefire was involved in about 400 interventions at Advocate Christ. Though Ceasefire lost $6.2 million in state grants in 2007; Advocate Christ gave the group $50,000 in 2006, $72,000 in 2007, and $95,000 in 2008 to continue the program (Shelton, 2008).

Baltimore's Violence Intervention Program (VIP) is for adults who have been previously hospitalized for at least one violent injury and are readmitted to the hospitalized for a violent injury. Those who participated in the program during the study period (1999-2001) were part of the intervention group and those who chose not to participate were part of the control group. The intervention consists of a long questionnaire that the victim completes. After the results are reviewed, the social worker or caseworker as well as other VIP team members, as necessary, design a service plan. The VIP multidisciplinary team members are representatives from medicine, social work, Probation, epidemiology, and other specializations. Then, post-discharge, home visits were made. Additionally, weekly joint meetings are held to discuss the cases. The results showed that the nonintervention group was four times more likely to be convicted of a violent crime than the intervention group and two times for likely than the intervention group to be convicted of any crime. The program also had a positive effect in hospital recidivism (Cooper, 2006).

While hospital-based violence intervention programs are becoming more common, there is still great variation amongst the programs as well as mixed findings on their effectiveness. For these reasons, standardization amongst the programs seems like a logical next step. This report is one step in sharing information in order to add to the knowledge in the field. Further rigorous evaluation would be an asset to this young field as well. While some programs are showing

more success than others, it would be beneficial to better understand what works, how it works, and how can it be sustained. Evaluation will get at these questions, making partnering with researchers all the more rewarding.

Evaluation Methodology

Our mixed methods evaluation design called for quantitative data analysis and qualitative long and short interviews, observations, and document review. The following describes the questions that we planned to address in our evaluation. These can also be found in the original grant proposal submitted to DCJS. This plan was shared with URMC and we had agreement among all parties to move forward with the evaluation.

The evaluation proposed to examine:
- How the program works,
- How well the program works,
- For whom the intervention works best,
- Under what circumstances are levels of success achieved.

In addition to these broad issues, there were a number of specific questions to be addressed. These questions include:

1. Is there a difference in outcomes for those who receive different intervention components versus the combination of interventions?
2. Who is the intervention reaching? Who is the intervention missing?
3. Are there differences in outcomes for shooting versus stabbing victims?
4. Is medical follow-up care maintained by the participants?
5. What is the medical cost to treat these victims?
6. Is injury recidivism reduced for those who participate in the intervention? Is violent retaliation reduced?
7. Are participants receiving mental health services at a greater rate than those not enrolled in the program?
8. Is this program replicable?
9. What are the behavioral factors, educational outcomes, and medical outcomes (prognosis) of these youth?

The research plan called for a control group design using multiple control groups and comparing them with the intervention group. The five control groups that were considered are: those with similar criminal record, age, demographic, and school data who were never (on record) treated for a violent injury; those who refuse to participate in the intervention; those who accept services but then drop out of the program either formally or informally; those with similar demographics

who receive ED care for non-violent injuries; and a group who are a geographic and demographic representation from the community that the victims are from.

Data sources would include: the relevant hospital databases, RYVP patient care log, mental health databases through Coordinated Care Services Incorporated (CCSI), criminal justice databases through the Monroe Crime Analysis Center, the Pathways database (local gang intervention program), and our own observations.

In discussions with URMC we were informed of a new development: it was not clear whether identified or de-identified data would be available for those who receive an intervention and for those who do not. It was agreed that every effort would be made to share the richest, most complete data and that limitations could be addressed through collaboration in the analysis process. The data collected would be both pre and post medical treatment. The ability to look at the patient's actions prior to the violent injury would help with the bigger picture of how the violence resulted. Data would be collected immediately, at 3 months, 6 months, and 12 months post injury. It was also agreed that the research would be governed by human subjects review processes at the URMC and RIT. These issues were discussed with program staff prior to work on a Memorandum of Understanding.

While URMC was charged with collecting and sharing the data specific to the participants, RIT researchers were to use semi-structured interviews, partner surveys, document review, and observations to evaluate the RYVP.

<u>Semi-structured interviews</u> (see appendix A) were to be used with key leaders of the program. These key leaders included representatives from the hospital, community agencies, the school district, and the office of Probation. Partner <u>surveys</u> (see appendix B) were disseminated to all the members of the partnership. These surveys were distributed via email and at a partnership meeting. Partnership <u>meeting minutes</u> and the list of attendees were reviewed. Additionally, the <u>in-hospital intervention documents</u> were reviewed (see appendix I and appendix J). Finally, <u>observations</u> were made at partnership meetings and other meetings related to the program and the evaluation.

The following section is a result of the above observations and interviews. The process description was formulated from the qualitative work that was done for the evaluation. It is an attempt at describing the program and includes two flow charts shedding light on the internal work done at the hospital related to the intervention.

Process Description

The Rochester Youth Violence Partnership Program is comprised of two major components: 1) an intervention and 2) a partnership (or coalition). Essentially, the Rochester Youth Violence Partnership is a coalition of over 30 agencies and a hospital-based intervention program for youth who are victims of violent penetrating injuries (gunshot and stab wounds). The program began in 2005 and continues to evolve as new problems and solutions arise.

The intervention targets those victims aged 17 and younger and includes an initial assessment done in the hospital to identify risk factors that may have led to the current injury as well as ongoing risks that may lead to additional injury if discharged. Hospitalization is employed by the social worker when discharge is felt to be unsafe or unwise. There is an effort to keep some victims in the hospital when there is an identified safety risk; in those cases a medical necessity is identified. In addition to injury-related medical care, hospitalized victims undergo a specialized intervention that is focused on a complete understanding of risk factors that may have led to injury as well as approaches aimed at preventing future injury. This process involves families and guardians and incorporates tools such as a locally produced video and a document of understanding that are both designed to engage participants actively in the process. The ultimate goal is to assure a safe discharge and to connect victims with resources that can provide the necessary services required to prevent further injury (i.e. gang intervention services, mental health treatment and substance abuse treatment, etc).

The program has no direct budget and there is no specific funding for those who carry out the process in the hospital. The intervention has been accepted by the hospital and the medical staff as the "standard of care" and is now part of the routine approach to patients who sustain injuries due to violence. While the program has no direct budget associated with it, there are still costs incurred, such as staff time, hospitalization costs, and paperwork.

The goal of the program is to reduce the incidence of violent re-injury. Related goals include coordination of service providers around the victim, ensuring safety throughout the victim's entire hospital stay, as well as reducing the likelihood of retaliation.

Intervention

The charts below, and the discussion that follows, illustrate the RYVP intervention process.

RYVP Hospital-Based Intervention Process

Pediatric Victim Presents to the ED with penetrating trauma

Medical necessity for admission apparent

Admit to ICU or medical unit

- Social Work evaluation/ risk assessment
- Medical/surgical treatment stabilization
- Security patient protection plan
- Child Life consult
- Psychiatry consult

Contacts school when indicated

Social Work evaluation/risk assessment →
- Street outreach
- Voices of Violence Video
- Document of Understanding

If indicated, contact
- school
- CPS
- Other referrals

Collaborates with treatment team to ensure safe discharge plan

Discharge with any referrals and recommendations

Medical stabilization for discharge possible

- Social Work evaluation/risk assessment
- Medical/surgical stabilization

If indicated, contact
- Street outreach
- CPS
- Other referrals

Collaborates with treatment team to determine if safe discharge is possible from ED without further evaluation or intervention

No | yes

Discharge with any referrals and recommendations

Street Outreach Role in Intervention

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┌─────────────────────────────┐
│ Social Work Evaluation      │
│ Reveals Need to contact     │
│ Street outreach and pages   │
│ Street outreach             │
└─────────────────────────────┘
        │
   ┌────┴──────────────────────────────────┐
   │                                        │
┌──────────────┐                    ┌──────────────┐
│ High         │                    │ Low          │
│ retaliation  │                    │ retaliation  │
│ risk         │                    │ risk         │
└──────────────┘                    └──────────────┘
   │                          ┌──────────┼──────────────┐
┌───────────────┐   ┌──────────────┐ ┌──────────────┐ ┌──────────────┐
│ Street        │   │ Crisis       │ │ Street       │ │ Street       │
│ outreach      │   │ Intervention │ │ outreach     │ │ outreach     │
│ makes         │   │ Services     │ │ makes        │ │ presents     │
│ connection    │   │ Provided     │ │ connection   │ │ child at     │
│ with youth to │   └──────────────┘ │ with youth   │ │ Safety Net   │
│ analyze       │                    │ to analyze   │ │ for case     │
│ community     │                    │ community    │ │ management   │
│ issues and    │                    │ issues and   │ │ follow up    │
│ outside       │                    │ outside      │ └──────────────┘
│ services      │                    │ services     │
│ needed        │                    │ needed       │
└───────────────┘                    └──────────────┘
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Partnership

The RYVP meets monthly at the URMC with the purpose of discussing any issues that have surfaced with the intervention, any process issues related to the intervention, current and future status of the intervention, coordination of violence-related efforts in the community, and any other issues related to the program. This is an open meeting, with a monthly reminder sent out to all the partners. The meeting is guided by an agenda and facilitated by one of the key leaders. Meeting minutes are created at every meeting and then shared at the beginning of the following meeting.

Health Project Coordinator

DCJS funded a new position for the RYVP, entitled the Health Project Coordinator, during this grant period. The Health Project Coordinator took on a number of roles, including a role related to evaluation and one in which she would conduct intervention services. While not anticipated, due to issues with evaluation outlined throughout this report, the HPC had to take on a much larger role within the evaluation than expected. The HPC had to take on the task of accessing the identified data, contacting and interviewing the consenting subjects, and formalizing the RYVP care log because the RIT researches were not allowed access to any identified data. With these newfound obstacles in place, the HPC was also eventually tasked with identifying, recruiting, and interviewing research subjects as part of the evaluation. Much of her time was focused on

updating and converting the RYVP client database to an official RYVP patient care log. She also took on the task of service coordination for both current victims treated for a violent injury at the hospital and previous victims of violent injury treated at the hospital. This was a position that was funded for one year. During the course of this evaluation, the position ended.

Results

The results of the qualitative data are shared below and, following that, the quantitative data are shown. The program has evolved since 2005 through the present and the interview and survey results will show the program is under constant development. From March 2006-August 2012, there were 260 victims aged 17 years and younger who were in the RYVP database as being treated for a violent penetrating injury at URMC. The mechanism of injury, length of hospital stay, intervention components received, and history with the various agencies are revealed. First, though, we begin with the interviews with the key leaders.

Interviews with Key Leaders

Eight key leaders of the partnership were identified to participate in a long-form interview. Of those asked to participate, three are considered the founders of RYVP and the others were identified through a consensus as having key roles in the partnership and intervention. One person was not able to be interviewed due to a resignation, making for a total of seven interviews conducted. Appendix A is the interview outline. The aims of these interviews were to better understand the program, document program development, understand program goals, get familiar with data collection, and identify obstacles and strengths.

History and Development

The experiences of several patients played a crucial role in the development of RYVP, including a teen who had been out at two in the morning and was stabbed, a young person who arrived to the hospital dead from a gunshot wound (but then medical records revealed that he had been treated twice before for violent injuries), and a youth who showed up stabbed and wearing bulletproof vest. These three cases brought together two of the key leaders through feelings of, "enough is enough." These two key leaders then had frank conversation around intervening in these young people's lives. One was a pediatric social worker and the other, the Director of Trauma Services. Together, they then reached out to the Child Psychiatrist that they both knew and began discussing what to do when the inevitable next victim of violence would need treatment. They believed that there was a role for them to play in some sort of intervention with these victims.

While there was concern for the victims, there was also serious concern around the safety and security of other patients in the ED as well as hospital staff. When these injuries were treated, security was often on edge as there were often retaliation scares and threats that the offender would arrive to the hospital to "finish the job." The leaders believed that there had to be a way to intervene for the safety of the patients, and also for the safety of others. Thus, they began to put together a plan to move forward and do things differently in the hospital.

Meetings took place internally to formulate ideas around strategy. Out of those conversations, which included other key staff at URMC, came the notion that Child Protective Services should be involved. The group felt that the issue of young people being out at two in the morning and becoming victims of violent injuries fell under the responsibility of the parent to protect their child from these kinds of events. Child Protective Services was then brought into the meetings. The key leaders made a strong argument that CPS has a role when a young person is violently injured and the parents are being uncooperative with services. After much discussion and numerous meetings, CPS came on board and today is now one of the program's strongest supporters.

The other importance in having CPS involved meant that, on a practical level, parents would have to listen to what the hospital staff had to say as they had the responsibility of protecting their child. CPS' involvement indicates that the medical staff now has leverage with the families for the intervention and service provision. This was a critical first step to the intervention.

Intervention

Now that they had leverage from CPS, the target population was rather quickly and easily chosen due to CPS' authority over the protection of children aged 17 years and younger. The target population was elected to be youth aged 17 years and younger who present to the hospital for either a gunshot wound or a stab wound. As one of the key leaders explained, "That was a pretty idiot proof way to decide who would be involved in the intervention." He went on to explain that from the outset, the key leaders understood that while they believed in this change, they are the ones who go home on the weekends and evenings, in the midst of the high activity for violent injuries. For this reason, they needed to ensure that all staff could easily identify the target population. The other essential piece was that an easily identifiable target population created ease of both training and replication.

The interviews revealed that throughout this process, the key leaders were interested in looking around and seeing what other cities were doing to intervene with this population. One key leader contacted other hospital programs for advice and recommendations. They were impressed with one particular program, and they, in turn, tried to emulate that program in the RYVP.

After target population identification was complete, the key leaders had to decide what they were going to do differently with these young people. First, would be the initial screening for age and injury presentment, and then would come a new screening for patient safety. The safety

screening would determine how safe it was to discharge the patient as well as ensure safety in the ED. As explained by a key leader, an initial safety assessment, including safety plan development as necessary, was nothing new to the social work department. This was a regular task when treating victims of child abuse as well as survivors of domestic violence. This screening tool (see Appendix I) was then adapted for this population and includes contacting Probation, the Police Department, and the gang intervention program (PTP) to better assess the safety of the victim. At this point a decision would be made as to whether the young person would have to be admitted due to safety issues or was safe to return home. One of the intervention components was thus created: admitting a patient due to safety concerns related to his or her violent injury.

If the decision was made that he or she would have to remain in the hospital, this is where the CPS leverage would be utilized, but only as needed. From the interviews it is clear that CPS rarely was used to keep a young person safe in the hospital. Once any youth is admitted to the hospital (regardless of type of injury), hospital policy requires that all adolescents undergo an adolescent screening. This screening would automatically be utilized with this population as well. This screening done by the social worker is an assessment of any safety issues and whether there is a safe discharge plan in place. If any concerns are identified, then the issues are addressed.

Next, one of the key components of this intervention, a child psychiatric screening tool, was to be utilized with this population. As one of the program leaders is a child psychiatrist, this was seen as a critical stage in the intervention. A key leader explained that there are well founded concerns that young people are misdiagnosed, not diagnosed, or not connected to appropriate services and it was important to assess these young people and connect them to services. It is difficult to make timely appointments with mental health services, regardless of socioeconomic status, but this stage of the intervention sought to assess the child *and* connect him or her to services post discharge.   One key leader explained the lack of child psychiatrists by stating, "child psychiatry is the most underserved medical specialty, bar none, period." Yet, through his efforts he was able to get timely appointments for these young people when needed.

While the intervention was steadily coming to fruition, the key leaders directly approached the hospital administration about what they were doing. One key leader explained that keeping leadership informed is absolutely integral to a successful intervention.   Hospital leadership was on board and at this stage in the planning, the need for community involvement was clear to the key leaders as they now had a sense of what would be done internally with the victim.

While the intervention components are clearly outlined above, it was evident during these interviews that, while some of those interviewed had a obvious grasp of the intervention, not everybody was fully informed as to what the intervention involves. Some of those interviewed were unable to articulate the intervention components and others were only clear on the piece that they were intricately involved with. There may be a reason for the lack of clarity, but it

would seem that all key players should have working knowledge of the intervention to better inform their actions with the youth and their family.

When the program began, the Voices of Violence video and the document of understanding, two current elements of the intervention, had not yet been created. It was not until the partnership developed that these two components were conceived.

Partnership Development

As the assessments were being developed, it became clear to the leaders that this is a community problem and that a community problem requires a community solution. The obvious next phase, then, was to reach out to the community.

One of the key leaders was familiar with a prominent community member through referring patients with chronic medical conditions to his organization. It was known that this particular community member was interested in violence reduction as he sat at a table that dealt closely with issues around violence. This table was known as Project Exile. Through their relationship, one of the key leaders was then invited to a Project Exile meeting to present the program. At that meeting he connected with community agencies and the partnership began. The original partner identified at the Project Exile meeting is still active in the partnership today and was one of the key leaders interviewed for the evaluation.

The rationale for the partnership was that there are resources and assets that the community has to offer and it makes sense to reach out to the community. The importance of the partnership was clear to a key leader who noted, "There are a lot of resources through the members of the partnership." This newly identified partner discussed his initial caution at joining the partnership during the interview. He explained that many other coalitions, groups, and consortiums exist in the community, but rarely make any progress on issues.

However, as he began to attend the meetings and see the work being done, this partner was invigorated and continued his strong involvement. He was also intrigued by one key leader's two questions regularly asked regarding violent injury, "Is it predictable and is it preventable?" This discussion and interest in doing something and really making things happen was of strong interest to the partner. The partner explained that he has not seen anything else like this in Rochester as there is authentic activity being done and it is "for the children."

The partnership quickly evolved to include numerous members representing community agencies, various departments at URMC, the medical community, law enforcement, and others. The key leaders felt that the partnership is critical due to the resources offered, the problem-solving that occurs, and the diversity of experts and services at the table. The interviews revealed that it is not crucial to have everyone at the table from day one, but it is important to continue to build upon the current membership. Further, the meetings are never held just to

meet. Rather, there is agreement that they should be held because there is work to be done and an agenda is set forth.

When the key leaders were asked who needs to be involved in the partnership, there was a plethora of responses.   One key leader stated that all are wonderful, and it is important to have the "doers" involved.   Another key leader felt strongly that the Office of Probation, the school district, and CPS must be involved. Another explained that mental health also needs to be present. Another key leader felt that the membership would be variable in every community, but that it should be dependent on resources available in that particular community.

As is elaborated in the program description, this program evolved over time and is now considered the normal way of doing business at the hospital. The intervention reaches nearly all of the young people who present at the ED for a violent penetrating injury (90%).

No Budget

The decision to have no external program budget was made early on. According to one key leader, when they reviewed other programs, the woes of having to search for money were echoed by program after program. RYVP did not want to get caught in this. There was also the issue that at least one of the key leaders was not familiar with grant writing and did not have the time or the interest in getting informed. The partners acknowledge today that there are some things that would have been absolutely advantageous to have funding for but, in looking at the overall picture, they all seemed to agree that they would not change their decision. Another key leader explained that they do not want to get pigeon holed in their work. There were also concerns that funding streams sometimes compel goals to be shifted or outright changed and they were hostile to that possibility.

Data Collection and Evaluation

In talking to the key leaders, it was clear that data collection and evaluation were not priorities for them at the program's inception. So much so, that when one key leader was asked about data collection he stated, "Oh no, I stay away from that." Over time they realized that it was important to collect data on what they do and who they see, but is still an area in need of improvement. One key leader stated, "At the beginning, we didn't realize that we wanted to prove that this works." As is common amongst practitioners, tracking, data collection, and analysis did not take precedence. It is also clear that while evaluation may have moved up in the priority list, the key leaders feel stronger that this is the "right thing to do" and that it should be done no matter what. The statement was made, "the alternative [response] is unethical."

When key leaders were asked about their thoughts on the effectiveness of the intervention, every one of them believed that this intervention had a chance to be effective in reducing the likelihood that someone would be violently reinjured. One key leader elaborated on a person he knew personally who was impacted by the intervention. This person was connected to resources that

he otherwise would not have been connected to and was doing well, improving his life. This same key leader believes that the most effective aspect of the intervention is that the young person is made to believe that they could have died, and that is powerful. He felt that the possibility of behavior change really speaks to them at this stage in the process.

Teachable Moment

All three of the founding leaders of the program stressed the use of the teachable moment as guiding this intervention. This is "the point in a learning experience which the leaner is more receptive to accepting and using new information, accepting new attitudes, or learning new skills" (p. 174, Leist & Kristofco, 1990). These are naturally occurring events in one's life in which they are more apt to take in information and then change their attitudes and/or behaviors in particular aspects of their lives. Taking advantage of this natural event has shown success particularly in the fields of smoking cessation, sexually transmitted disease prevention, and alcohol abuse prevention. For the hospital program, this teachable moment is viewed as occurring both for the victim *and* for the victim's parents. The belief held by the founders is that this person has just been violently injured and there is a chance that he or she might be more willing than previously to listen and change his or her risky behavior through the new tools and service connections made. Johnson et al. (2007) completed one of few studies that looked at the impact of the teachable moment on those presenting at the Emergency Department for an assault penetrating injury and the results were promising. Preliminary support was found for the presence of the teachable moment with those patients. URMC has used the teachable moment in STD prevention previously, so this idea, then, was nothing new to URMC, but its use with this particular population was novel.

The idea of the teachable moment is the theory behind the inclusion of the video and Document of Understanding in the intervention. Both of these use hard facts to explain to the family that because of this injury, the victim is now much more likely than others who have not been violently injured, to be re-victimized. They go on to explain that these experiences occur because this person is leading a risky lifestyle and that to lower his or her risk level, he or she needs to engage in healthier behaviors.

Program Goals

The three founding leaders clearly agreed on the goal of the program: to reduce recidivism for violent injury (specifically stab or gunshot wound) for those treated at URMC. However, the other key leaders interviewed felt that the program had additional goals, such as: break the cycle of violence, provide safe management of the patient while in the hospital, and safe discharge. It might be useful for the leaders to specify any goals other than the original intention, as there appear to be other things that are trying to be influenced through this intervention. And, as noted earlier, assessment of effectiveness in meeting program goals was not adopted as a significant component of the program.

Victim Refusal

When asked about the incidence of victims refusing the intervention, it was clear that this has not been an issue. One particular key leader explained that this has not come up frequently as a program concern. When the issue has surfaced, CPS was quickly involved, but the following day, in every case, the family and/or victim came around and were open to talking. Further, one key leader discussed the impact that the video and Document of Understanding appear to have on the family. The key leader explained, "I have had parents tell me after watching the video that they were planning to go out and retaliate, but after watching the video, they will no longer do that. That is powerful." He also discussed other instances when retaliation was clearly the next step for those dealing with this victimization, but that by the end of the intervention, they had completely changed their tune to not committing violence. He also talked about a case in which a victim refused to back down about getting out immediately, to go and victimize the person that injured him. With such serious concerns, probation was contacted and he was placed in jail for a violation of his conditions of probation. While confinement was not the desired outcome, the founders of the intervention believe that they saved someone's life that night and that it at least allows for a cooling off period.

Case Review Meetings

The structure of the partnership is based on the Project Exile Model. Project Exile was established in Virginia in 1997 with a goal of creating harsher sentences for those caught with firearms. This was to be done through taking *any* possible gun charge and transferring it from local or state prosecution into the Federal Court, making the crime eligible for a 5 year minimum sentence. Deterrence theory framework was at the root of the intervention in that harsher sentences would deter people from carrying guns and thus reduce the number of people who died or were injured as the result of a firearm. This required communication between multiple criminal justice agencies in a formal, standardized way. To make this run smoothly and effectively, task forces were created in a number of cities that had Project Exile. Rochester was one of those cities and continues to be today. Monthly meetings are held amongst the key criminal justice agencies in which information is shared, new tactics are discussed, and challenges are addressed. In Rochester there are 30 regular attendees to these monthly meetings. In addition to the large monthly meetings, specific case meetings are held monthly amongst those involved in the specifics of certain cases, ensuring that information is shared and the most effective approach is made with every case.

As Project Exile had the case meetings, RYVP was interested in having similar meetings in addition to the larger monthly partner meetings. For a little less than a year they were able to pull off the case review meetings in which those directly involved with the particular individual would meet to discuss follow-up. However, there were issues with these meetings particularly in regards to confidentiality, as the patient had already been discharged. Another problem involved

the lack of information shared by the school district. There is hope that these issues can be resolved and that the meetings can resume, but as of the evaluation period, that had not occurred.

Unanticipated Positive Outcomes: The program leaders saw the several positive outcomes from the program partnership including:

1. Development of the Document of Understanding
    The idea of having some document to be reviewed with the victim and his family really came out of the social workers' interest in formalizing the discussion with the family on the high risk lifestyle. The key leaders felt that this was a way to both guide the conversation as well as ensure that the social work staff was indeed discussing this issue with the family and victim. The Document of Understanding was drafted by the key leaders, but then the partners assisted with language changes, edits, and recommendations. The document went into use in September 2008. While it has continued to be used with the victims of violent injuries, upon consultation with a legal representative, it was decided that the document would no longer be stored in the patient's medical record as there was concern of the possibility of medical records subpoenaed. Instead, then, as of October 2010 the review of this material is not captured in the patient care log and there is no data available on the number of patients who signed the document since October 2010.

2. Video
    As is seen in the development of the program, initially there was no video component to the intervention. However, with the involvement and (critically) the support of the partnership, a video was drafted and produced for the victims to watch with their family members and to then discuss with the social worker. The video shows interviews with previous local victims of violent injury, as well as family members, in order to better understand how the shooting came to be, the impact on family, and how the victim turned his life around. This took complete advantage of the teachable moment. One partner had connections with the local not for profit TV production company and everyone who appeared in the video as well as those who wrote the script all volunteered their time. This video is called: Voices of Violence and it went into use in May 2009. What has been really critical to the video is that it has not been widely disseminated for others to view. The key leaders are sensitive to the possibility of too many people watching the video and it losing its power. Schools and community agencies have requested to view the video and the key leaders have contemplated the issue. They have decided that it is most important to leave the video for those who have been violently injured, as it directly speaks to them and their family.

3. Poster Contest
    The program is an intervention, but the partnership has had more and more discussions around prevention. The partners have been very interested in including some sort of prevention component to the program. Thus, with the agreement of the RCSD

representative, an anti-violence poster competition through the RCSD was devised. The leaders all felt that this was a really important achievement and that there is no way it would have occurred without the partners. The spring of 2012 was the third year of the poster contest. The contest has even grown since its inception, as it now is run in conjunction with a lesson plan on community violence.   This lesson plan includes special guest presenters who are all members of the partnership who volunteer to present in RCSD classes on violence prevention.

4. Culture Shift
Early in the process, program leaders had hoped that there would be a change in attitudes of hospital staff toward the victims of violent injuries. One key leader explained that the adolescent unit had previously really struggled with this population, but with the implementation of the intervention, he has noticed that the staff are showing more compassion and hope for this population. The leaders also disclosed that the hospital security used to struggle with this population and with the partnership of Pathways to Peace they now feel confident in their ability to assess the safety of the hospital. Last, one key leader discussed how this has truly become the normal way of doing business and he is very proud of that feat. The notion that many hospitals did (and some still do) live by, - "treat 'em and street 'em"- is no longer accepted in this hospital. Program staff saw that as a critical success.

These continuing challenges were noted in our interviews:

1. Long-term Follow-up
One challenge to the program identified by the key leaders is the lack of longer-term follow-up. While the hospital can control what occurs within the hospital while the patient is being treated, there is no authority or ability to compel the patient to receive services post discharge. Further, without funding to support follow-up services, the intervention relies on community resources which can dwindle over time, program missions can change, and leadership can impact the services. The key leaders have watched over the years as the particular outreach program has received less and less funding to provide the needed services at URMC. Because of this, some of the key leaders have assisted and supported grant applications by this agency in order to keep the program intact.

2. School District Involvement
Another major challenge early on was representation from the Rochester City School District (RCSD), both as a partner and as a vital component of the intervention. Key leaders continued attempts to engage the RCSD, with little positive results. It was not until a change in leadership at the superintendent level that there was any movement from the School District. As a new superintendent took over, the key leaders set up a meeting and as a result of the meeting, there has been a representative at a high level in the District involved both at intervention level and partnership meetings.

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The key school leader who did eventually come on board was familiar with public health and violence issues. Further, in her role of overseeing youth development and family services, she was positioned to take an active role in this intervention. She has access to student records, which include behavioral issues, truancy, academics, and sibling status. She also has the unique ability to assist with a school transfer for those youth who were treated and had significant safety concerns and required a transfer to ensure their safety.

The school leader explained that school attendance is a significant indicator of what is going on in the youth's life and can be a key factor in decision-making around the youth. In her role in the intervention she then gathers information on attendance, the school social worker, human service agencies, school nursing, and then she shares that information with the URMC. If there is a need for more services by RCSD, she is contacted by URMC and a phone conversation is held to gather more information and make better decisions.   When asked about data collection, the key leader explained that she keeps a hard file on the young people, but there is no tracking system or list available for all the youth she has been contacted about. Since her involvement in the intervention, RCSD records have been accessible and are an important tool in the process.

3. Involving Other Local Hospitals
An ongoing struggle has been to implement the intervention at the other hospital that receives a high number of victims of stabbings and gunshot wounds in Rochester. There has been representation on the partnership by Rochester General Hospital (RGH), and other outreach efforts have been made, but the intervention has not been implemented there. Since RGH is not a trauma center, there are staffing limitations, such as the unavailability of social workers around the clock. While the URMC program is run through the social work program partly because it is staffed 24/7, there are ways that this could run through the nursing department or another department that is staffed 24/7. Also, a program champion at RGH would expedite the process. All the key program leaders saw RGH's lack of an intervention as a challenge to the community.

4. Faith Community Involvement
A few key leaders wished that there would be more involvement in the partnership by faith leaders in the community. While the leaders felt that there had been attempts to engage the local churches and faith community, they had little success. One key leader talked about the Chaplains available at the hospital, but he felt that there was no significant connection to the churches in the communities where the victims live. This continues to be a struggle for the partnership.

5. Staffing
As one key leader put it, "Staffing the intervention in the beginning was absolutely a challenge."   As expected with any new initiative, there was a significant learning curve. While this was a challenge to overcome, the key leaders took training seriously and made

sure to train the hospital staff as thoroughly and frequently as possible. Turnover is often high is hospitals, with the new staff members often working the less desirable hours and the more experienced staff working more attractive hours. Therefore, as new employees come in, it was all the more critical to train them on the intervention components and process, the key leaders all agreed that training must be ongoing, but most of the staff have now been trained on the intervention.

6. Coordinator
Something that seemed to be more appreciated as time went on was the role of a coordinator. A key leader explained that the Health Project Coordinator had many important job duties, but that coordinating services for victims post-discharge was integral to the work. The HPC not only referred patients to follow up services, but she also attended meetings in the specific neighborhood that the victim had returned to in order to ensure that he or she would receive appropriate services, and to strengthen client connections with their community. She conducted individual follow-up work with the clients as well. She was seen as being in a position that managed the intervention internally, documenting the clients being seen, making sure that she was contacted for the intervention, and tracking clients in the patient care log. While this role appeared to help the intervention, the key leaders do not all agree that there is a need for this position. There is clear interest in keeping this program as no budget, and thus requiring a position to manage the program would change that dramatically. Once the HPC left her position, the injury prevention coordinator was tasked with continuing the work that had been done. In order for a hospital to be considered a Level One Trauma Center, it must have an injury prevention coordinator position. The position is funded through the trauma center and job responsibilities include tracking injuries that come through the hospital, assisting with prevention activities, conducting community prevention outreach, and organizing continuing education for medical staff. However, follow-up interviews have found that the transition did not occur and the injury prevention coordinator is not managing the program.

Next Steps: The interviews ended with the key leaders discussing next steps, or where they see the program in the future. The following summarizes the key leaders' responses:

Spreading the Word
One key leader stated, "It might be good to let the community know that we are doing this." Another noted, "None of us at the table are egomaniacs; I think that is clear, but there would be some value in letting more people know about the work." The key leaders felt strongly that the work being done is too important to keep quiet about. One leader felt that neither the Mayor of Rochester nor the County Executive was aware of this effort and that they should be better informed about it.

Target Population Expansion
During the course of this evaluation, expanding the intervention to older victims was a major topic of discussion in the partnership. Thus, the decision was made to expand the intervention to adults aged 25 and younger. This means that more resources will be utilized at the hospital. One of the issues that is currently being addressed is the lack of leverage with older clients (CPS has no authority). So the partners have been formulating ways to engage the older clients.

Hospital Policy Change
While this intervention has become the normal way of treating young victims of violent injuries, there have been no changes to the official hospital protocol around treating these victims. A goal for some of the key leaders is to have a policy instituted that is similar to that of dealing with a child burn victim. That has yet to come to fruition.

Enhanced Follow-up
As mentioned above, follow-up with patients after their release has been an ongoing issue and the key leaders again expressed that they would like to see more done. Some even explained that they would like to revisit the case review meetings. The problem with follow-up is that the hospital has no authority over this part of the intervention because they are relying on other agencies. This is also where confidentiality issues can be cumbersome.

Inclusion of Blunt Trauma Victims
This is probably the area that is in need of the largest overhaul. As is understood from the interviews, the intervention is often done with victims of blunt trauma, but it is not documented anywhere. Without documentation, we have no way of knowing what is being done, how frequently, and if there is any impact. The key program leaders all felt that specific blunt trauma injuries fell under this intervention, so it is a matter of being clearer in program mission.

Involve Secondary Victims
 A few of the leaders mentioned that there is a need for intervention with family members of program participants and those who witnessed the violent acts. While close family members, specifically parents, are involved in the intervention, there is not consistent service connection offered to family members. This was an area identified as in need of expansion.

As is evidenced above, the interviews were extremely informative in understanding program development, program description, partnership role, challenges, success, and future plans. The intervention has evolved over time, and continues to evolve. The next section discusses the results of the partner surveys. These help to better understand the role of the partners and the monthly meetings.

Partner Surveys

While there are 30 "official" partner agencies, there are an even higher number of participants at any given partnership meeting. Partner agencies will often come with more than one

representative and the URMC has a number of representatives present at the meetings. So while there are 30 agencies, there is an even higher number of participants who have attended meetings and consider themselves to be a part of the partnership. Short surveys were administered both via email and at a partnership meeting for the participants to fill out. The short surveys completed by the partners yielded valuable findings. Sixteen surveys were completed and returned to the researchers. These included representation from law enforcement, community agencies, the Office of Mental Health, URMC, and other agencies. The following section synthesizes the survey responses.

1. When did your organization join RYVP?

The responses spread the entire spectrum, from program inception to as recent as 2012. A small number of respondents explained that while they had only been participating for a few years, that their successor had participated as well, demonstrating that partnership affiliation can survive turnover. It was also evident that there were instances in which an individual was representing both their organization as well as a personal special interest, particularly violence reduction.

2. How did you/your organization become a member of the partnership?

A large number of respondents became a member by a direct relationship with one of the three key leaders. The respondents stated that a key member approached them or their organization about RYVP and that they subsequently joined. Others had joined due to another partner asking them to join and still others had taken over a position from a previous partner and were continuing the partnership. One participant stated that she had attended a presentation on the program by a key leader and was surprised to see that her organization was not represented in the partnership. She subsequently asked to be a partner and has been involved since then.

3. What is your agency's role in the partnership?

The largest number of respondents was directly involved in the hospital-based intervention. Others explained that their role is to network with others, identify community resources, and ensure community connection in the area of violent victimization. A few respondents identified their role as sharing data with partnership members. One respondent felt that their role was to develop additional awareness around victims' needs. It was clear that within the partnership, there are those who are directly involved in the intervention and after-care, while the remaining partners are more viewed as the community agencies who interface with the victims in other ways and maybe not as directly as others. These responses demonstrated the diversity of the partnership members.

4. How often do you/an agency representative attend partnership meetings?

The overwhelming majority responded that they attend the meetings either monthly or regularly. Only a few responded that they try to make the meetings but due to scheduling conflicts are

unable to regularly attend the meetings. One person stated that she is present regularly throughout the school year, but that during the summer months she is often not present. This is something that the partnership has struggled with throughout its development. There have been some summers where the meetings are suspended during the summer months, but as recent as 2012 a decision was made by the partnership to continue to meet during the summer months as that is the time of year when violent injury victimization typically spikes.

5. How does membership with the RYVP fit into your work?

Many of the respondents expressed that they either work directly with the victims or that they are indirectly involved as a community partner with accessible services for the victims or family members. The community partners expressed that their work fits well with the Partnership's efforts because both are trying to meet the needs of the victim, and often the community partner is doing this once the victim is discharged from the hospital and returns to the community. The responses indicated that there is a service continuum in place and that the direct service is done in the hospital, but that the partnership also brings together community agencies, different sectors of the community (school, law enforcement, mental health systems, etc), and policymakers to convene over the same cause: youth violence. Only one member expressed that he was not clear how RYVP membership fits into his work.

6. Additional Comments

There was space provided for the partners to make any additional comments relating to RYVP. The additional comments were mostly directed towards the positive work that the partnership has facilitated, the commitment to reducing violence, and the networking that occurs at the meetings. One partner explained, "I am so proud of the RYVP, it is a perfect example of the possibility of community organizing." Another partner felt that the victims of violence are difficult to get through to, and that this network provides several different avenues to reach out to the victim.

Finally, there were a few challenges that were identified, one which revealed issues around mental health, diagnosis, treatment, and service accessibility. The respondent went on to explain that when a problem is dissected, numerous layers are exposed, further complicating the intricate issues. And while it is important to study these problems, it does not necessarily make the work any easier. The partnership is a starting ground for this work, but more needs to be done outside of the partnership; both inter and intra agency work. Another concern was that the RYVP has focused strongly on young people, specifically those aged 17 and younger. While there has been a recent interest in expanding the age group, survey comments revealed that it might be helpful to also expand to include the family and the family's needs.

Discussion

The short surveys allowed the partnership members to share information on membership, partnership roles, and how RYVP fits within their work. Consistent with the long RYVP

interviews, RYVP has open and ongoing membership and does not deny anyone membership. This open door policy is evident in reviewing the surveys for agencies represented and length of time involved in RYVP. The consistent meeting attendance is a strength of the partnership, as the meetings allow work to get done. It was evident in the survey results that the partners see a clear relationship between their work and the work done with RYVP. Lastly, as would be expected, there was a clear division of partner members who directly interact with the intervention and those whose work involves providing resources and services to the victim and his or her family post discharge, and sometimes even years down the road. While the partnership has loose membership rules, the regular meeting times, pre-made agenda, meeting minutes, regular key leader attendance, and experienced meeting facilitation, demonstrate key components which have assisted in the partnership's duration at URMC. The partners regularly discuss the evolution from 2005 through 2013 and there is always recognition around the continued, never dwindling support of the partners, both those at URMC and those outside of the hospital.

The concerns expressed demonstrate that there is still more to be done and that while some may believe that the partnership should only be for young people, many in the group have an interest in expansion, but there is need to recognize what those changes would mean and how they would impact the current state of the RYVP. For the service delivery issues and the needs of the victims and families, there is still much work to be done and only time and direction will tell where the partnership lands on those issues. In the mean time, the partnership appears to be a consistent piece to the intervention and it has also played a strong role in both advocacy but also in the intervention itself (document creation, intervention guidance, and video production).

Document Review

As part of the intervention, there were three products created: a patient care log to track the cases, a video, and an educational document to be reviewed and signed by the victim. These documents were reviewed and are discussed below.

The patient care log evolved over the years and in its current state it includes the following client variables: name, date of birth, social security number, address, zip code, date of intervention, date, interventions received (Pathways response, Probation status, Document of Understanding, watched video, CPS referral, RCSD referral), Mechanism (bb gun, GSW, stab wound), hospital admission or treated and released, length of stay if admitted, if deceased before discharge, if deceased w/in 12 months, if early mortality post 12 months, injured prior to this incident, reinjured post w/ intervention received, and re-injured w/o intervention received. As discussed below, select aggregate data from this log was shared with the researchers for analysis. Over the years, various staff members have been responsible for completing this log. At one point a trauma nurse was in charge of this and over the course of the evaluation the Health Project Coordinator and the Child Psychiatrist were tasked with filling out the case log. It would be most beneficial to have one identified person responsible to input data into the log, with set days that data inputting will be done. Further, during this time the URMC switched over to electronic

medical records, making data collection even more difficult. Once the switchover is complete, it is anticipated that a large amount of the data in the log will be automatically populated. Again, ensuring that this is the case would be crucial for continued data collection.

The Document of Understanding was created with the help of the partnership over the course of six months in 2008. Numerous drafts of the document were shared with the members in order to receive feedback. The final document (Appendix J) was implemented in September 2008. The document is read by or to the victim and their close family members with a goal of informing the person and his or her family that this kind of violence is often not random, and that it is part of a high risk lifestyle. After the document is read, the social worker then discusses the document further with the family and encourages discussion around the incident. During this conversation, service referrals are offered and the family is given opportunity to problem-solve and discuss next steps. This document was put into place in order to take advantage of the teachable moment.

This Document was originally part of the patient's medical record, but over a year after its implementation, the URMC staff were informed that in order to protect the client, it is recommended that the document is not part of the medical record, in order to avoid any issues related to medical record subpoenas. There are questions around doctor-patient confidentiality privileges; one would think that this document would fall under that category. However, URMC has decided to remain cautious and thus not track the intervention component in the log. So, currently the document is not part of the medical record, but it is also not being tracked in the case log. This is alarming because in order to document whether all of the components of the intervention are being utilized and to conduct an outcome evaluation, little can be said about the impact of the document with limited, inconsistent information on its use. It is recommended that there is documentation in a central log whether the document was used and whether it was signed, and if signed by whom. At this time, we cannot say the impact of this document.

Video

The Voices of Violence Video was also put together with feedback and support from the partnership. A partner narrated the video, other partners connected with previous victims of violent injuries to invite them to participate in the film, and another partner managed the entire process. The premise of the video, and the video at different stages, was shared with the partners, again, inviting their feedback. The video is viewed by the victim and his close family members with the social worker as part of the hospital-based intervention. The video features interviews with previous victims of violent injuries and discusses their lives both before and after their injuries, as well as what changes they made in order to improve their life. After the video is finished, the social worker then directs conversation with the victim and his/her family in order to hear their responses to the video and to, again, discuss steps towards safer, healthier decision-making. This video along with the Document of Understanding take advantage of the teachable moment.

Although we were not able to look at patient outcomes dependent on intervention components received, there is substantial research on the effectiveness of brief video interventions in the medical field. A study was conducted with over 38,000 participants on the impact of watching a brief video intervention on transmission of sexually transmitted infections. All participants were receiving treatment at a clinic for a sexually transmitted infection. Those in the experimental group watched a video on protection from STIs while the control group received the typical services in a waiting room. The results revealed that showing the video reduced new infections by almost 10%, supporting the efficacy of the video intervention (Warner, Klausner, Cornelis, Rietmeijer, Malotte, et al. 2008).

As explained in the section on the long interviews, the notion of the teachable moment is not uncommon in the medical literature. This is the period when someone is seen as more open to advice on behavior change as seen in tobacco cessation, sexually transmitted disease prevention, alcohol abuse prevention (Severson, Eakin, Stevens, Lichtenstein, 1990; Williams, Brown, Patton, Crawford, & Touquet, 2005; Rietmeijer, 2007).

Again, we are unable to determine the impact of the Voices of Violence video due to the limited data we received from URMC. Without access to case level data identifying intervention components received, service connection, violent revictimization, and other factors, we are unable to make any conclusions on the effectiveness of the specific evaluation components.

Partnership Meetings

The partnership piece of the RYVP consists of over 30 collaborative partners, including: law enforcement, District Attorney's Office, City School District, child protective services, Probation, mental health organizations, not-for-profit organizations, and universities. The monthly meetings are held to discuss program developments, challenges, and future plans. The same key leader conducts the meeting as well as records and later distributes the meeting minutes. A reminder email is sent out to the group the week of the scheduled meeting in order to get the highest number of partners present. The meeting is almost always held in the same room at the URMC, which is a feat, in and of itself, when working out of a trauma center. Further, parking passes are made available to the partners, as well as refreshments. The meetings last an hour and a half and are guided by an agenda, created ahead of the meeting. There is always a report from the hospital, about the number of victims treated, an especially interesting case, an uptick in specific types of victims (e.g. females) or a report sharing recent news about the intervention. There are then updates from law enforcement, Pathways to Peace (the street outreach organization), and Probation. Occasionally another partner asks to be added to the agenda to inform the Partnership of something, and they are easily added.

From meeting observations, it is clear that the meeting facilitator has a good handle on time management and documentation. He is also able rein in those who may go off topic. While the meetings were clearly a space to update others on violence in the community, it was also a venue

to discuss the issues around violence and how young people end up in violent disputes and with violent injuries. There is also room in the meetings to further develop the intervention, such as the creation of the Document of Understanding and the production of the video. With so many partners in the room, it also allows time to discuss any process issues with the intervention. For example, the hospital security partner present may bring up a recent issue with retaliation concerns in the ED and what could be done to ensure that there is safety in the hospital.

Case Review Meetings

During 2010 there was an interest in a smaller group of partners meeting to discuss specific cases. These case review meetings were held at URMC and were run by staff from the outreach program Pathways to Peace (and were described in the key leader interview section). These meetings were not held during the evaluation period. The goal of these meetings was to get the direct service providers (e.g. school district, probation, etc) in the room and involved in the discussion on an individual basis. This was a way to share information and determine whether more action is needed, by whom, and how. These meetings also helped the hospital to get a bigger picture around the effectiveness of their intervention and where improvements could be made. The monthly meetings went on for less than a year for a variety of reasons, including: issues around consent, confidentiality, data sharing, and data collection. URMC was concerned with discussing patients who were no longer in their medical care and the agency identified to run the meetings had limited data to report as data were not being collected consistently. There has been recent discussion around bringing those meetings back. Before the meetings return, though, these issues should be resolved.

Health Project Coordinator

Service coordination was the major focus of the Health Project Coordinator (HPC) and over the course of the evaluation period, she reached out to 79 victims of violent injuries treated at URMC (some were treated for injuries prior to 2012). She provided services for 61 of those victims and averaged working with 7 clients weekly. She coordinated and tracked services such as connection to mental health treatment, help with medical issues, and assistance with other various services. The HPC was charged with creating a formalized case management tracking system for those patients treated for violent injuries. This tracking system would create a smooth transition for patients as they leave the hospital and return to the community. The return to the community includes ensuring that follow-up is done with these clients by specific agencies. As part of this tracking system, she created a service referral document completed by the hospital social worker, which is undergoing finalization. When the grant funding ended September 30, 2012, the HPC position also ended as there were no other funds reallocated for that position. The transition plan was to have the hospital's Injury Prevention Coordinator take over some of the HPC's responsibilities. In follow-up interviews, it was apparent that the Injury Prevention Coordinator had not taken over any of the HPC's responsibilities, as the Coordinator already has

sufficient job duties and responsibilities. The Coordinator also shared that he has never seen the RYVP database, he is not involved in service coordination, and that he has not seen the tracking system. With DCJS funding a position for a program that is no budget, it was evident that the HPC was able to do a lot of work related to RYVP during the course of the funding. It is worth noting that there may be a case to make here that the RYVP intervention does need a designated, paid person to manage the program, including data input, tracking, and analysis, as well as client management and service connection.

Data Analysis

As previously mentioned, data analysis was to be done in conjunction with URMC. Once the research had begun it became clear that the evaluation would not move forward as planned. We began meeting with the URMC team working on this project and assisting us with the data for the evaluation. After our initial URMC and RIT meetings around evaluation, it became evident that URMC would not share any identifiable data or, in fact, case level de-identified data with the RIT research team. The RIT research team had hoped to have access to the list of victims treated for violent injuries to allow summarization of results using the pre-identified data sources. When the situation was clear, we informed DCJS that we would not have access to identified data. Although there appeared to be considerable agreement across key program staff and the researchers on several ways that the problem could be addressed, representatives of URMC human subjects review indicated the obstacles would not be overcome despite the fact that the program occurred in a teaching and research oriented hospital.

A related obstacle also arose when we were informed of concerns regarding consent. The URMC review representatives noted that even though anonymity would be guaranteed, for URMC staff to gather data on the victims from any other sources (e.g. Rochester City School District data, mental health data, Family Court Data, medical record data, and DCJS data), the victims (research subjects) had to provide consent. This meant that a new plan had to take precedence, one in which the URMC clinical team would have to reach out retrospectively to program participants and ask them to participate in a new study as well as consent to URMC gathering data from the sources listed. On the ground, this meant that any data other than what the hospital had, including any that was not considered public data, would need a consent signature behind it. It should be noted that the treated population is widely recognized as transient, wary of research, and difficult to engage. It was clear that the consent requirements as they were described was likely to limit data collection to the point it would have little, if any, value for assessing the program.

Even with that recognition there remained the hope that something useful could be learned if we could gather self-reported data from the small group of program participants who could be expected to consent to involvement in the research. The RIT research team, however, was not allowed to participate in this consent process or the interviews, as we could not have access to names and other identifying information. So, in the next step, the RIT and URMC teams worked

together to produce a survey and a semi-structured interview for those who would be recruited to participate in this new process (see Appendices G and H).

Next, URMC went through its Human Subjects Research Board (HSRB) for project approval. RIT collaborated with URMC on survey creation, and semi-structured interview template creation. Data coding sheets were created covering specific agencies for those subjects who consented. Written into the proposal for URMC's HSRB was that victims treated prospectively for violent injuries would be asked to sign a series of release forms to obtain records from the already listed agencies. This was done so that moving forward we would not have the same problem with accessing records that are not public information.

When HSRB approval was granted from URMC, URMC began retrospective client recruitment for interviewing and consent for release of information. Work began with new clients as well.

Meetings with URMC were held discussing project status over the next few months and it was clear that we would have a very low response rate. We learned that seven subjects or 1% of the 170 subjects who were eligible to participate in the study consented to release of information. We also learned that none of the clients treated since the consent issue had been resolved, have signed releases of information. The new participants could, therefore, not be included in the study. The program's protocol for gaining consent and collecting data resulted in virtually no useable data.

With this understanding, we continued discussion regarding the patient log to determine what case level data we would be able to glean from that data source. Program staff reported that they would likely be able to share with us de-identified case level data from this log. It seemed clear that this was the only data that was likely to be available and even with that, some variables, such as zip code would not be shared at case level.

At that point, then, we were expecting the following from URMC:
1. Surveys completed by 1% (n=7) of program participants
2. Case-level data on the 7 consenting retrospective victims from CCSI, Family Court, DCJS, and RCSD as well as from the patient care log (see Appendices C-F for data collection instruments)
3. Case-level data from the RYVP patient care log on all 260 victims treated for violent injuries at URMC.

We also learned that URMC would not be able to share the patient care log data even without including identifying information. The issue cited was that these patients had not consented to sharing these data. Thus only data summaries would be available. Without case level information, aggregate data provide little basis for further analysis and contributes little value to the evaluation. Still, we felt that it was important to receive the aggregate level data in order to at least report out something and to conduct a preliminary analysis.

While the HPC did provide us with the themes garnered from the interviews with the seven retrospective patients, we have not received the surveys nor have we received the case-level data from URMC as expected. Essentially, then we did not receive the three products that we had anticipated URMC would share with us for analysis. Rather, we only received aggregate, de-identified patient data from URMC, which are described in the following paragraphs.

The tables below include the de-identified, aggregate data that we received from URMC for analysis. We received the data in a PDF document with the categories shown in the tables below, the variables, and the frequency. In order to better understand the data, we calculated percentages and converted the table into a more accessible excel file. We received these data in January 2013 and the data span over a little more than 6 years (3/26/2006-8/15/2012).

The data provide a limited description of program participants. From program inception, 260 youth victims of a gunshot wound, a BB gun wound, or a stab wound had been treated at URMC. Of those injuries, 43% were due to stab wounds and 54% were due to gunshot wounds. Sixty-four percent of the 260 patients were admitted, though we do not have data on the number that were admitted due to any reason other than medical intervention (e.g. high retaliation risk, gathering information to assess, etc). The majority of victims (70%) stayed in the hospital 2 days or less, 13% stayed 3-5 days and the remaining 17% stayed 6-90 days, with the most frequent being 8-10 days. It appeared that victims were most likely to be treated for a gunshot wound and most stayed in the hospital five days or less.

The data supplied by URMC provided insight into the RYVP intervention components. As one of the first steps in the intervention is the social work assessment, 90% of the 252 victims (8 were dead on arrival - DOA) underwent the social work intervention. The outcome of the social work evaluation directs the remaining intervention components. More than half (54%) of the patients received the psychiatric intervention, 63% received the Pathways to Peace intervention, 36% underwent the CPS intervention, and 11% received the RCSD intervention.

The Document of Understanding was implemented in September 2008, but was then recorded in a separate log beginning in October 2010. Therefore, the data presented here is not an accurate representation of the number of victims who received this intervention. Unfortunately, we did not receive data on the total number of victims who received the Document of Understanding intervention, whether recorded in the patient log or not. The Voices of Violence Video was implemented in May 2009. With the data provided, from 2009-August 2012, there were 141 youth victims treated for violent injuries, with 56 patients watching the video, therefore 40% of the patients treated during that time period watched the video and had the follow-up discussion with the social worker.

Risk factors for violent injury were collected and shown in the data. While we were not allowed access to zip code data, we received summary data on gang-related injuries, PINS (persons in need of supervision) history, Probation history, CPS history, legal history, and trauma recidivist information. Half (55%) of the injuries were identified as non-gang-related, while 12% were

clearly gang-related and 33% were unknown. Less than a fifth (17%) of the sample had PINS history, a quarter (26%) had Probation history, 14% had CPS history, 27% had legal history (family and criminal court), and 5% were known trauma recidivists.

Of the sample, 73% were African-American, 14% identified as White, and 8% identified as Hispanic. The total population in the City of Rochester is 210,565 (US Census, 2010) and of that, 44% identify as white, 42% identify as Black, and 16.4% of the total population identify as having Hispanic descent (US Census, 2010). More than half of the sample (58%) were 16-17 years old, 30% were 14-15 years old at the time of injury, and the remaining 12% were 13 years or younger at the time of injury.

RYVP Aggregate Data Summary
Date range: 3/26/2006-8/15/2012

	variable	frequency	percent	percentage
Age at injury	11 yrs and younger	12	0.045977	4.60%
	12-13 years	21	0.08046	8.05%
	14-15	76	0.291188	29.12%
	16-17	151	0.578544	57.85%
	other	1	0.003831	0.38%
	total	261	1	100%

Year of injury	2006	27	0.103846	10.38%
	2007	49	0.188462	18.85%
	2008	43	0.165385	16.54%
	2009	56	0.215385	21.54%
	2010	44	0.169231	16.92%
	2011	23	0.088462	8.85%
	2012	18	0.069231	6.92%
	total	260	1	100.00%

Mechanism	bbgun	8	0.030769	3.08%
	GSW	140	0.538462	53.85%
	Sw	111	0.426923	42.69%
	unknown	1	0.003846	0.38%
	total	260	1	100.00%

Admitted or discharged	admitted		166	0.638462	63.85%
	discharged		86	0.330769	33.08%
	DOA/ED death		8	0.030769	3.08%
	total		260	1	100.00%

Length of stay	2 days or less		186	0.7045455	70.45%
	3-5 days		34	0.1287879	12.88%
	6-7 days		10	0.0378788	3.79%
	8-10 days		11	0.0416667	4.17%
	11-14 days		6	0.0227273	2.27%
	15-30 days		9	0.0340909	3.41%
	31-60 days		5	0.0189394	1.89%
	61-90 days		3	0.0113636	1.14%
	total		264	1	100.00%

SW intervention	none		21	0.080769	8.08%
	N/A		8	0.030769	3.08%
	yes		228	0.876923	87.69%
	unknown		3	0.011538	1.15%
	total		260	1	100.00%

Psychiatric intervention	none		109	0.419231	41.92%
	N/A		9	0.034615	3.46%
	yes		136	0.523077	52.31%
	refused		1	0.003846	0.38%
	unk		5	0.019231	1.92%
	total		260	1	100.00%

Pathways to Peace intervention	none		88	0.338462	33.85%
	N/A		9	0.034615	3.46%
	yes		159	0.611538	61.15%
	unknown		4	0.015385	1.54%
	total		260	1	100.00%

Probation Intervention	none	208	0.8	80.00%
	N/A	10	0.038462	3.85%
	yes	36	0.138462	13.85%
	unknown	6	0.023077	2.31%
	total	260	1	100.00%

Document of Understanding (in use 9/2008; Oct 2010 stopped capturing in log)	none	182	0.7	70.00%
	N/A	12	0.046154	4.62%
	yes	49	0.188462	18.85%
	unknown	17	0.065385	6.54%
	total	260	1	100.00%

Voices of Violence video in use 5/2009 to present	none	184	0.707692	70.77%
	N/A	12	0.046154	4.62%
	yes	56	0.215385	21.54%
	unknown	8	0.030769	3.08%
	total	260	1	100.00%

Child Protective Services intervention	none	155	0.596154	59.62%
	N/A	10	0.038462	3.85%
	yes	90	0.346154	34.62%
	unknown	5	0.019231	1.92%
	total	260	1	100.00%

Rochester City School District intervention	none	83	0.319231	31.92%
	N/A	5	0.019231	1.92%
	yes	29	0.111538	11.15%
	unknown	143	0.55	55.00%
	total	260	1	100.00%

Identified gang-related injury	no	144	0.553846	55.38%
	yes	31	0.119231	11.92%
	unknown	85	0.326923	32.69%
	total	260	1	100.00%

Identified PINS history	no	176	0.676923	67.69%
	yes	43	0.165385	16.54%
	unknown	41	0.157692	15.77%
	total	260	1	100.00%

identified probation history	no	152	0.584615	58.46%
	yes	67	0.257692	25.77%
	unknown	41	0.157692	15.77%
	total	260	1	100.00%

Identified CPS history	no	186	0.715385	71.54%
	yes	36	0.138462	13.85%
	unknown	38	0.146154	14.62%
	total	260	1	100.00%

Known trauma recidivist	no	208	0.8	80.00%
	yes	14	0.053846	5.38%
	unknown	38	0.146154	14.62%
	total	260	1	100.00%

Race and Ethnicity	African American	191	0.7346154	73.46%
	White	37	0.1423077	14.23%
	Hispanic	22	0.0846154	8.46%
	other	2	0.0076923	0.77%
	unknown	8	0.0307692	3.08%
	total	260	1	100.00%

Identified legal history	no	170	0.6538462	65.38%
	yes	71	0.2730769	27.31%
	unknown	19	0.0730769	7.31%
	total	260	1	100.00%

Patients who received no intervention	total	35	0.5142857	
deceased	before D/C	15	0.4285714	
	within 12 months	2	0.0571429	
	post 12 months	1	0.0285714	

The data presented above indicate that many of the intervention components were received by the majority of those youth who were treated for violent penetrating injuries at URMC. It would be helpful to better understand if there were any differences between lengths of stay for those treated for stab wound injuries versus gunshot wound injuries, what kinds of injuries the trauma recidivists had, the ages of those who received specific interventions and those that did not, the total number who signed the Document of Understanding, and other questions.

The data above are for the penetrating injuries, but interviews with key leaders reveal that the intervention is being done on victims of blunt trauma as well. There appears to be no documentation on what blunt trauma victims receive the intervention and what components they receive and those that do not receive the intervention. This is a large gap in data collection and should be addressed.

These data provide a preliminary understanding of the RYVP intervention. Future researchers should work with URMC and its Human Subjects Review Board to find a way to share case level data, at a minimum, on the patients treated for violent penetrating injuries at URMC. It appears that the intervention is reaching those that we would expect it to, though we are not able to look at those who are more likely to receive specific intervention components than others. We were also not able to conduct a process evaluation to determine whether all the patients who should be receiving the intervention components are indeed receiving the intervention. We would hope that future analyses would be able to answer these questions.

The interviews were not transcribed and we were not expecting them to be during this evaluation, but the HPC shared with the researchers themes that were gleamed from the follow-up patient interviews in which seven people were interviewed. The themes identified are:
- Denial of risk factors
- A lack of awareness of the appropriate resources and how to access resources
- The inability to recognize steps needed in order to reach goals outlined for themselves

As of February 2013, we had not received the 7 surveys completed by the retrospective victims nor the case-level data on the 7 consenting retrospective victims from CCSI, Family Court, DCJS, and RCSD as well as from the patient care log. Information for those sources is thus not included in this report.

Conclusion

Our evaluation was designed to describe the program and achieve greater understanding of the impact of RYVP. While we are able to better understand the Partnership, the RYVP history, and the development of the RYVP, the evaluation did not answer all of the questions we were seeking to answer. Critical questions originally posited that relied on case-level data remain unanswered. Questions such as,

- Is there a difference in outcomes for those who receive different intervention components versus the combination of interventions?
- Who is the intervention reaching? Who is the intervention missing?
- Are there differences in outcomes for shooting versus stabbing victims?
- Is medical follow-up care maintained by the participants?
- What is the medical cost to treat these victims?
- Is injury recidivism reduced for those who participate in the intervention? Is violent retaliation reduced?
- Are participants receiving mental health services at a greater rate than those not enrolled in the program?
- Is this program replicable?
- What are the behavioral factors, educational outcomes, and medical outcomes (prognosis) of these youth?

While we did not get answers to questions around the impact of the intervention, there are some noteworthy findings as it relates to the Partnership and RYVP process. Findings include that 260 young victims of violent penetrating injuries were treated at URMC over the course of more than 6 years and of those, nearly 90% received a social work intervention. There is reason to believe that these numbers are better than other hospital-based violence intervention programs (NNHVIP Annual Conference, 2012, Project Ujima presentation). Further, once the video was instituted, close to half (40%) of the victims treated viewed the video. When recalling that there has been no official hospital policy implemented for this intervention, with so many victims receiving the various components, it is surprising that the intervention impacted such a large number of victims. It would be helpful to know more about who was missed and what led to some victims receiving specific interventions over others or in addition to others.

The small surveys and semi-structured interviews had some revealing results. From the interviews a program description and intervention process flow charts were created. The strength of the partnership is clear in not only the survey and interview responses, but also in the ability to get things done, such as the video and poster contest. The partnership has a very direct relationship with the intervention, which is interesting in and of itself. The short survey results demonstrate the partners' commitment to the program. It was not anticipated that so many would respond that they regularly attend the partner meetings. When considering many communities,

including Rochester, there are often many coalitions formed that garner much interest in the beginning, but then, due to various reasons, do not endure. The RYVP is a clear indicator that something is being done right. The consistent meetings, meeting reminders, regular participation by the key leaders, and the agenda likely play a role in the continued commitment of the partners.

The long interviews were critical in gathering information on the program, specifically pertaining to the history and the program's continued development. Again, the willingness of key leaders to volunteer their time for the hour long interview was valuable and helped to direct the evaluation.

Unfortunately, due to constraints on data sharing, we had a very difficult time drawing any meaning from the data analysis, particularly with regard to program effectiveness. In the field of program evaluation protection of human subjects is extremely important. But in similar hospital programs around the country those protections have not imposed such severe limitations on evaluation. RIT researchers and RYVP program staff have spoken with other hospitals about the data collection barriers posed here, and we found that the obstacles to evaluation of RYVP seem, at best, unusual. As the recommendations outlined below will show, more significant efforts around data collection, data sharing, and meaningful evaluation is crucial to the development of this program. Without the data to support its continued existence, it is difficult to defend this program and impossible to support, based on evidence of effectiveness, its extension or replication.

While there are many advocates of the program both in and outside of Rochester, we recommend that quantitative data are collected, shared, and analyzed by an outside entity, free from bias in order to know if the program really does what it is meant to do. As is described in this report, this is not a novel issue to RYVP, as hospital-based interventions around the country have struggled with data issues. There must be a better resolution than we have found here if anything significant is to be learned about program efficacy and the larger issue of violence reduction.

The no budget feature to this program is one factor that has been intriguing to other medical centers. This may be something worth championing and is certainly worth understanding better. Establishing an evaluation on cost-benefit regarding this program would be a good next step, but it is also an extremely nebulous area in the field of research. Questions around costs versus charge, cost of medical doctors' time spent on patients, cost of other staff time spent with patients, and collapsing it to an hourly figure can get so messy that it becomes meaningless. Understanding all of the nuances of conducting a cost-benefit analysis does not mean that it cannot be done, but rather, it would be interesting to have a worthwhile cost-benefit analysis conducted with this program.

This program has managed to informally institutionalize a protocol for treating youth victims of violent penetrating wounds in this community. Changing the normal way of doing business anywhere is no easy task, but changing the way of business at a trauma center is quite an

accomplishment. While there is yet to be a formal protocol established within the hospital around these kinds of victims, there is an unwritten code, which some may argue is even stronger than a written policy, as to how these victims will be treated including an intervention process.

Other hospital intervention programs involve a budget and usually an MOU or some other formal document with a service agency, in order to connect clients to resources. Some hospitals even contract with service agencies to have them conduct the intervention in the hospital. The program at URMC utilizes staff that are already doing similar work, and requires that they take on a more job duties. This is something that likely could be replicated in other hospitals. With funding streams shrinking, an initiative that does not require additional outright funds has a place in the medical world. There is something attractive about a program with so much potential and so little cost.

There is no question as to the potential value of hospital based anti-violence interventions. That, belief, however, is insufficient to justify any specific intervention. The devil is in the details and it is important to systematically evaluate specific interventions to better understand what influences specific outcomes and how to ensure optimal results. This evaluation set out to do that but unfortunately, there is nothing generated from this evaluation that can support that this program should be replicated. The lack of data access has strongly inhibited this evaluation and that is, arguably, a shame. Many people have been involved in the creation and development of the intervention, and substantial resources are dedicated to it. The issues around data sharing for research purposes must be resolved.

Recommendations

The evaluation issues noted above are important but we do not let them overshadow recognizing the superior work that has been done by the URMC staff, the key leaders, the partners, and others. There is reason to hope that this intervention does have an impact, and a rigorous analysis must still be done.

Keeping in mind the above, the following outlines key recommendations on moving forward the RYVP. The recommendations come out of the evaluation results and best practice efforts.

1. Create a mission statement
   It was clear that partners had an idea around the program and what it is trying to do, but descriptions did not always meld with others and in order to best understand the program, it is important to create a mission statement. This helps to ensure that everyone is on the same page regarding the program.

2. Resolve data collection issues
   Data collection must be strengthened within RYVP. Not only should there be one person inputting data into the patient care log, but even prior to that effort, it should be decided

who will house the data. As is clear, working with a medical facility under HIPAA guidelines has implications for research. Thus, recognizing and being informed of potential barriers and finding solutions are critical to any further evaluation. Lastly, it is imperative that patients are offered the opportunity to sign releases of information and consents to participate in future study while they are in the medical facility. Tracking down patients is not only difficult and time consuming, but it also yields very low response rates.

- Determine who will input data into the patient care log
- Determine who will house the data; either an inside or outside entity
- Resolve confidentiality issues: have documentation signed at the time of treatment (release of information and consent to participate)
- Track blunt trauma victims

3. Work out data sharing issues
Continuing the conversation from above, it is necessary to work out all of the data sharing issues with the research partner prior to commitment to an evaluation.

4. Formalize hospital protocols when dealing with violent injury (similar to the protocol when deal with a child burn victim)
This was echoed specifically by the key leaders of the program who have a familiarity with specific protocol related to specific types of injuries, and it was clear that there is reason supporting the creation of official hospital protocol when treating victims of violent injuries. This protocol should go from security response to victim and family response all the way up to medical response.

5. Expand goals
While this evaluation focused on the RYVP which works with victims aged 17 and younger, during the course of the evaluation and from reviewing local crime statistics, existing research, and hospital records, it is evident that a majority of the victims treated for the injuries are aged 17 through 25. Therefore, in order to reach a larger segment of the population, it is important to engage those at highest risk. Additionally, with 58% of the victims treated aged 16-17, in order to meet the goal of no one returning for a violent injury, then the age need to be increased to assess this.

6. Identify and assess the actual costs of the intervention.
The zero-budget concept clearly does not reflect the reality of program related costs. In the long run ignoring costs can only jeopardize the program and confuse those who might wish to adopt a similar effort.

7. Resume the case review meetings
While these were not occurring during this evaluation period, it was clear that there is some value in conducting follow-up case review meetings with those who directly serve

the particular individual. This is a way to ensure that the individual is being supported by those who have the capacity to give support. It also closes the gap for those who typically have fallen between the cracks.

8. Strengthen the service delivery upon discharge
It was clear from the conversations with the key leaders that one area that needs to be enhanced is that of service provision once the patient is discharged from the hospital. Often the patient is set up with a mental health appointment or some other service, but then he either does not go to the first appointment, or he does but then he never goes to another meeting. Better understanding client needs, accessible services, and barriers to getting services would likely improve service usage and in turn, increase the positive outcomes.

9. Implement program in RGH
While the program is running well and strong at the trauma center, it has had a difficult time with implementation at the other local hospital which treats victims of penetrating injuries as well. We should have data-driven reasons to believe that there is a need for this intervention at RGH. Even without that, it would seem desirable to renew talks between the two facilities and to consider implementing this intervention at another medical facility.

The recommendations above should be useful in moving the RYVP forward. RYVP has developed into a strong partnership and a comprehensive intervention over the last six years. In order for continued expansion, there are many things that should continue (partnership meetings, open meeting invitation, intervention components) and also many parts that should be altered (data collection and sharing, creation of a mission statement, and client connection to services) in order to achieve the best result.

There are many strong features to this program. Our hope is that RYVP will continue to move forward and that its progress will include a more systematic approach to data collection and analysis. This will support its own internal development and will provide useful information to those who might consider implementing a similar program.

Appendices

RYVP Leaders Semi-Structure Interview

What
How did you get involved in this?
What is the intervention/program?
How well does implementation match what it is actually supposed to be?
What are the goals? Have they changed over time?
What are the key elements needed to replicate this?

Theory
What makes you think this will work?

History
How come to fruition?

People/Members
Who are the key players?
Who is involved?
What roles do people play?
How is it working with Pathways?

Communication/sharing information
Explain the purpose of the extra case meetings
How get around confidentiality?

Changes/improvement
What improvements have been made?
Why were the changes made, i.e. why add document of understanding, video, etc?

Data Collection
How is the data collected and reported back?
What paperwork is unique to the program?
What do you think the outcomes are and how should they be measured?

Milestones
Identify major successes in the program

Roadblocks
Identify roadblocks and how they were overcome

Anything that I missed?
Who else should I talk to?

Appendix B
Partner survey
Good Afternoon,
My name is Janelle Duda. I am a Research Associate at RIT in the Criminal Justice Department and I am conducting a research evaluation of the Rochester Youth Violence Partnership for the Division of Criminal Justice Services.   In order to do this, I need to interview members of the partnership. Currently there are about 28 different members of the Partnership. Further, a manual of the intervention will be created in order to implement this in other cities.

The information you share with me will be extremely valuable to this evaluation as it could significantly increase our understanding of the Partnership and intervention. This interview will take about 30 minutes of your time. I will take specific precautions in order to maintain confidentiality. These precautions include: not identifying you by name in any reports and storing the email responses on a password protected flash drive stored in a locked file cabinet in my office. As I cannot guarantee confidentiality, the likelihood that it would be breached is very slim. I will not link your name to anything you say in the text of my evaluation or any other publications. You will simply be referred to as a member of the Rochester Youth Violence Partnership.

There are no other expected risks of participation.

Participation is voluntary. If you decide not to participate, there will be no penalty or loss of benefits to which you are otherwise entitled. You can, of course, decline to answer any question as well as to stop participating at any time, without any penalty or loss of benefits to which you are otherwise entitled.
Both anecdotal and aggregate data from the interview responses will be used in the report.

If you have any additional questions concerning this research or your participation in it, please feel free to contact me or our university research office at any time:
Janelle Duda, Research Associate, RIT (585-475-5591) or jmdgcj@rit.edu
Heather Foti, Associate Director of HSRO, RIT (585-475-7673) or hmfsrs@rit.edu

If you agree to participate, please answer the following questions about the RYVP and return it to me via email. Thank you for your time.
Organization name:

1) When did you/your organization join the RYVP?
2) How did you/your organization become a part of the partnership?
3) What is your/your agency's role in the partnership?
4) How often do you/an agency representative attend partnership meetings?
5) How does membership with the RYVP fit into your work?

Any additional comments:

Appendix C

Division of Criminal Justice Services
Evaluation of the Rochester Youth Violence Partnership (RYVP)
DATA COLLECTION INSTRUMENT
Strong Memorial Hospital Medical Records Data

1. Date of birth ____/____/_____ (MM/DD/YYYY)

2. Race:
    ☐ White
    ☐ Black
    ☐ American Indian/Alaskan Native
    ☐ Asian/Pacific Islander
    ☐ Other
    ☐ Unknown
    ☐ No information

3. Ethnicity:
    ☐ Hispanic Origin
    ☐ Not of Hispanic Origin
    ☐ Unknown
    ☐ No information

4. Sex:
    ☐ Male
    ☐ Female

5. Date of injury ____/____/_____ (MM/DD/YYYY)

6. Date of medical treatment or hospital admission ____/____/_____ (MM/DD/YYYY)

7. Date of discharge from acute care ____/____/_____ (MM/DD/YYYY)
    a. Transferred to other facility
        ☐ Yes
        ☐ No

8. Date of discharge home ____/____/_____ (MM/DD/YYYY)

9. All diagnostic codes that apply to injury _____

10. Did injury involve firearms?
       ☐ Yes
       ☐ No
       ☐ Unknown

Explanation:

_____

_____

11. Was the patient admitted to the hospital for this injury?
       ☐ Yes
       ☐ No

    a. If admitted to hospital, was it because of:
       ☐ Psychosocial risk
       ☐ Medical severity of injury

12. Did treatment providers note that this a gang-involved crime?
       ☐ Yes
       ☐ No
       ☐ Unknown
       a. If yes, how determined:_____

13**.** RYVP assessments and interventions provided during this episode:
       ☐ None
       ☐ Psychosocial Evaluation
       ☐ Document of Understanding
       ☐ RYVP Video
       ☐ Psychiatric Evaluation
       ☐ Agency Referrals:
             ☐ RCSD
             ☐ Pathways to Peace
             ☐ Other:_____

14. Length of Stay _____

15. Discharged Diagnostic codes:

_____

16. Psychiatric Diagnosis: _____

17. Psychiatric follow-up recommended?
        ☐ Yes
        ☐ No
        ☐ Unknown
Explanation:

_____

_____

18. Medical follow-up treatment recommended?
        ☐ Yes
        ☐ No
        ☐ Unknown
Explanation:

_____

_____

19. Was CPS involved at the time of presentation?
        ☐ Yes
        ☐ No
        ☐ Unknown
Explanation:

_____

_____

20. Was CPS called during the course of treatment?
        ☐ Yes
        ☐ No
        ☐ Unknown
Explanation:

_____

_____

21. Was Probation involved at the time of presentation?
        ☐ Yes
        ☐ No
        ☐ Unknown
        a. If yes, what is the nature of involvement?_____

        _____

        b. Was probation contacted during the course of treatment?
        ☐ Yes
        ☐ No
        ☐ Unknown

Explanation:

_____

_____

22. Was patient treated at Strong Memorial Hospital for a penetrating wound two years prior to injury?

    ☐ Yes

    ☐ No

    If no, proceed to question 25. If yes, proceed to the next question (#23).

23. How many times was patient treated for a penetrating wound over those 2 years:____

24. For each time treated, please answer the following questions:

    a. Did participant receive RYVP assessments and interventions?

        ☐ No

        ☐ Psychosocial Evaluation

        ☐ Document of Understanding

        ☐ RYVP Video

        ☐ Psychiatric Evaluation

        ☐ Agency Referrals:

            ☐ RCSD

            ☐ Pathways to Peace

            ☐

        Other:_____

    b. All diagnostic codes that apply to injury _____

    c. Did injury involve firearms?

        ☐ Yes

        ☐ No

        ☐ Unknown

    d. Was the victim admitted to the hospital for this injury?

        ☐ Yes

        ☐ No

        If admitted to hospital, was it because of:

        ☐ Psychosocial risk

        ☐ Medical severity of injury

    e. Did treatment providers note that this a gang-involved crime?

        ☐ Yes

        ☐ No

        ☐ Unknown

        a. If yes, how determined: _____

    f. Length of Stay _____

    g. Discharged Diagnostic codes: _____

h. Psychiatric Diagnosis: _____

i. Psychiatric follow-up recommended?
- ☐ Yes
- ☐ No
- ☐ Unknown

Explanation:

_____

_____

j. Medical follow-up treatment recommended?
- ☐ Yes
- ☐ No
- ☐ Unknown

Explanation:

_____

_____

25. Up to two years after discharge to home, was the participant violently reinjured and treated at Strong Memorial Hospital?
- ☐ Yes
- ☐ No

If no, proceed to question #28. If yes, proceed to the next question (#26).

26. How many times was the patient treated for a penetrating wound over those 2 years:
_____

27. For each time treated, please answer the following questions:

a. Did participant receive RYVP assessments and interventions?
- ☐ No
- ☐ Psychosocial Evaluation
- ☐ Document of Understanding
- ☐ RYVP Video
- ☐ Psychiatric Evaluation
- ☐ Agency Referrals:
  - ☐ RCSD
  - ☐ Pathways to Peace
  - ☐

Other:_____

b. All diagnostic codes that apply to injury _____

c. Did injury involve firearms?
- ☐ Yes
- ☐ No

☐ Unknown
d. Was the victim admitted to the hospital for this injury?
    ☐ Yes
    ☐ No
    If admitted to hospital, was it because of:
    ☐ Psychosocial risk
    ☐ Medical severity of injury
e. Did treatment providers note that this a gang-involved crime?
    ☐ Yes
    ☐ No
    ☐ Unknown
    a. If yes, how determined: _____
f. Length of Stay _____
g. Discharged Diagnostic codes: _____
h. Psychiatric Diagnosis: _____
i. Psychiatric follow-up recommended?
    ☐ Yes
    ☐ No
    ☐ Unknown
Explanation:

_____

_____

j. Medical follow-up treatment recommended?
    ☐ Yes
    ☐ No
    ☐ Unknown
Explanation:

_____

_____

28. Was patient treated in the Emergency Department at Strong Memorial Hospital for any medical reason other than a penetrating wound up to two years prior to injury?
    ☐ Yes
    ☐ No
    If no, proceed to question #30. If yes, proceed to the next question (#29).

29. For each instance of medical treatment answer the following questions:
    a. When was the patient treated ____/____/_____ (MM/DD/YYYY)
    b. How long was the patient treated for in the hospital: _____days/hours (circle)
    c. All diagnostic codes that apply to treatment _____

Explanation:

_____

_____

30. Up to two years after discharge home, was the patient treated in the Emergency Department at Strong Memorial Hospital for any medical reason other than a penetrating wound?
   ☐ Yes
   ☐ No
   If no, proceed to question #32. If yes, proceed to the next question (#31).

31. For each instance of medical treatment answer the following questions:
   a. When was the patient treated ____/____/_____ (MM/DD/YYYY)
   b. How long was the patient treated for in the hospital: _____days/hours
   c. All diagnostic codes that apply to treatment _____
   Explanation:

   _____

   _____

32. Narrative explanation of any interesting factors not captured in above data questions:
_____
_____
_____
_____
_____
_____
_____

Appendix D

Monroe County Family Court Code Sheet

Subject # _____

<u>JD File/PIN</u>
Is there a JD file (previously PIN)? Yes/ No
If yes, for what? _____
(What happened?) Case outcome: _____
Were any services referred? Yes/   No
If yes, services referred:

_____
_____
_____
_____
_____
When was the file opened? _____
When was the file closed? _____
<u>Article 8</u>
Has an OP been filed against the subject? Yes/ No
       Date:
Has the subject been a petitioner for an OP (including OBO)? Yes/   No
       Date:

<u>CPS File</u>
Were they the subject of a CPS petition: Yes/ No
If yes, circle one: child victim or adult perpetrator or adult victim
If yes, when? _____
If yes, for what (Neglect, Physical Abuse, Sexual Abuse, etc.)?
_____
Outcome of the case?
_____

Appendix E

DCJS Coding Variables

Var Name	Var Description	MF Var
CYCLE IDs		
cycleid	Criminal Cycle ID	
cjtn	Criminal Justice Tracking No	
cyclebeg_mo	Earliest Data Date Month	NYSID (chars 8-13)
cyclebeg_day	Earliest Data Date Day	NYSID (chars 8-13)
cyclebeg_yr	Earliest Data Date Year	NYSID (chars 8-13)
cycle_arr_dv	Arrest Agy Domestic Incident Report Filed	EV5
cycle_cc_dv	Court Case Domestic Incident Report Filed	X61
cycle_sealed	All Events in Criminal Cycle are sealed	
cycle_status	Cycle Aggregate Sealed Status	X19
PERSON DATA		
nysid	NYSID Number	NYSID (chars 1-7)
chkdgt	Check Digit for NYSID	
person_dna	Sample on File with NYS DNA Databank	
person_dnaq	Person Qualifies for DNA Sample	
person_dnac	DNA Analyzed (CODIS)	
person_sor	Sex Offender Registrant	
cohort	Cohort Indicator from Cycle	X6
arr_birth_place	Place of birth recorded at arrest	EV1
modal_birth_mo	Modal Birth Month	X1MO
modal_birth_day	Modal Birth Day	X1DAY
modal_birth_yr	Modal Birth Year	X1YR
modal_sex	Modal Sex Code	
modal_race	Modal Race Code	
ever_hisp	Hispanic Indicator	X5
arr_birth_mo	Arrest Birth Date Month	EV4MO
arr_birth_day	Arrest Birth Date Day	EV4DAY
arr_birth_yr	Arrest Birth Date Year	EV4YR
arr_age	Age at Arrest	X2
arr_sex	Arrest Sex Code	X3
arr_race	Arrest Race Code	EV2
arr_ethnicity	Arrest Ethnicity Code	EV3
arr_re_combi	Arrest Combined Race/Ethnicity	ev6
OFFENDER PRIORS		
p_felarr	Prior Felony Arrests	X7

p_misdarr	Prior Misdemeanor Arrests	X8
p_vfoarr	Prior VFO Arrests	
p_drugarr	Prior Drug Arrests	
p_minorsarr	Prior Child Victim Arrests	
p_weparr	Prior Weapons Arrests	
p_soarr	Prior SOR Arrests	
p_felcon	Prior Felony Convictions Not YO	X9
p_felyo	Prior Felony Convictions YO	X11
p_misdcon	Prior Misdemeanor Convictions Not YO	X10
p_misdyo	Prior Misdemeanor Convictions YO	X12
p_vfocon	Prior VFO Convictions Not YO	
p_vfoyo	Prior VFO Convictions YO	
p_drugcon	Prior Drug Convictions	
p_minorscon	Prior Child Victim Convictions	
p_wepcon	Prior Weapons Convictions	
p_socon	Prior SOR Convictions Not YO	
p_soyo	Prior SOR Convictions YO	
AREA AND DATE FIELDS		
arr_mo	Arrest Date Month	X16mo
arr_day	Arrest Date Day	X16day
arr_yr	Arrest Date Year	X16yr
arr_ori	Primary Arresting ORI	X24 (chars 1-5)
arr_county	Arrest County	X22
arr_region	Arrest Region	X22a
arr_nycpd_nysp	Arresting agency NYCPD/NYSP Indicator	X23
crime_mo	Crime Date Month	X15mo
crime_day	Crime Date Day	X15day
crime_yr	Crime Date Year	X15yr
crime_county	Crime County	
crime_region	Crime Region	
disp_mo	Overall Top Dispo Date Month	X17mo
disp_day	Overall Top Dispo Date Day	X17day
disp_yr	Overall Top Dispo Date Year	X17yr
conv_mo	Overall Top Dispo Conviction Date Month	
conv_day	Overall Top Dispo Conviction Date Day	
conv_yr	Overall Top Dispo Conviction Date Year	
court_ori	Overall Top Disposition Court ORI	X24 (chars 6-10)
disp_county	Overall Top Disposition County	X25
disp_region	Overall Top Disposition Region	X25a

court_type	Overall Top Disposition Court Type	X26
cdisp_mo	Top Charge Disposition Date Month	X17mo_c
cdisp_day	Top Charge Disposition Date Day	X17day_c
cdisp_yr	Top Charge Disposition Date Year	X17yr_c
cconv_mo	Top Charge Disposition Conviction Date Month	
cconv_day	Top Charge Disposition Conviction Date Day	
cconv_yr	Top Charge Disposition Conviction Date Year	
ccourt_ori	Top Charge Disposition Court ORI	X24 (chars 6-10)
ccourt_type	Top Charge Disposition Modified Court Type	X23

Appendix F
Division of Criminal Justice Services
Evaluation of the Rochester Youth Violence Partnership (RYVP)
DATA COLLECTION INSTRUMENT
Rochester City School District Participant Data

1. Date return to school after injury: _____
    Number of missed school days due to injury: _____

2. Two years pre-injury:
    Total number events or concerns _____
        Number of other disruptive incidents _____
        Number of assault – physical injury incidents_____
        Number of minor altercations_____
        Number of IHMB No physical contact _____

   Two years after return to school from injury:
    Total number events or concerns_____
        Number of other disruptive incidents _____
        Number of assault – physical injury incidents_____
        Number of minor altercations_____
        Number of IHMB No physical contact _____

3. Two years pre-injury:
    Total number of suspensions: _____
    Total days on suspension: _____
        Number of long-term suspensions_____
        Number of short-term suspensions_____

   Two years after return to school from injury:
    Total number of suspensions: _____
    Total days on suspension: _____
        Number of long-term suspensions_____
        Number of short-term suspensions_____

4. Promotion to next grade during two year pre-injury time period: Yes_____
                                       No_____

   Promotion to next grade during two years after return to school from injury: Yes_____
                                       No_____

5. Number of unexcused absences during most recently completed school year prior to injury
_____

Number of unexcused absences during most recently completed school year after return to school from injury _____

6. Number of unexcused absences 30 days prior to injury _____
   Number of unexcused absences 30 days after return to school from injury _____

7. GPA of most recently completed school year prior to injury _____
   GPA of most recently completed school year after return to school from injury _____

8. Was this youth referred to PINS by RCSD?
                __Yes
                __No
                __Unknown
                If yes, the number of times referred _____

        If yes, was this youth referred to PINS by RCSD two years pre-injury:
                __Yes
                __No
                __Unknown
                If yes, the number of times referred during the two-year time period_____

    Two years after return to school from injury:
        Was this youth referred to PINS?
                __Yes
                __No
                __Unknown
        If yes, number of times referred _____

9. In the RCSD's *Risk Factors to Graduate* ranking, within two years and closest to the date of injury, how did the youth rank?
                __ Low
                __ Moderate
                __ High
                __ Unknown

    In the RCSD's *Risk Factors to Graduate* ranking, two years after return to school from injury, what was the youth's most recent ranking:
                __ Low
                __ Moderate
                __ High
                __ Unknown

Appendix G

Participant Survey

Survey

The following survey is about what Strong Memorial Hospital did for you due to your specific type of injury. Please circle "yes" "no" or "unsure" to the following questions about your experience at Strong.

Service, Program and Hospital-Based Questions	Yes	No	Unsure
Did a social worker or other hospital staff person speak with you about the circumstances that led to your injury?	Yes	No	Unsure
Do you remember any other assessments that occurred in the hospital?	Yes	No	Unsure
Do you remember watching the Rochester Youth Violence Partnership Video?	Yes	No	Unsure
Do you remember signing the Document of Understanding that was presented to you by a member of the Rochester Youth Violence Partnership?	Yes	No	Unsure
Do you remember anyone from Pathways to Peace contacting you?	Yes	No	Unsure
If so, about how many times did they contact you?			
Did anyone from Pathways to Peace visit your home?	Yes	No	Unsure
Did you receive follow-up medical treatment for your injury?	Yes	No	Unsure
If so, where did you receive follow-up medical treatment?			
Were you referred to any other agencies for additional services? *	Yes	No	Unsure
Do you believe that any further violence has occurred as a result of your injury or the circumstances that lead to your injury?	Yes	No	Unsure
Was your injury part of a larger, on-going conflict?	Yes	No	Unsure
Have you been involved in any other unrelated conflict(s) resulting in an injury since your last visit to the hospital?	Yes	No	Unsure
Are you concerned that you will be involved in a violent conflict in the future?	Yes	No	Unsure

*If yes, interviewer prompts participant to answer the questions on page 2.

Please check under the boxes provided if you have been referred to, contacted and/or utilized any of the agencies listed in the first column. In the last column please rate each agency that you have been referred to, had contact with and/or utilized help on the scale of 1 to 5. 1=very unhelpful, 2=unhelpful, 3=not unhelpful/not helpful,4=helpful, 5=very helpful or unknown/do not know.

Agency, Service or Support	Referred	Contacted	Utilized Help	Rating of help	
1. Pathways to Peace	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
2. Child Protective Services	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
3. Probation Department	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
4. Division of Health and Human Services (DHS and/or DSS)	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
5. Rochester City School District	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
6. Hillside Children's Center*	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
7. If you have had contact with Hillside, which Hillside Program(s) have you been involved with?					Unknown
9. Mental Health Services*	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
10. If you have had any contact with Mental Health Services, where have you received these services?					Unknown
12. Employment Services*	Yes or No	Yes or No	Yes or No	1 2 3 4 5	Unknown
13. If you were in contact with Employment Services, what type(s) of services?					Unknown
14. Have you been in contact with any other agencies or services that are not listed on this survey? If so, which agencies and services?					Unknown

Participant Semi-Structured Interview

EXERCISE AND GOAL SETTING INTERVIEW SCRIPT

I.   **Exercise**
    a. **Provide the participant with a blank piece of paper and pen.**
    b. **"I would like you to take a few minutes and answer the following question on the top side of your paper: 'In a perfect world, where would you like to see yourself in five years.'"**
    c. **Once participant has had enough time to answer the question, ask participant to share his/her answer with you and discuss the answer together.**
    d. **After discussion of the first question have participant turn the paper over and propose another question: "Due to the fact that the world is not perfect, realistically, where do you see yourself in five years?"**
    e. **After participant finishes writing the second question, ask the participant if he/she would please share with you his/her answer.**
    f. **After exercise begin interview questions.**

II.   **Interview**

1. **Can you identify any barriers that stand in your way of achieving your goals?**

2. **Can you share with me anything that would make it easier for you to achieve your goals?**

3. **You came to the hospital because you were shot and/or stabbed. Are you aware of any lifestyle issues that contributed to you getting hurt?**

4. **We are interested in knowing how the hospital could help prevent future violent injuries?**

    a. **What did the hospital do that worked?**
    b. **What did not work at the hospital?**
    c. **What would you suggest the hospital doing differently?**

5. **How do you deal with conflict in your own life?**
    a. **What could help you improve that?**

Appendix I

Pediatric Assault Victim Psychosocial Assessment ADDENDUM

To SMH 1056MR and SH 1056CMR

(To be completed for Pediatric victims of gun shot wounds or stabbings)

Legal Guardian: **Phone:**

Relationship:

Name of Primary Care Provider: **Phone:**

CHILD'S HOUSEHOLD COMPOSITION

Siblings/ Age:	*1.*	*Age:*	*4.*
Other Children/ Age:	*2.*	*Age:*	*5.*
Adults: Age:	3.	Age:	6.

Status of siblings (e.g. incarcerated, previous victim, foster care):

ASSAULT VICTIM SPECIFIC CONTACTS

☐ Police Consultant*****   ☐ CPS   ☐ Pathways to Peace   ☐ CPS

☐ Center for Youth   ☐ Residential Facility   ☐ SPOA/Case Manager ☐ Parent

☐ Probation Officer   ☐ Other Community Service   ☐ Youth & Family Partnership   ☐ EMT

Name   Relationship Agency

Telephone

*Required

Description of event:

RELEVANT PSYCHOSOCIAL INFORMATION

Patient's Presenting Risk Characteristics

☐ Physical signs of gang involvement – i.e. gang clothing, red/blue bandanna, gang tattoo   ☐ Previous assault wounds

☐ Intoxication ☐ altered mental status   ☐ Combative/Defiant/Oppositional

☐ Cognitive limitations/Special Ed.   ☐ Mental Health Hx/Diagnosis/Admissions

Details **(specify source of information)**

Patient's Current Involvement with School and Community Agencies

☐ In school: School Name: Grade Level:

☐ Home Tutoring   ☐ Suspended   ☐ Special Ed.   ☐ Drop Out
☐ Probation   ☐ PINS   ☐ Youth & Family Partnership
☐ SPOA/Case Manager ☐ Other

Contact Name   Phone   Reason for involvement

Patient's Current Living Situation
Details:

Patient's History With

☐ Probation   ☐ PINS   ☐ CPS   ☐ Foster Care   ☐ Other
☐ Detention Facility ☐ Residential   ☐ Mental Health ☐ DDSO
        When:
        Why:

Parent Risk Factors

☐ Disabilities   ☐ Mental Health Hx/Diagnosis/Admissions ☐ Parent with homicidal/suicidal thoughts?
☐ Substance Abuse   ☐ Incarceration   ☐ Major medical problems
☐ Available support person ☐ probation/parole   ☐ CPS
        Name   Relationship
Telephone

SAFETY ASSESSMENT

☐ Assailant known to victim   ☐ Assailant arrested
☐ Has patient previously been assaulted by this individual or friends or relatives of this individual?
☐ Does patient have access to a gun? If yes, document plan to remove gun.
☐ Does patient want to retaliate?
☐ Does patient feel suicidal, hopeless, helpless, depressed? **(If yes refer to Psych Ed)**
☐ Has patient witnessed the assault of others?
☐ Is patient involved in a gang?
☐ Did patient's parent or guardian provide adequate supervision or guardianship? **(Seek consultation from CPS consultant)**

Risk Impressions:

DISPOSITIONAL PLAN – Developed in collaboration with the Child Protective Consultant

Place patient – will be discharged to: (**If other then to parent or guardian complete SMH 25**)

- ☐ Admitted (complete patient protection plan)
- ☐ Parental Home
- ☐ Relative Home, Name of relative: Address: Phone:
- ☐ Emergency Youth Housing, Name: Phone:
- ☐ Correctional Facility, Name: Phone:
- ☐ Unable to discharge (**check with CPS consultant**)

Details of Plan:

SERVICES REFERRED TO (consents obtained):

- ☐ Pathways to Peace 428-6339
- ☐ Monroe County Preventive Programs
- ☐ Center for Youth 271-7670 (24 hours)
- ☐ Pre Diversion Programs 238-8210
- ☐ CPS
- ☐ CHN
- ☐ Behavioral Health (**specify below**)
- ☐ SPOA/FACT 613-7654
- ☐ Other

Staff Signature: **Ext:**   **Date**

Appendix J

Adolescent Violent Injury: Document of Understanding

You are being treated for injuries suffered as a result of a gunshot or a stab wound. National research, as well as our own experience here in Rochester, shows that you are at **_HIGH RISK_** of being injured again, or possibly killed, as a result of violence.

Please read and sign the following document of understanding, attesting to the fact that you have been informed about these risks as well as the resources and services being offered to help you prevent further injury. Your parent or guardian will also be asked to review and sign this document.

What we believe:

1) No child should <u>EVER</u> be shot or stabbed. This type of injury is <u>NOT</u> a normal part of childhood and should <u>NEVER</u> be ignored.

2) Being shot or stabbed is rarely, if ever, an accident. It should be seen as an indicator of significant, sometimes ongoing, exposure to violence as well as a marker for increased risk of repeat violent injury or death.

3) Every child has a parent or guardian who is responsible for protecting them from harm.

What we know:

1) Once you have been shot or stabbed, your chances of being shot or stabbed again _INCREASE SIGNIFICANTLY._

2) The chances that you will _DIE_ as a result of a gunshot or stab wound increase significantly with each new injury. Twenty percent (1 in 5) of those shot or stabbed are _DEAD_ as a result of repeat violent injury within five years.

3) While the injury caused by your current gunshot or stab wound may not be serious, the risks described above remain real. What got you shot or stabbed the first time can get you killed the next time.

What we offer:

1) We have created a program that helps adolescents at risk for violent injury stay safe. With your permission, we work directly with you and your family to help identify and minimize the factors that put you at risk for future violent injury.

2) We have access to many resources, both at the hospital and within the community that can greatly improve our ability to help you stay safe.

What you need to understand:

1) Injury due to violence is rarely an accident. You have to understand the risk factors that you are exposing yourself to, and you have to accept responsibility for what happens in your own life. Only you know what choices and circumstances led to your injury and only you know what has to happen in order to prevent it from occurring again. We can help, but it starts with you.

2) Your parent or guardian has a legal obligation to protect you by providing adequate supervision. This document serves as notice to your parent or guardian that you are at high risk of being injured again and you are at real risk of being killed because of the potential risks you are exposing yourself to. Once again, we can help, but it has to start with you.

****

By signing this document of understanding, I acknowledge that I have been informed about the known risks associated with injuries due to violence, as described in the above document. Furthermore, I acknowledge being informed about the continuing risks to my own personal safety due to the way in which I was recently injured. Lastly, I acknowledge being offered access to specific services and resources designed to help me decrease my exposure to future violent injury.

Name	Signature	Date

As the parent or guardian of a child who has sustained a gunshot wound or a stab wound, I acknowledge that I have been informed about the real risks to my child for repeat injury or death as a consequence of violence. Furthermore, I understand that I have a responsibility to do what I can to prevent situations that could result in additional injury or death to my child. Lastly, I acknowledge being informed about the many options that have been offered to my child in order to prevent further injury or death as a result of violence.

Name of parent/guardian	Signature	Date

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Attachment 1

On the following pages you will find the
**New York Hospital-Based Violence Intervention
Implementation Manual**

New York Hospital-Based Violence Intervention Implementation Manual

March 2013

Prepared for New York State Division of Criminal Justice Services

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Introduction

Violent crime, specifically shootings and stabbings, are issues that medical facilities often confront. For decades, criminologists have attempted to understand and even explain violence. With violence recognized as a public health issue by the U.S. Surgeon General in 1985 and that view reinforced in 1996, and with the World Health Organization putting violence on its agenda, the medical field has become more involved in violence prevention than it previously has been (World Health Organization). In the past, when dealing with victims of penetrating injuries, the mantra all too frequently was, "treat em' and street em,'" fortunately, that attitude has slowly begun to change. There are very real safety concerns when treating victims of violence, both for the medical staff and for the patients. Without a sufficient, safe way to handle these patients, facilities might often prefer to get the patients discharged as soon as possible. However, in one particular trauma center in Rochester, NY, the opposite is now true: regular practice ensures that the patient is safe and has a safe place to return to, prior to discharge. Changing how the entire hospital staff not only view but also intervene with young victims of violent, penetrating injuries is a process deserving ample explanation. In the following pages, steps to implementing a hospital-based violence intervention program in an upstate New York trauma center will be described. The process, in its current form, took years to develop and continues to evolve.

Chapter one of this report will examine background data on violent injuries, the medical model, community violence, and the public health approach. Chapter two will give background data on other hospital-based violence intervention programs. Chapter three will discuss state-wide and Rochester data, specifically crime data and the community. Chapter four will then describe the hospital-based violence intervention program and the implementation steps. Essentially, chapter four is the core of the manual for those wishing to develop a similar program in their community. Chapter five discusses lessons learned. And, lastly, chapter six describes implications and next steps.

As we embarked on this effort to review the Rochester hospital program, we had planned a comprehensive review, which would include an empirical evaluation of program effectiveness. Although there was agreement over the research design, after extensive and repeated efforts it became apparent that the program did not collect and could not provide the necessary data to assess effectiveness. We recognize this as a significant limitation to this report and, more importantly, to the accumulation of knowledge about this intervention model. Efforts to implement similar programs elsewhere should make every possible effort to help fill this gap.

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CHAPTER 1: Background Data

National Data

Violent crime in its most serious form is measured in homicide. Homicide spiked in the mid eighties and early nineties across the nation and then in the mid to late nineties the rate of homicide substantially decreased (Levitt, 2004).   From 2000-2007 the number of homicides nationally remained steady at around 16,500 per year, and from 2008-2010, the rates have steadily declined, decreasing from a rate of 5.7 per 100,000 to 4.8 per 100,000 (FBI Uniform Crime Reports, 2012). However, the rates have never decreased enough to measure up against other industrialized countries.

In 2010, there were 14,748 homicides (murder and nonnegligent manslaughter) in the United States, with firearms accounting for about 68% of those homicides (FBI Uniform Crime Reports, 2012). This was a drop from 2009, when there were 15,241 homicides in the United States (FBI Uniform Crime Reports, 2012). According to the FBI Uniform Crime Reports, within that same year, knives and other cutting instruments were the second most commonly used weapons, with 13% of homicides involving a cutting instrument. In 2010, there were 59,344 nonfatal firearm injuries reported nationally (Department of Health and Human Services, 2012). This increased more than 11,000 from 2009, when the Department of Health and Human Services reported 48,158 incidents of non-fatal firearm injury. This seemingly reverse relationship between fatal and nonfatal victimization trends may be due to advances in the medical field, as hospitals are able to produce more viable outcomes for gunshot wound patients.

According to Pridemore (2003), "excess mortality due to violence disproportionately influences a population's life expectancy, because victims of violence tend to be younger than those dying of internal causes." African-Americans have half the risk of suicide as Caucasians but more than five times the risk of becoming homicide victims (Hemenway, 2004). In 2005, African-Americans were victims of an estimated 805,000 nonfatal violent crimes and an estimated 8,000 homicides. Though African-Americans accounted for 13% of the population in 2005, they accounted for about 15% of the victims of nonfatal violent crimes and close to half of all the homicides. Further, close to 14% of the nonfatal violent crimes against blacks involved an offender armed with a firearm and about one third resulted in an injury to the victim.   From 1993-2001 violent victimization rates for blacks declined, but these rates remained stable from 2001-2005 (Harrell, 2007). In one review of data across 16 states, homicide rates were highest for those between 20-24 years old and blacks accounted for the majority of homicides (50.6%) and approximately one third of homicides were precipitated by another crime (Karch, Lubell, 2008).

During the 1980s and 1990s, the violence-related morbidity and mortality amongst African-Americans began to be viewed as a serious public health issue. In 1998 the age-adjusted homicide rate for Whites was 7.3 per 100,000 and the rate for Blacks was 25.2 (Pridemore, 2003).

Penetrating Injury Data

Firearm-Related

Youth are often the hardest hit when it comes to violence. Firearm injuries are largely the most severe forms of community violence (Mock, Pilcher, & Maier, 1994; Waters, Hyder, Rajkotia, Basu, Rehwinkle, & Butchart, 2004). These injuries are likely to be costly, long-term, and affect daily functioning.

Of the 59,344 assault firearm nonfatal injuries in the United States in 2010, 6,106 were injured females and 53,238 were injured males. An estimated 30,087 of these victims were hospitalized for their injuries, and 25,678 were treated and released (National Center for Injury Prevention and Control CDC, 2012). However, results are mixed on the number of nonfatal violent injuries nationally as not all injuries are reported to law enforcement and/or medical facilities (Prothrow-Stith, 2004, p. 40). It has been estimated two nonfatal injuries occur for every firearm death (Firearm & Injury Center at Penn, 2011). Yet, a trauma study completed in Ohio regarding non-fatal violence showed that for every one homicide during the study period, 25 assaults were reported to the police and 100 were reported to the Emergency Department; thus showing the vast disparity in incidence for these injuries. These disparate numbers may mean that those that are likely reported to law enforcement and/or receive medical treatment are the more serious injuries, while the less serious injuries may not be receiving any medical or law enforcement attention, keeping both the victims and offenders out of radar. It is also possible that the person who does not receive medical treatment is at a higher risk for future violence simply due to the fact that he or she did not receive medical care for their injury. This could be due to involvement in illegal activities, lack of concern for health, and/or plans of retaliation.

While African Americans have disproportionate levels of firearm related injuries, certain age groups are also disproportionately represented in violent crime, which should inform the interventions used. According to the CDC's preliminary 2010 National Vital Statistics Report, assaults (homicide) are the second leading cause of death for those aged 15-24, falling behind accidents (Murphy, Xu, & Kochanek, 2012).

A national study using 1997 data found an estimated 35,810 victims were treated for firearm-related injuries in hospitals nationally. Of these, 18,751 were treated for assault related injuries; 2,871 were treated for self-inflicted injuries; and 11,026 were determined to be unintentional cause. Unintentional or accidental causes have reporting issues as it is entirely plausible that someone who was planning to commit suicide and missed may not fess up to the intended act (Firearm and Injury Center at Penn, 2011). The high number of non-fatal unintentional firearm injuries is noteworthy. The average length of stay was six days, with an estimated total of 111,506 hospital days for firearm-related assault cases (Coben & Steiner, 2003). With an average length of stay six days, a firearm injury is often a serious injury, requiring surgery and other costly procedures. According to an 11-year study on trauma at a predominantly African-American serving Howard University Hospital (90% of patients identify as African-American) from 1994-2005 there were a total of 10,383 trauma admissions. Of these admissions, from 2001-2005 there were an average 1,204 trauma admissions per year. From 1994-2005 there were a total of 365 trauma deaths and of those, 205 (56%) were due to gunshot wounds. The majority,

of the deaths, nearly 75% (270), was due to intentional injuries (gunshot wounds, stab wounds, and assaults) (Lyn-Sue, 2006).

Cut/Piercing-Related

Stab wound data other than incidence, are not readily available as there are few published studies on stab wound injuries. Possible reasons for the lack of research include: often low cost to treat, many victims do not receive medical treatment for the wounds, difficulty identifying the injuries through medical coding, and often not reported to law enforcement by the medical community. The available data show that in 2010, an estimated 16% percent of all aggravated assaults were knife or cutting instrument related (Federal Bureau of Investigation, 2012). Knives are the most common instrument used in stab wounds (Perkins, 2003). Further, in 2010, there were 232,145 nonfatal violence-related cut/pierce injuries reported and 18% of those treated were aged 7-18 years old. And of the cut/pierce injuries, 154,738 were treated and released while 39,765 were hospitalized for their injuries (National Center for Injury Prevention and Control CDC, 2012).

According to the Bureau of Justice Statistics National Crime Victimization Survey, most victims are attacked with a knife or sharp object when they are away from home on a leisure activity (25.1%), followed by attacks at home (23.2%) from 1993-2001 (Perkins, 2003). According to the State Master's Crime Statistics data for 2005, 20.8% of violent crime victims in New York are killed with a knife or other cutting instrument. According to the FBI's UCR system, in 2010 nationally there were 1,704 homicides from knives or cutting instruments (Federal Bureau of Investigation, 2012). While homicide by firearm is the most common method of homicide, 20% of homicides from cutting/piercing instruments is not something that should be ignored. In 2010, Canada reported 30% of its 554 total homicides were caused by a cutting/piercing instrument (31% caused by firearm). The most common method of homicide in England and Wales is by a sharp instrument, where this method accounted for 36% of all homicides in 2010/2011 (Smith, Osborne, Lau, & Britton, 2012). The second most common method is by hitting or kicking (19%) and the third is by firearm (17%).

Youth Violence

The topic of youth violence has been widely discussed in the public health literature since 1980 (Taylor, Esnbenson, Peterson, and Freng, 2007). According to Prothrow-Stith, "Guns are involved in over three-quarters of the violent deaths of teenagers in this country" (2003, p. 73). Taylor and colleagues looked at 5,935 eighth-grade public school students across the nation who were administered a survey on violent victimization. The results found that Native Americans, African-Americans, and Hispanics were more likely than Whites to be victims of violent crimes. One interesting result revealed that the differences in the likelihood of being violently victimized may be attributed to the community that the youth lived in; thus community played a significant role. Overall, the study found that close to half of the participants surveyed reported being violently victimized.

Taylor et. al. (2007) highlighted the importance of viewing the issue of youth violence through the public health lens, using Mercy and O'Carroll's model. This model includes the following

four steps: (1) surveillance of the problem, (2) risk group identification, (3) risk factor exploration, and (4) program implementation and evaluation. This is the public health model as it is viewed throughout the literature in this area. In essence, there is a "disease" that needs to be contained and eventually extinguished. In order to take care of it, doctors must first see the extent of the problem, next determine what groups are contracting the disease, then determine possible vaccinations to the problem or other protective factors, and lastly, the vaccinations and educational programs must be implemented.

Cost

Nationally, trauma-related disorders are the second most expensive medical conditions to treat (Medical Expenditure Panel Survey Statistical Brief #248, Soni, 2009). The Brief reveals that ten years prior, in 1996, trauma related disorders were also among the top five most expensive medical conditions to treat. Of the five conditions that were most costly to treat in 1996 and 2006 (heart disease, trauma-related disorders, cancer, asthma, and mental disorders) the medical expenditures increased substantially from 1996 to 2006 for only mental disorders and trauma-related disorders. Trauma-related disorders increased more than $20 billion from $46.2 billion in 1996 (in 2006 dollars) to $68.1 billion in 2006. Violent injuries associated with community violence (gunshot wounds, stab wounds, blunt trauma assault) are all trauma related disorders.

Research suggests that the medical cost of a firearm injury lie between $15,000 and $35,000 per injury (Vassar & Kizer, 1996; Nelson, Puskarich, & Marks, 1987; Cook, Lawrence, and Ludwig, 1999). Victims of violence-related injuries are the least likely to have health insurance. It has even been found that, in order to cover the costs of uncompensated care, health insurance premiums are estimated to be 8.5% higher than they would otherwise (Garson, 2007). Further medical costs associated with firearm injuries are a small portion of the total costs, such as change in quality of life and deterioration in the quality of community living (Firearm and Injury Center at Penn, n.d.; Cook, 2000; Miller, Fisher, & Cohen, 2001; Butchart, Brown, Khanh-Huynk, Corso, Florquin, & Muggah, 2008).

There is a note of caution when determining the cost to treat a specific violent injury, such as a firearm injury. Factors to consider include, age, pre-existing health conditions, injury occurrence, number of bullets, among other factors, thus making costing a difficult process. While there are studies available that identify a specific dollar amount to treating firearm injuries, these cannot be assumed to be true for every injury in every jurisdiction, thus caution is imperative. Medical cost studies are faced with overwhelming issues around actual cost, charge, and reimbursement figures (all of which do not match), making the study of cost not particularly meaningful (Duda, Klofas, Montanaro, 2008).

Medical Field

The medical model is a concept identified as the traditional Western approach to diagnosis and treatment of an illness. This model involves a physical examination, testing to identify the illness, and then a prescribed treatment for the illness (Medical Dictionary, 2012). While the

medical model is the traditional model used by medical doctors, other models include the social model as well as a more holistic model, which is the model nursing practice reflects.

In recent years, the American Medical Association has taken an official approach concerning the different forms of violence. The American Medical Association now has recommended specific policies addressing violence. The section entitled School & Youth Violence (Section D-515.987) states that "Our AMA will continue to study the timely issue of violence in our schools, including youth violence prevention and early identification and intervention." (p.8). Section D-515.995 ("Time for Action on Youth Violence") states that the AMA will advocate for the creation of a national task force to address youth violence and prevention. The section under the heading, "Community Violence," includes the following sub-sections on injury prevention: Violence as a Public Health Issue and Public Health Policy Approach for Preventing Violence in America. Some of the efforts supported by the AMA include the CDC continuing to develop appropriate surveillance methodologies for tracking violence-related injuries and it reaffirms its current policy that violence in America is a major public health crisis and it supports research in intervention and prevention. One of the major sections is H-515.965 Family and Intimate Partner Violence. Under this section is the notion that all forms of family and intimate partner violence are major public health issues, all physicians should be trained in issues of family violence which should be done at the undergraduate, graduate, and continue at the professional development level. Clearly, the AMA sees violence as a priority and as something in need of further research and understanding behind it, in order to identify successful interventions and prevention strategies.

In 1996 the American Academy of Pediatrics developed model protocols for handling adolescent assault victims, indicating the need was there for establishing this protocol around youth violent injuries (Wilkinson, Kurtz, Lane, and Fein, 2005). Further, in 1999 the American Academy of Pediatrics Task Force on violence essentially made a call to action for screening for risk, encouraging preventive education, and linking patients to follow-up services (Wilkinson et al. 2005); again, representing the urgency of the issue.

Medical Relationship with Community

For years, the medical community has collaborated with the broader community on a number of medical issues. Some more current issues include: obesity prevention, lead poisoning, and injury prevention. In recent years, the medical community has become involved in less obvious medical issues, such as family violence. Those trained in medicine are often asked to sit on coalitions, participate in strategic planning, and participate in community collaboratives around medical issues. What is unusual about the Rochester hospital-based violence intervention is that the Trauma Department has become actively engaged with the reduction of youth violence. The Adolescent Behavioral Health unit, as well as the Department of Social Work are the other two major medical constituents behind the creation of the partnership. This violence intervention program includes both an intervention component as well as an ongoing partnership. The partnership will be described in more detail in chapter 4, but it is made up of over 30

participating partner agencies and meets monthly at the hospital to discuss issues around youth violent injury.

Community Violence

Community violence is defined in various ways and while there is not an agreed upon definition of community violence, there is general consensus that there are three categories of community violence: direct personal experience, exposure through witnessing violence, and vicarious experience (Aisenberg & Ell, 2005). Most definitions distinguish between family violence and community violence in that community violence occurs outside of the home, and involves some sort of violent threat, force, or activity with the intent of causing harm (Rosenberg & Fenley).

Exposure to community violence has shown to have a range of negative effects on one's wellbeing (Farley et al., 2007; Lumeng, Appugliese, Cabral, Bradley, & Zuckerman, 2006; McCart at al. 2007; Parkes and Kearns, 2006; Stafford et al., 2007). Further, studies have found that fear associated with community violence have contributed to higher rates of obesity, less physical activity, and higher psychological distress than those living in neighborhoods reporting less fear of violence.

Stress, and specifically Post Traumatic Stress Disorder, is related to community violence in that higher levels of chronic stress are often a result of living in neighborhoods with community violence exposure. Chronic stress has documented, long-term physiological and cognitive impacts, such as increased levels of serotonin and cortisol (leading to their eventual depletion), resulting in depression, sleep disturbance, perceiving threats that are not, and memory loss (Krasner,M., lecture, 2010). Other effects include: Obesity, Diabetes, Cancer, negative attention and memory bias, decision-making difficulties, attention difficulties, inability to learn new associations, negative mood, Hypertension, and Thyroid/endocrine burnout.

Firearm injuries tend to be concentrated in specific neighborhoods, thus exacerbating the impact of community violence in specific areas. This exacerbation creates neighborhoods with people living in fear of crime and suffering the consequences of that fear.

Teachable Moment

The teachable moment receives much attention in the medical field. This is "the point in a learning experience which the leaner is more receptive to accepting and using new information, accepting new attitudes, or learning new skills" (p. 174, Leist & Kristofco, 1990). These are naturally occurring events in one's life in which they are more apt to take in information and then change their attitudes and/or behaviors in particular aspects of their lives. Taking advantage of this natural event has shown success particularly in the field of smoking cessation. Specific to smoking cessation, McBride, Emmons, and Lipkus (2003) found the following needed to be in place for a teachable moment to be possible: the extent to which the event 1) increases perceptions of personal risk and outcome expectancies, (2) prompts strong affective or emotional responses, and (3) redefines self-concept or social role. (p. 156).

The teachable moment is a critical element to the hospital-based violence intervention, as the intervention relies heavily on this theory. The belief is that the person being treated for violent injury was leading a risk lifestyle and this is a byproduct of leading that kind of life. Through the framework of the teachable moment: the person has now been injured, is possibly scared, and is likely to have family and friends worried for his or her wellbeing, thus, the hospital staff use a number of resources and tools to engage the patient in making a decision to change his or her current beliefs and behaviors around violence. Johnson et al. (2007) report one of few studies that looked at the impact of the teachable moment on those presenting at the Emergency Department for an assault penetrating injury and the results were promising. Preliminary support was found for the presence of the teachable moment with those patients. The teachable moment is key to this particular hospital-based intervention and will be explored in greater detail in Chapter Four: Implementation of a hospital-based Violence Intervention Program

Violent Re-injury

The *best* predictor of who will be a victim of a violent injury is previous violent injury. This finding helps to explain why a small number of people in the total population is disproportionately affected by violent crimes. Some reports even show that 4% of the population experience 44% of the crime (Farrell & Pease, as cited in Planty & Strom, 2007). Other studies found that the overall risk of personal victimization, in any form, is 2.2%, but for those who have been victimized once, 18% were re-victimized (Tseloni and Pease, 2004). Age is a risk factor for re-injury as young people treated for violent injury are at greater risk for violent re-injury (Horowitz, Kassam-Adams, Bergstein; 2001).

Research has also shown that the more time someone spends with delinquent peers, the more likely they are going to be a victim of a crime (Schreck, Stewart, & Fisher, 2006). Researchers, thus, assert that victimization is not a random event; rather it is an event that occurs more often to people engaged in certain lifestyles. Research has also found that those who offend have similar attributes to the offenders. Thus, someone's participation in crime is very much positively related to their risk of victimization (Shreck, Stewart, & Fisher, 2006).
Further, behavioral factors play a contributing role in this higher risk and most personal crimes involve a victim and an offender where they have some form of relationship prior to the crime (Horowitz, Kassam-Adams, Bergstein, 2001)

Gallagher (2005) found that those who do receive medical treatment for intentional injuries are reinjured at rates 2-4 times greater than those receiving medical treatment for unintentional injuries. It was further revealed that those who do not receive medical treatment for their intentional injury are at even greater risk of intentional re-injury, at rates three to four times that of those who were treated for violence related injuries. The hospital associated with the hospital-based intervention described in Chapter Four recognized violent re-injury as a significant issue among young victims of penetrating injuries. For this reason, the single goal of the intervention is to reduce the incidence of violent re-injury.

Public Health Model

Violence officially became recognized as a public health issue in 1985 during the Surgeon General's Workshop on Violence and Public Health.   Then, in 1992, the Centers for Disease Control and Prevention (CDC) received its first funding for curbing high rates of homicide among youth. Four years later, violence was placed on the international agenda with the World Health Assembly's adoption of a resolution declaring violence "a leading worldwide public health problem." And, in 2002 the World Health Organization's *World Report on Violence and Health* used the report findings as a platform for increased public health action towards preventing violence. In essence, violence is a confirmed public health issue.

This approach focuses on conditions and diseases of the entire population, aiming to maximize effective strategies and interventions (CDC, 2008; Dahlberg & Krug, 2002). The Centers for Disease Control and Prevention ascribe to a four-step public health approach:
1. Define and monitor the problem
2. Identify risk and protective factors
3. Develop and test prevention strategies
4. Assure widespread adoption

In the World Health Organization's prominent *World Report on Violence and Health* released in 2002, the specific public health approach to violence prevention was outlined by Dahlberg and Krug. While the approach is based on the one above, it is made more explicit here in regards to preventing violence:
1. Uncover as much information about all the aspects of violence
2. Investigate why violence occurs, including causes, protective factors, and risk factors
3. Explore ways to prevent violence
4. Implement interventions that appear to be promising, and widely disseminate the information as well as the cost-effectiveness of interventions.

Colorado University's Center for the Study and Prevention of Violence (2004) has an excerpt from Hamburg's (1998) book on youth violence which states, "The public health model includes five essential features:
1. Community-based methods for problem identification and the development of solutions across entire population groups;
2. Health-event surveillance for gathering data to establish the nature of the health problem and to track relevant risk factors and the trends of its incidence and prevalence;
3. Epidemiological analysis to identify risk factors and associated co-factors associated with the health problem;
4. Intervention design and evaluation; and
5. Outreach/education/information dissemination."

It is clear that the public health model involves defining and measuring the incidence of a problem, identifying risk and protective factors, developing a sound intervention, and conducting outreach and knowledge dissemination.

Project Exile

Project Exile was established in Virginia in 1997 with a goal of creating harsher sentences for those caught with firearms. This was to be done through taking any gun charge and transferring it from local or state prosecution into the Federal Court, making the crime eligible for a 5 year minimum sentence. Deterrence theory framework was at the root of the intervention in that harsher sentences would deter people from carrying guns and thus reduce the number of people who died or were injured as the result of a firearm. This required communication between multiple criminal justice agencies in a formal, standardized way. To make this run smoothly and effectively, task forces were created in a number of cities that had Project Exile. Rochester was one of those cities and continues to be today. Monthly meetings are held amongst the key criminal justice agencies in which information is shared, new tactics are discussed, and challenges are addressed. In Rochester there are 30 regular attendees to these monthly meetings. In addition to the large monthly meetings, specific case meetings are held monthly amongst those involved in the specifics of certain cases, ensuring that information is shared and the most effective approach is made with every case. The hospital-based violence intervention described here was created based on this partnership model.

Summary

This chapter highlighted information, theories, and models that all play a role in the creation of the youth violent injury intervention explained in Chapter 4. This background data sheds light on the state of violent injury not only nationally, but locally, and how the medical environment was ripe for a program of this kind to be implemented. The following chapter highlights the few hospital-based violence intervention programs that have popped up across the nation over the past two decades and any findings associated with the programs.

CHAPTER 2: Hospital-Based Violence Intervention Programs

Programs

There are a handful, but growing number, of hospital-based violence intervention programs across the nation. The oldest ones include Caught in the Crossfire implemented in Oakland in 1994 and Project Ujima implemented in Milwaukee in and the Violence Intervention Program out of Baltimore. In more recent years, more hospitals have implemented or begun the steps towards implementation of violence intervention programs. With the increase in programs, the National Network of Hospital-based Violence Intervention Programs (NNHVIP) was created as a resource for the various programs.

NNHVIP is run through University of Pennsylvania's Firearm and Injury Prevention Center and has a steering committee with national membership. As explained on NNHVIP's website, the programs that are part of the network incorporate the use of the window of opportunity for victims of violent injuries recovering in the hospital, with a goal of reducing retaliation and future violence.   With such a nebulous description of hospital-based violence intervention programs, the programs identifying themselves as such have varying program structure, measures, and outcomes. This chapter will shed light on some of the programs and current research state of these programs.

Before describing a select number of programs, the first point to be made is that *all* of the programs, except for RYVP, have an identified program budget. RYVP is unique in that its program is run without an identified budget. The intervention is run through the hospital, with hospital staff who are trained in the process. As will be explained in Chapter Four, RYVP has found a way to integrate the intervention into the regular way of doing business. As one will imagine, there are drawbacks and benefits to running a no budget program, which will also be expanded on in the same chapter.

Hospital-based intervention programs use various intervention strategies, from mentoring to case management to referral coordination to home visitation to service planning, to brief, directed behavior change counseling (Aboutonos, 2001; Cheng, Haynie et al, 2008; Cheng, Wrught, et al, 2008; Cooper et al, 2006; Cunningham et al, 2012, Johnston at al, 2002; Shibru et al, 2007; and Zun et al, 2006). The interventions are mostly focused on young people who are victims of violence, often between the ages of 13 and 20. Further, the programs last anywhere from one day to one year. While these intervention programs have varying elements, there have been a number that have undergone evaluation.

Caught in the Crossfire (Oakland) has been evaluated twice, once in 2004 and again in 2006. Through the use of Crisis Intervention Specialists, youth who have been hospitalized for violent injuries are engaged with the program. The Specialists are young adults who are from the same community and many have been formerly incarcerated or are disabled due to violent injury.

They meet with the youth and the youth's friends and family immediately after the youth has been hospitalized and then conduct visits throughout the duration of the hospitalization as well as post-discharge. The Specialist assists with referrals, job placement, probation hearings, and other related issues. The first study looked at a 6-month follow-up period post-hospitalization. The treated cases were those who had successfully completed the program, while the control group were those who were similar but were somehow left out of the program (i.e. moved, overlooked at the hospital, wrong identifying information, etc.). The results showed that youth who were treated were 70% less likely to be arrested for any offense 6 months post injury than the control group. Regarding violence-related arrest rates and probation rates, the results were not statistically significant; however none of the treated group participants were arrested for violence-related offenses 6 months post injury (Becker, 2004).

From 1998-2003 Caught in the Crossfire was again evaluated. This study was similar to the previous study, but it looked at 18 months post injury and it also examined the cost-effectiveness of the program. While the results found similarities between risk of physical re-injury and death, there were fewer treated patients were involved in the criminal justice system. When controlling for ethnicity and gender, the program's effect on reducing criminal justice involvement was more effective with younger participants. From the results, data were gathered on cost and it was determined that the program's annual cost is $60,000 less per patient than the cost of incarceration (Shibru, 2007).

CeaseFire (now Cure Violence) in Chicago has a hospital approach to violence reduction as well. The Advocate Christ Hospital in Oak Lawn, Ill collaborated with Ceasefire three years ago, and treated the hospital committed substantial funding to have chaplain staff available 24/7 for those who are treated for a violence-related injury. The hospital surgeons were getting frustrated at the number of repeat victims of violence showing up to be treated (it is estimated that between 10-45 percent of victims treated for violence related injuries are repeat victims). So, the doctors approached Ceasefire to ask if their street violence interrupters could do some outreach at the hospital as well. In 2007, Ceasefire was involved in about 400 interventions at Advocate Christ. Though Ceasefire has lost $6.2 million in state grants in 2007; Advocate Christ gave the group $50,000 in 2006, $72,000 in 2007, and $95,000 in 2008 (Shelton, 2008).

Baltimore's Violence Intervention Program (VIP) is for adults who have been previously hospitalized for at least one violent injury and are currently hospitalized for a violent injury. Those who participated in the program during the study period (1999-2001) were part of the intervention group and those who chose not to participate were part of the control group. The intervention consists of a long questionnaire that the victim completes. After the results are reviewed, the social worker or caseworker and probation or parole officer assigned to the program design a service plan. Then, post-discharge, home visits were made. Additionally, weekly joint meetings are held to discuss the cases. The results showed that the nonintervention group was four times more likely to be convicted of a violent crime than the intervention group and two times for likely than the intervention group to be convicted of any crime. The program also had a positive effect in hospital recidivism (Cooper, 2006).

While hospital-based violence intervention programs are becoming more common, there is still great variation amongst the programs as well as mixed findings on their effectiveness. For these

reasons, standardization amongst the programs seems like a logical next step. This manual is one step in sharing information, specifically successes and what works, in order to add to the literature in the field. Further rigorous evaluation would be an asset to this young field as well. While some programs are showing more success than others, it would be beneficial to better understand what works, how it works, and how can it be sustained. Evaluation will get at these questions, making partnering with researchers all the more rewarding.

CHAPTER 3: New York Data

New York State

As described above, the use of firearms in assaults and murders is not uncommon. In New York State, firearms accounted for 63.6% of all murders between 2002 and 2011, according to the *Crime, Arrest, and Firearm Activity Report* prepared by the Division of Criminal Justice Services (DCJS) of New York State. The number of nonfatal shooting injuries reported by the 17 counties participating in Project IMPACT in 2011 was 799, down from 819 the year before and totaled 64 fewer victims than in 2006 with 836 nonfatal injuries. The Project IMPACT counties are the 17 counties in New York State that account for 80% of the crime outside of New York City.

Local (Rochester)

The Rochester community has seen its population steadily decline over the past five decades. In 1950 Rochester's population topped over 330,000 and 2010's US census recorded a population of 210,565 (U.S. Census Bureau, 2012). According to the *What's Goin' On* report on African-Americans in Rochester, it was found that thirty nine percent of children under the age of 5 residing in the city are living in poverty and 17% of children countywide are living in poverty (African American Health Status Task Force, 2003). The Rochester City School District's 4-year graduation rate was at 46.1% in 2010 (New York state Department of Education, 2011). And this graduation rate has consistently hovered right below 50%. The Schott report found that the numbers were alarmingly lower for black males in Rochester, who had a graduation rate the lowest in the country, at 9% (2012).

The incidence of violent crime in Rochester has been on the decline in the last two years, but prior to 2010, violent crime remained steady in Rochester. In spite of the recent decline, violent crime in Rochester remains higher than the national average. In 2007, Monroe County's violent crime rate was 406 per 100,000 (Division of Criminal Justice Services, 2008). Monroe County's violent crime rate is the third highest in New York state outside of New York City (Monroe falls behind Erie and Albany Counties). However, Monroe County ranks second (only behind Erie County) in New York State (including all New York City counties) for violent crime with a firearm (Division of Criminal Justice Services, 2008).

For black youth ages 15-35, homicide is the leading cause of death (Violence Policy Center, 2008). In Rochester, African-Americans make up 41.7% of the population and Hispanics make up 16.4% of the population; however, African-Americans make up more than 80% of homicide victims annually (US Census, 2010; Rochester Police Department, 2012). From 2000-2011 there were 2,235 shootings in Rochester with an annual average of 172 shootings (Rochester Police Department, 2012). Rochester averages 21 homicides per 100,000, but for a city the size of Rochester (population of 210,565), the rate should be closer to 12 or 13 per 100,000. For this

reason, Rochester has the undesirable label of being the homicide capital of New York State, while New York City boasts a homicide rate of 6 per 100,000.

In Rochester, police have identified an estimated 60 gangs which are comprised of close to 2,300 gang members and associates. These gangs are both fluid and dynamic, with new and even hybrid crews established regularly. Members of gangs typically utilize, for the purpose of identification, a common name, hand signs, colors, tattoos, symbols, or geographic area. Typically street level drug sales are interwoven with gang activities and the inherent culture of violence surrounding gangs and gang members is evident in Rochester's crime. Gang related violence often stems from interpersonal disputes over relationships or drug rip-offs, amongst other issues. In 2010 alone, 63 different gangs were represented in violent crimes and 25.8% of shooting victims were gang involved. An additional 85 gang members were arrested for criminal possession of a weapon in 2010. (Monroe Crime Analysis Center, personal communication, June 5, 2012).

The map below shows the concentration of all firearm crime during 2007-2011. As can be seen below, the shootings are concentrated in specific areas of the city which are faced with other serious issues including, high unemployment rates, high rates of criminal justice supervision, high rates of concentrated poverty, and high rates of teen pregnancy.

5 yr Density of Firearm Crime in the City of Rochester (2007-2011)
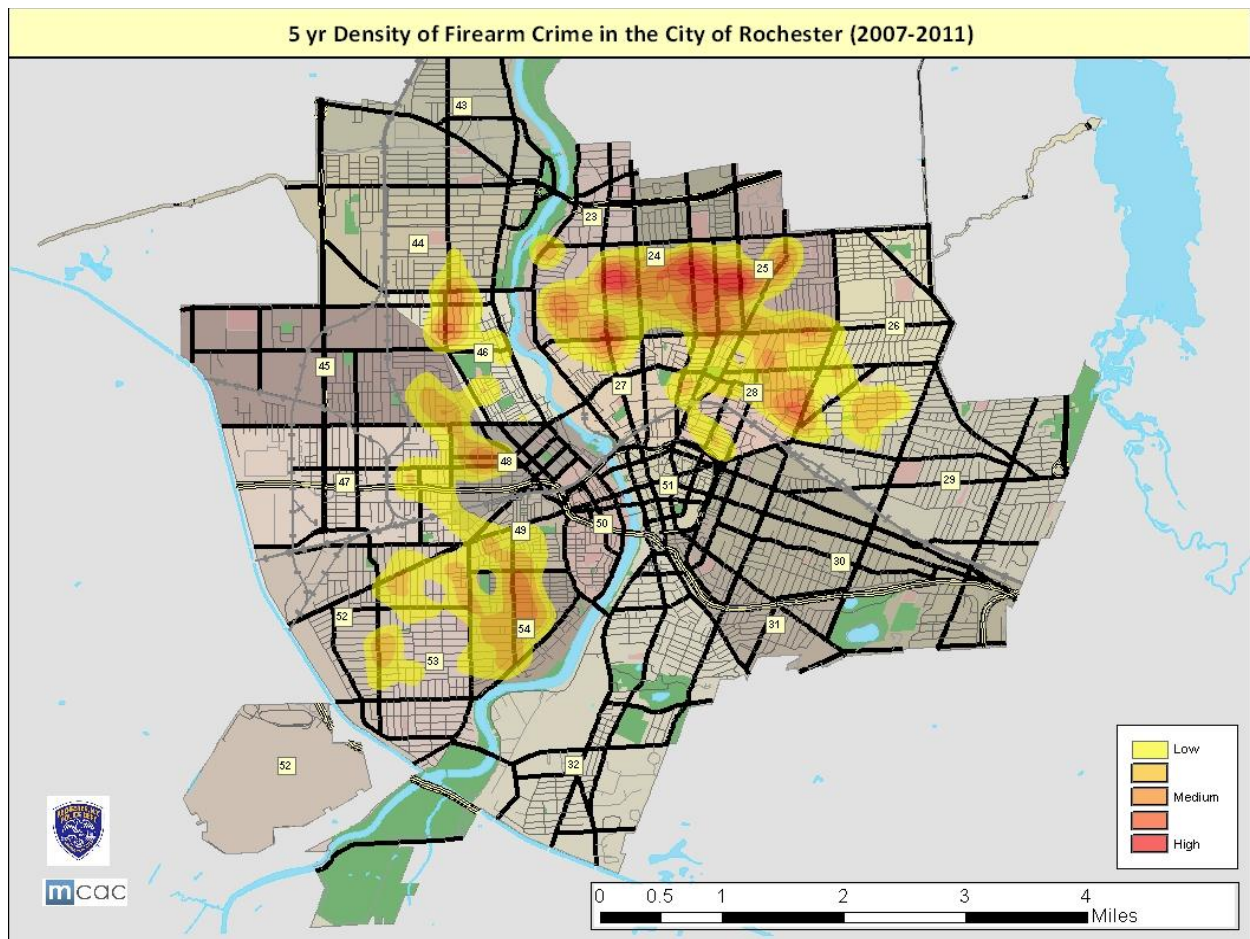
According to the New York State Department of Health's report on trauma centers from 1999-2002, there were a total of 2,858 gunshot wound victims hospitalized with completely coded data in the New York State trauma registry from 1999-2002. Of these patients, New York City accounted for 65.75% of them, while the Finger Lakes Region, which only includes Strong Memorial Hospital, was the second highest region to treat gunshot wounds, accounting for 8.01% (or 229) of these patients. Local data show that youth treated for penetrating injuries at the regional trauma center average about 25 victims annually. The chart below represents the number of victims aged 17 and younger treated for specific injuries.

Youth (aged 17 years and younger) Treated at Strong Hospital for Penetrating Injuries 2005-2010
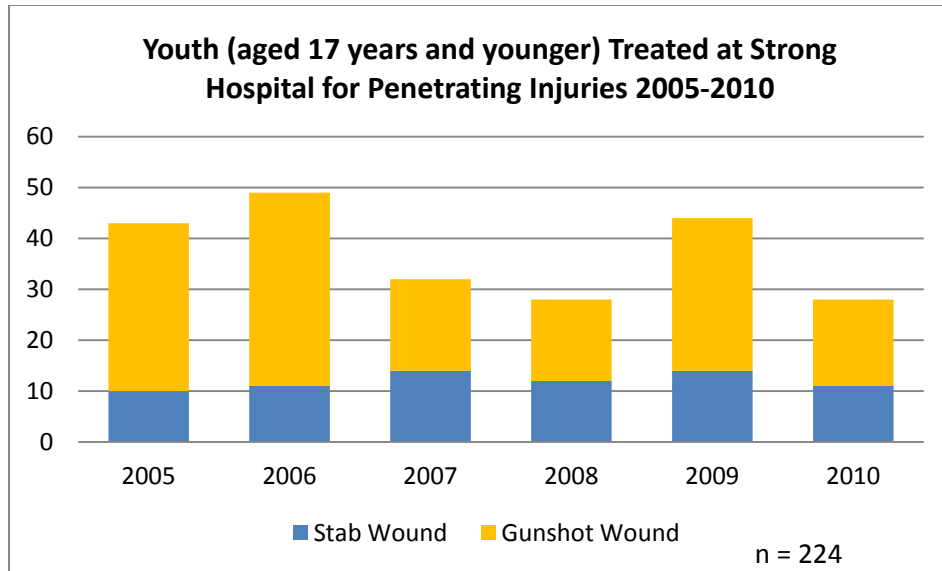
Violence is not a new concept to Rochester; rather it has been a longstanding, serious issue in the community. With the involvement of the medical community, there are new resources to address this issue as described in the following chapter.

CHAPTER 4: Rochester Youth Violence Partnership: Steps for Implementation

Program Description

The Rochester Youth Violence Partnership Program is comprised of two major components: 1) an intervention and 2) a partnership (or coalition). Essentially, the Rochester Youth Violence Partnership is a coalition of over 30 agencies and a hospital-based intervention program for youth who are victims of violent penetrating injuries (gunshot and stab wounds). The program began in 2005 and continues to evolve as new problems and solutions arise.

The intervention targets those victims aged 17 and younger and includes an initial assessment done in the hospital to identify risk factors that may have led to the current injury as well as ongoing risks that may lead to additional injury if discharged. Hospitalization is employed when discharge is felt to be unsafe or unwise. In addition to injury-related medical care, hospitalized victims undergo a specialized intervention that is focused on a complete understanding of risk factors that may have led to injury as well as approaches aimed at preventing future injury. This process involves families and guardians and incorporates tools such as a locally produced video and a document of understanding that are both designed to engage participants actively in the process. The ultimate goal is to assure a safe discharge and to connect victims with resources that can provide the necessary services required to prevent further injury (i.e. gang intervention services, mental health treatment and substance abuse treatment, etc).
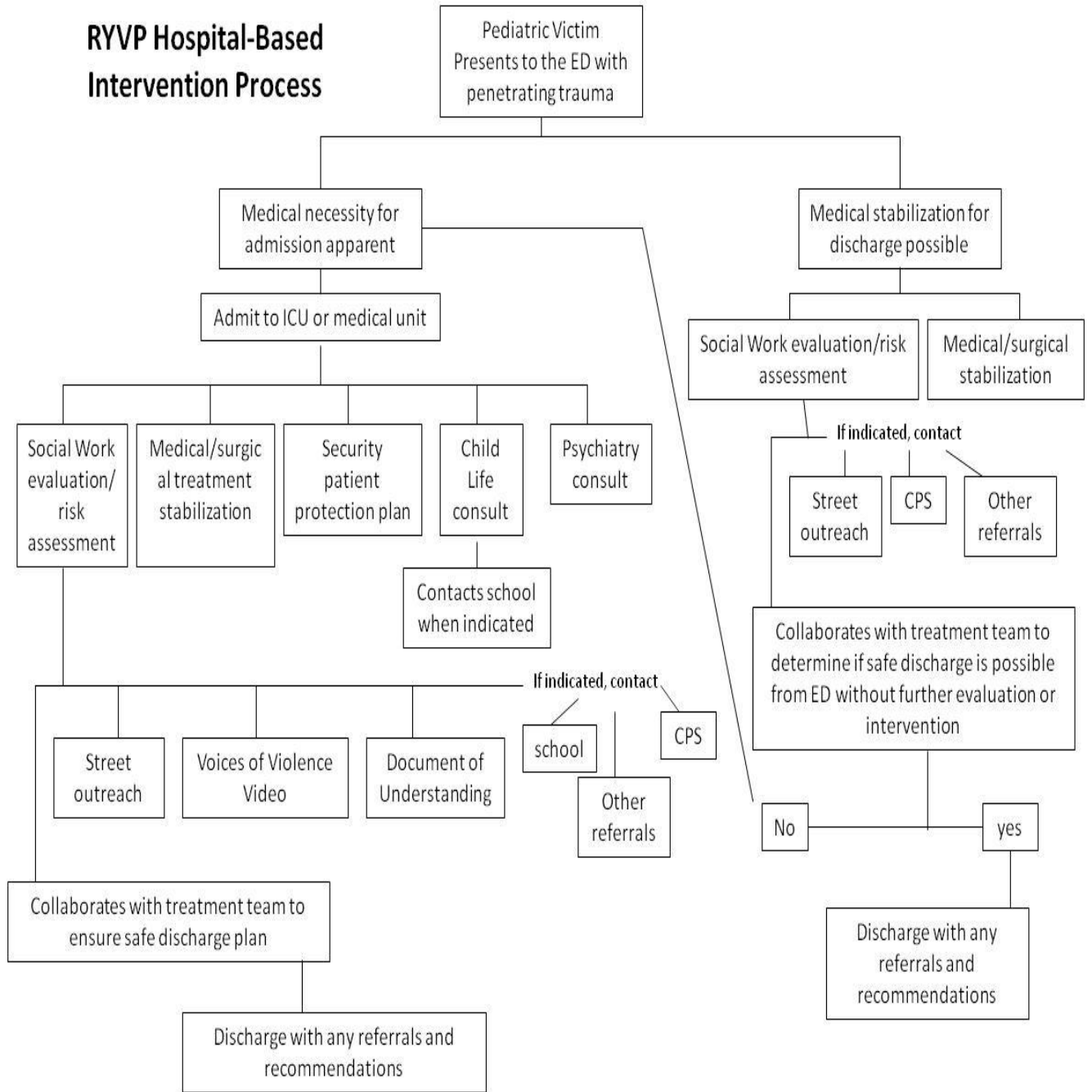
The program has no direct budget and there is no specific funding for those who carry out the process in the hospital. The intervention has been accepted by the hospital and the medical staff as the "standard of care" and is now part of the routine approach to patients who sustain injuries due to violence. While the program has no direct budget associated with it, there are still costs incurred, such as staff time, hospitalization costs, and paperwork.

The goal of the program is to reduce the incidence of violent re-injury. Related goals include coordination of service providers around the victim, ensuring safety throughout the victim's entire hospital stay, as well as reducing the likelihood of retaliation. The table below outlines the major activities that fall under each component.
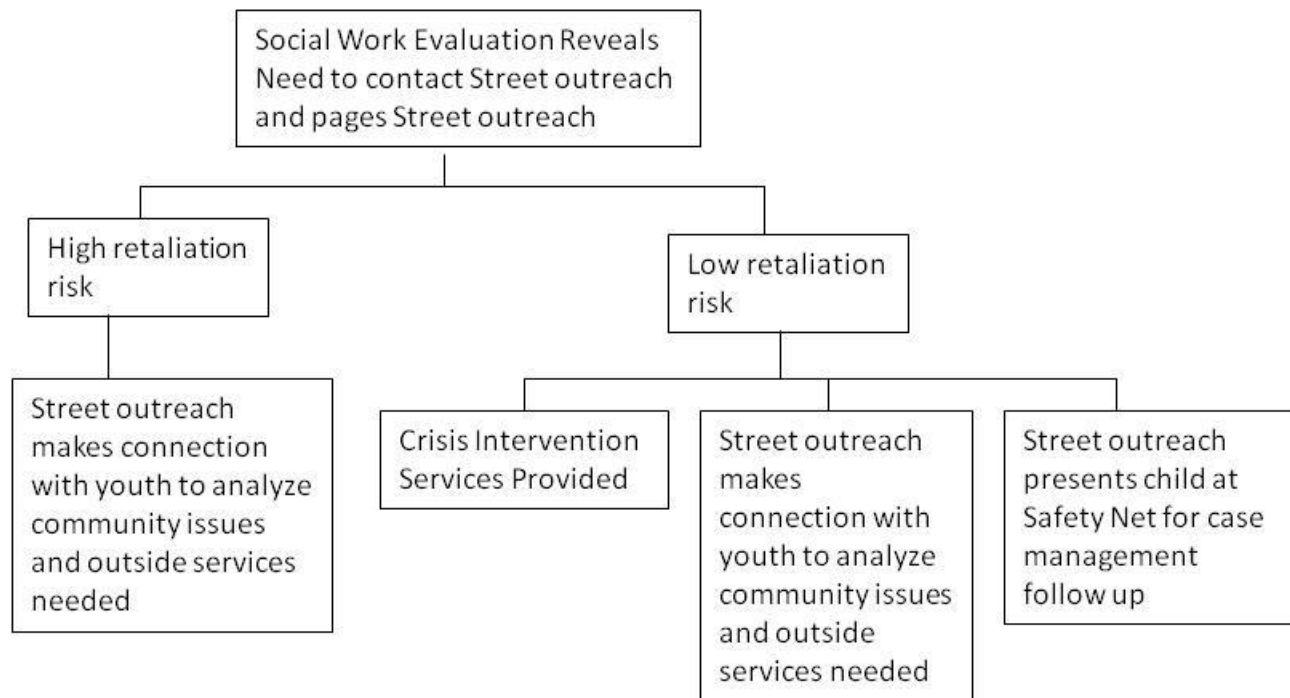
Intervention
1. Psychosocial Assessment: Safety and ongoing Risk Assessment
2. Hospitalization
3. Psychiatric Evaluation
4. Voices of Violence video and group/family discussion
5. Document of Understanding
6. Agency Referrals, including Street Outreach Program
7. Street Outreach Program to follow-up and provide case management services post-discharge

Partnership
30 collaborative partners, including: Law Enforcement, District Attorney's Office, City School District, Child Protective Services, Probation, Mental Health organizations, not-for-profit organizations, Universities
Meet monthly to discuss program developments, challenges, and future plans

RYVP Hospital-Based Intervention Process

Pediatric Victim Presents to the ED with penetrating trauma

Medical necessity for admission apparent

Medical stabilization for discharge possible

Admit to ICU or medical unit

Social Work evaluation/risk assessment

Medical/surgical stabilization

Social Work evaluation/ risk assessment

Medical/surgical treatment stabilization

Security patient protection plan

Child Life consult

Psychiatry consult

Contacts school when indicated

If indicated, contact

Street outreach

CPS

Other referrals

Collaborates with treatment team to determine if safe discharge is possible from ED without further evaluation or intervention

If indicated, contact

Street outreach

Voices of Violence Video

Document of Understanding

school

CPS

Other referrals

No

yes

Collaborates with treatment team to ensure safe discharge plan

Discharge with any referrals and recommendations

Discharge with any referrals and recommendations

Street Outreach Role in Intervention

```
                    ┌─────────────────────────┐
                    │ Social Work Evaluation  │
                    │ Reveals Need to contact │
                    │ Street outreach and     │
                    │ pages Street outreach   │
                    └─────────────────────────┘
                     │                        │
          ┌──────────────────┐      ┌──────────────────┐
          │ High retaliation │      │ Low retaliation  │
          │ risk             │      │ risk             │
          └──────────────────┘      └──────────────────┘
```

High retaliation risk	Low retaliation risk		
Street outreach makes connection with youth to analyze community issues and outside services needed	Crisis Intervention Services Provided	Street outreach makes connection with youth to analyze community issues and outside services needed	Street outreach presents child at Safety Net for case management follow up

It will be true that some victims of firearm injuries are not involved in high risk lifestyles and that they were simply "at the wrong place, at the wrong time." However, in order to ensure that there is no rush in making that determination (as victims may initially state that they were not doing anything that put them at high risk), the process outlined above creates a way to ensure that those who are engaged in high risk lifestyles do receive the intervention and that in the rare case that it truly is a victim "in the wrong place at the wrong time," he or she will not go through the remaining components of the intervention, as they do not meet the requirements of the intervention. With this process in place, cases will not be dismissed from the intervention easily.

Implementation of Hospital-Based Violence Intervention Program

In this chapter we outline the unique implementation steps of a hospital-based violence intervention program in a trauma center in Rochester, NY. While hospital-based violence intervention programs are not a novel idea, they are still in the formative stage across many jurisdictions. With that, a guide was produced on implementing a hospital-based violence intervention program, entitled *Key components of hospital-based violence intervention programs* in 2010 (Martin-Mollard & Becker). This guide is a resourceful tool and it's recommended to be used in conjunction with the implementation steps outlined in this chapter. The components addressed in that guide are:

1. Secure hospital buy-in
2. Select target population
3. Establish program goals and objectives
4. Streamline referral process
5. Determine structure of service provision
6. Engage resource networks
7. Make informed direct service staff hiring decisions
8. Support direct service staff through training and supervision
9. Conduct effective evaluations
10. Set funding goals for sustainability

These are important components that should not be ignored. What is proposed in this manual incorporates these components within the steps outlined below. Further, detailed explanations follow each step as well as possible obstacles are identified.

How the RYVP Began

The program planning began in 2003 when the Director of Trauma at a major trauma hospital in Western New York started getting frustrated at the number of young people (under 18 years old) showing up in the Emergency Department (ED) for violent penetrating injuries, treated for their injuries, discharged, and then returning to the ED for another violent penetrating injury. The Trauma Director began talking with a Pediatric Social Worker about the issue.

While having these conversations, there were a number of memorable cases of young people being treated for violent injuries. The following patient especially stood out to the ED staff: Donald (name changed), a 17-year-old male, showed up in the ED shot dead with a bullet wound to his head. The staff reviewed his medical record and found that at 15-years-old he was treated and released for a shooting injury, and then at 16-years-old he was treated and released again for another shooting injury. In both incidents prior to his fatal one, there was no safety plan put into place, no connection to services, and no parental involvement made by the hospital. Essentially, the medical staff stitched him up and sent him on his way the two previous times; the Trauma Director saw this as a serious disparity.

During this time, there was another young person treated for a shooting injury, while he survived the injury, he arrived for treatment wearing a bullet proof vest. As one would imagine, the Director knew that something more had to be done. It was at this stage that he determined that these violent injuries are both preventable and predictable, and that the hospital had the responsibility to take on an active role to ensure safety of the victim. And this is a stance that the program has taken on since its inception and continues on through today.

Next, the Trauma Director began conversations with a Pediatric Social Worker who then brought in the Director of Pediatric Psychiatry to formally address the issue. The ultimate outcome of those meetings was that Child Protective Services was deemed to have an important role to play in this issue. The three felt that there were a number of young people treated in which there appeared to be a strong case of neglect against the caregiver, as many times these young people

would be violently injured during late-night hours. Mandated reporting is a serious matter and upon further review of the cases they often saw in the ED for violent penetrating injuries, those cases appeared to closely reflect issues of child protection. This was not a particularly novel idea for medical staff when treating children for injuries, as burn victims receive a specialized protocol when they are treated for burn injuries, as do other kinds of patients.

The novel part of the idea, rather, was applying the notion that some sort of child abuse or neglect had possibly occurred when a young victim of a violent injury showed up for treatment. Appendix A shares the specific part of the law (in bold below) that the hospital would refer to as necessary. Once the groundwork had been done, the intervention and partnership came to fruition.

"Neglected Child" means a child less than 18 years of age:

    i.   **whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of the child's parent or other person legally responsible for the child's care to exercise a minimum degree of care.**

Implementation Steps

To support the replication of the hospital-based program, the implementation steps are outlined below. The term *Intervention* refers to what happens inside the hospital, coordinated by the hospital and is considered "no budget," in that no funds are directed towards this intervention and no positions have been created to fill these roles. The term *Partnership* refers to the members of the Rochester Youth Violence Partnership, housed at the hospital, who have guided and supported (through various ways) the evolution of the *Intervention*, with some partners more directly involved than others. Lastly, the term *Program* refers to both the Intervention and Partnership.

The hospital that this is implemented in is a regional trauma center serving nine counties in upstate New York. The focus of this intervention is on pediatric victims of penetrating injuries presenting in the ED with pediatric defined as ages 17 and younger within this particular facility.

1. Identify that there is a problem with a need for a hospital approach; find the champion

Explanation
The first step in any public health approach is to define and monitor the problem. In order to best understand the problem, lay the data out. There are numerous data management tools used by medical centers, so the resources abound. Determining the actual number of victims treated for violent injuries, their ages, their type of treatment, and their length of stay will all be critical to informing the hospital approach taken. Identifying these numbers will also help to begin thinking through an evaluation design, with an understanding of the quantity of victims treated at the hospital. These are data that will only help you to understand the significance of your problem. It can be useful to look at other kinds of pediatric injuries treated in your facility, in order to allow for comparison. During information gathering, a champion must be identified. It

is ideal that this champion be both emotionally and physically present, even guiding the process. Having a champion will ensure that buy-in happens with the hospital administration initially, but then also throughout the program the champion is entrusted with keeping it at the forefront of the hospital and even the community's agenda. Programs, collaborations, and initiatives too often end after short time; the champion with authority ensures the longevity of the program.

Recommendations
- Examine the data and clearly define the problem to be addressed.
- Meet with the hospital staff around the issue gain a better understanding of the problem from their perspective.
- Identify the best way to gather the information around the problem. Be sure to determine the number of shooting victims treated, the number of stabbing victims treated, the number of pediatric victims treated, the number of pediatric victims hospitalized for their injuries, the number of pediatric victims treated and released, the number of repeat victims of violent injury treated at the facility, the length of stay, the neighborhoods the victims are coming from (for resource referral)
- Survey the community to find out who else is doing work around this topic and who the experts are; meet with them to learn more.
- Determine who has a role in managing the problem at the hospital, and then what the next steps are in order to get them involved
- Throughout this process, identify a champion, someone in the hospital who has both authority to make decisions and changes to the usual way of doing business, as well as a sincere concern about the problem.
- Create a working document with the data, supporting that there is a problem and that the hospital has a role to play, identifying in the document who/what specific roles need to be involved in this intervention

Possible Obstacle
Gaining hospital administration buy-in can be a difficult task. Without a champion, implementing the intervention may be difficult or impossible. However, gathering the data to support that there is a problem, looking both at the hospital's data systems as well as out in the community's, and then putting together a document can be important first steps. Be patient and begin the conversation with those in authority positions in the hospital. Be able to articulate the benefits to the hospital if an intervention is implemented (safety of staff and other patients, utilization of outside resources who best understand this population, no additional funding, etc). Clarity around the identified problem and who was involved in the problem identification process can effectively demonstrate the range of staff concerned with the problem.

2. Get Leverage: Meet with Child Protective Services

Explanation
Getting patients to participate is critical. One way to get patient compliance may be to determine what resources can be used as leverage in the process. With this particular injury, a crime has been committed, yet often times this disenfranchised group has fear and distrust of law enforcement, as well as concerns of continued violence from the perpetrator(s). Thus, the patient

often wants to stay out of the radar or does not feel that they need help. This is where the leverage is key. While those concerns are valid and understandable, there is still an indentified concern for the patient; thus services of some kind are likely relevant. The staff can then use leverage to gain buy-in from the patient and his family, giving the patient another way to access services.

Gaining leverage is not an easy task. For example, Child Protective Services initially had a difficult time making the connection between a young person getting shot by someone outside of the home and relating that to maltreatment within the household. However, the argument was made that these young people are engaging in violent behavior, often during late night hours, and that they all have a caregiver who is responsible for their well-being, yet they have been seriously injured in a crime that is viewed as preventable and predictable, thus, an adult should be held accountable. Eventually, this argument was successful, and Child Protective Services (CPS) has since been one of the biggest proponents of the intervention. CPS is at the table constantly and regularly reminds staff that if there is any question of child abuse or neglect, then a call should be made to CPS, at a minimum, for consultation. The advantages to a relationship with CPS are many, such as CPS receiving new information on an open case or on a case undergoing an investigation, training and making hospital staff more aware of CPS protocol, and, importantly, a renewed focus on the interest of the *child*.

Leverage can come from another source, depending on what works within particular facilities. Some facilities may want to expand their age group, making CPS ineffective for older victims, but social service agencies or family members may be possibilities to consider when searching for leverage. RYVP has and continues to wrestle with this issue because despite being victims of gun violence, the victim may have no interest in changing his or her lifestyle, and absent CPS, there may not be any other resources there for leverage.

If a new way of doing business is identified in order to create leverage, affecting a major institution, then it is critical to meet with leaders of both the medical facility and those of the other institution to work through the details. For RYVP, once CPS bought into the model, the hospital leadership needed to be engaged in this new way of doing business. A meeting was organized and the evolving preliminary program ideas were shared. The hospital leadership believed in the cause and gave the go ahead to proceed. Now it was time to decide just what exactly the program would do and who it would include.

Recommendations
- Determine if CPS is the right place to gain leverage with the patients
- Have the champion meet with CPS to begin the conversation. Be ready to have multiple meetings and discuss both the benefits and drawbacks of contacting CPS. Share the numbers of victims treated for violent injuries to help CPS best understand the problem and to plan for what to expect.
- Work together on the problem.
- Draft a document that ensures both the hospital and CPS are on the same page so that if a referral is made to CPS, then it is taken by CPS and investigated.
- Meet regularly to share feedback on the process

3. Review Other Programs

Explanation
An ample amount of literature exists on other hospital-based violence intervention programs across the nation. Take advantage of the published studies, available program descriptions, and consult with the numerous programs to best understand their inner workings. Look closely at the National Network for Hospital-Based Violence Intervention Programs (NNHVIP; http://nnhvip.org/). This resource will shed light on what other medical facilities are doing across the country to reduce the incidence of violent re-injury. These programs are also good resources when developing data collection tools (as described below), program goals, and overcoming obstacles.

For this program, it was decided from the very beginning that this would be a no budget intervention. This is different from the other programs represented in the NNHVIP. The other programs seemed to have to pool resources to secure grant funds, obtain a budget line within the medical facility to support the program, or were weighed down with other constraints that moved program ownership and program goals from the key players to funders. Instead, RYVP would rely on existing resources to run the program. The no direct budget decision early on in the process helped to guide other decisions that were made during the course of program implementation. For example, with this program model, outreach and case management services offered by youth workers are not part of the intervention. The street organization is part of the intervention in two other critical ways, but the work done post-discharge is not part of the defined intervention. There are a number of reasons for this, one of them being funding and, second, the hospital recognizes that it has a lack of control once a patient is discharged.

When reviewing other programs, pay attention to the evaluation of the programs, not only to determine effectiveness, but to also understand the types of evaluations designs that were done (e.g. randomized control, pre and post time series, etc). This became a major issue in the review of the Rochester program.

Recommendations
- Read everything you can find about other programs.
- Contact programs that most closely resonate with your hospital and community and ask to speak to the Director of the program. Have a guided conversation around what has gone well, obstacles, key players, sustainability, evaluation, program design, and data collection.
- Create a working document that lists the important information gleaned from each conversation as well as key elements that stick out. Continue to add to this document.

4. Choose Target Population

Explanation
While it is critical to recognize that decisions made initially regarding the program are not set in concrete, they can at least guide the process. One such topic area involves selection of the appropriate patient population. The target population is defined as those patients whom the intervention will serve. Within the hospital, clarifying the target population is even more vital

because specific staff will need to be trained on this new program, for example pediatric versus adult. It is important to clearly define the target group. For example, the target group may be pediatric victims of penetrating violent injury who present at the ED. Choose your target population based on the information gathered and analyzed in Step One.

The age of program clients for this particular program, was established both initially, and then as a result of the hospital's decision to use the leverage from Child Protective Services (17 years old and younger). As the program was started with a concern over gun violence, it was easy to determine that shooting victims would be included in the target population. But it was also decided that victims of stab wounds would also be included as these victims were likely to be seen again for more serious injuries (i.e. gunshot wound injuries). Serious blunt trauma would also be included, again, due to the likelihood of those victims being seen again for more serious violent injuries.

Recommendations
- Clearly define the target population based on the data gathered and analyzed in Step One
- Revisit the identified target population regularly to determine if this still makes sense or if there should be changes made
- When thinking about intervention expansion, discuss with all those involved and, over time, determine the best way to implement with a smooth transition.

Consider Possible Obstacles
While it may be important to target everyone who is treated in the hospital for violent injuries, it can be helpful to identify a smaller sub-population when piloting the intervention. Changing protocol in an entity as large as a hospital, with thousands of employees, and numerous employees working with every patient that comes through its doors, means that the importance of a succinct intervention and paperwork trail is imperative. In order to get it right, do not start too big. While there may be those at the hospital who believe that if the intervention is to be done, it must be done with all patients, explain the importance of a pilot intervention to iron out the wrinkles moving forward. Also, enforce the importance of continued surveillance and monitoring. So, when thinking about expansion, repeat Step One to get a grasp on the number of individuals and related data if the intervention were to expand.

5. Establish the Specific Details of the Intervention

Explanation
This is the most important step in implementation. The severity of the problem is understood, the champion exists, you've got leverage with the population, and now you've determined who the intervention will serve. But, what, exactly, is the intervention? This is where looking around at other programs reaps its reward: you've done the research, now the decision must be made, with attention to understanding the strengths of your facility, your staff, and the resources within the community. Questions raised include: Will this be an active intervention, requiring the patient to make decisions? Will this involve family members and significant others? Or will this be passive, behind the scenes work done solely by partners and hospital staff? Or, will this be a combination of both an active and passive intervention? Will the intervention occur within the

hospital or outside of the hospital as well? Will there be a follow-up component? This step, clearly, is significant.

In the case of the RYVP, the intervention is thought of as limited to what is done in the hospital, which is different than most other hospital-based violence intervention programs, nearly all of which define their program to include post-discharge case management services.

The RYVP intervention is thoroughly explained above, but to highlight the intervention, it consists of:
- A social work safety assessment to determine if hospitalize the patient or if it is safe to treat and release the patient
- As part of the safety assessment, contact the street outreach organization to both support the hospital security and assist with the safety assessment (sharing information on the victim and likelihood of retaliatory violence)

- If admitted, then the following occurs:
  - Psychiatric assessment
  - Patient reviews and signs the Document of Understanding (placed outside of the medical record)
  - Watch a video that discusses the impact of continuing a violent lifestyle trajectory
  - Discuss the Document of Understanding and video with the hospital social worker
  - Connection/referral to services
  - Referral to street outreach worker (via pager or cell phone) to participate in case management services provided by the organization
  - Contact Probation as necessary
  - Contact CPS as necessary
  - Contact the School District as necessary

Recommendations
- Create a program description, with goals and measureable objectives.
- Share this document with all those involved for feedback.
- Once finalized, share the proposal with the hospital administration to ensure that they back the intervention.
- Be flexible and dynamic during this process.
- Identify within the intervention, where paperwork and data collection should take place.
- Clearly identify all of the internal and external partners who must be involved to make the intervention work (Department of Trauma, Department of Social Work, Department of Nursing; Probation, Law Enforcement, street outreach organization, School District).
- Consult with a researcher on the intervention to think through data collection and evaluation.

6. Define the Process

Explanation
Hospitals can be overwhelmed by the needs of the patients, emergencies, paperwork, and staff, making a defined process critical to successful intervention implementation. Training around the

process should be done in the beginning of implementation as well as a refresher training a few months in. Hospital positions turnover regularly, requiring more support for a well-defined process and training. Without a clearly defined process in place, the intervention may results in inconsistent execution, lack of documentation, and difficulty reaching the prospective patients. Creation of a flow chart of intervention steps and staff roles can be helpful. While the process is being clearly defined, this is also the time to identify the person in charge of managing the process. This person will be responsible for ensuring data are being inputted, the process is being followed, receiving feedback from staff on the intervention, communication regarding the intervention, and any other management related issues.

Recommendations
- Once the intervention is defined, create a flow chart with the identified people and/or positions responsible for each step in the process.
- Review this process regularly and determine if there are any impediments, what is working well, and what needs improvement.
- Train staff on the process.
- Identify a person to manage the process.

7. Design the Necessary Documentation

Explanation
With regard to evaluation needs, the patient service connection, and hand off of clients throughout the process, managing documentation is critical. Paperwork should be clear, concise, non-repetitive, and easy to learn. Assurance should be built into the process guaranteeing that the paperwork is following the client. Further, establishing paperwork demonstrates that this is something different, something important enough to generate a paperwork trail. If possible, incorporating new fields within existing tracking forms means fewer changes, and thus less likelihood of overlook, while new paperwork must be monitored closely; both are reason for updated training. The simpler the new paperwork is, as well as the fewer people/departments involved in the paperwork documentation, the less room there is for error, and importantly, the fewer staff who will require training, which is desirable in a hospital setting.

When identifying new documentation efforts, there should be discussion and decisions made around paperwork inclusion or exclusion from the medical record. These decisions should be made prior to implementation. This step should be created in concert with a researcher, who can assist with forms and data collection processes (see Step 8 below). Consent forms are also crucial to participation in evaluation of the intervention, and should be seriously considered during this step.

For RYVP, the paperwork trail includes a social work assessment for everyone under age 18 who presents in the ED with a violent injury. If it is deemed that it is not safe to release the patient, then they are hospitalized. Once hospitalized, paperwork includes a psychiatric assessment, a signed Document of Understanding, and documentation in the chart as to what interventions were received, as well as any other related data.

- Work with a researcher throughout this step.
- Consider electronic forms.
- Try to work within existing forms, but do not force this if it does not make sense.
- Train and continuously train all the staff who will encounter these forms.
- Put in place a way to monitor whether the paperwork is being filled out and how accurate the data collected is.
- Create easy to simple, easily understood consent and assent forms.

8. Put in Place Data Collection Processes

Explanation
This can be a daunting task, but it does not have to be. Data collected in the hospital setting must adhere to HIPAA standards, and while there are policies and guidelines set forth by the United States Health and Human Services Department, it will be most productive to familiarize yourself with these concerns early on in the process. Understand these policies and make sure that the data are in a position to be analyzed when the time comes. If this issue is not addressed in the beginning, then it could pose serious issues to future evaluation efforts. As with the paperwork process, work with your hospital and researchers regarding data collection and sharing. Remember, data are not useful if they cannot be shared for analysis. See Appendix C for the HHS' polices regarding research of health protected data. Data collection should be seamless and require minimal training. Information collected should not be elaborate as there is plenty of handoff and already enough paperwork being done within the hospital, and so adding anything more may be seen as burdensome and staff may resent the intervention.

Recommendations
- Think through what will be part of the medical record and what will not be part of the medical record. Consult with the experts in this matter, either the human subjects research board, attorneys, or administrators. Clarifying between what is and is not part of the medical record will save you many headaches.
- Identify a person who will be responsible for data input. This person can be the injury prevention coordinator, someone in the social work department, or a care coordinator.
- Establish a regular reporting period and where the data will be pulled from. As mentioned previously, there are numerous medical databases that are in use at any one time in the hospital, so determine which databases will be used and pull the data to create a separate log of the patients who receive the intervention. It is probably best to capture all those who were eligible for the intervention, with a field documenting whether they received the intervention or not. Please see Appendix B for an example of a data collection worksheet.
- In every program it is recommended that the data collection process is put in place early on, but it is even more critical when working within the healthcare field as access is a serious issue.

Consider Possible Roadblocks
Identification of the person to input data may be a difficult assignment, with every position full of work responsibilities. One person who could take on the data management role is the injury

prevention coordinator. While this may not be feasible in every trauma center, it may be possible in some. The person in this role can be charged with reviewing nightly hospital records on a daily basis so that he or she is not going back in weeks later to identify patients to go in the database. Asking them to do monthly reporting out to the partnership (with aggregate numbers) builds in accountability. Remember, if accurate records are not kept you reduce the chance of learning what does and does not work, limiting your ability to improve the program over time or to justify supporting its implementation in other hospitals.

9. Come up with an Evaluation Plan and Schedule

Explanation
Too often this can be the last thing on a practitioner's mind. While practitioners may believe that they have little interest in evaluation, it is often not true. Evaluation plays a crucial role in program justification, providing information to other hospitals interested in the program, identification of appropriate programmatic changes, and overall effective evolvement of the program. This makes evaluation all the more vital, as is the importance of a clearly defined outcome which the evaluation seeks to assess. Again, a consent process must be outlined early on as well as a form for release of information. Thinking through a research design must be done initially, and, depending on the design, some patients may receive different parts of the intervention than others, which would need to be understood during implementation.

It is often helpful to collaborate with a research team, either within the facility you are working, or outside of the facility. Work with the team to come up with a solid research plan, always being concerned with the transiency of this population and difficulty of follow-up. Determine what your expected outcomes are and how you will measure those. Will you use other databases to gather information, such as school, mental health agencies, and law enforcement agencies? These should be decided in the beginning and then assessed on an ongoing basis.

Recommendations
- Work with a researcher on an evaluation design.
- Create an evaluation plan and share it with the appropriate people, ensuring that data access will be granted.
- Make sure that there are clearly defined expected long and short-term outcomes of the program.
- Gather victim consent and assent.

10. Involve the Community

Explanation
Working with the community is important in and of itself, has numerous advantages, and is integral to the success of an intervention, particularly one relying on no external budget. The partnership is a true collaboration of numerous sectors serving the community and inviting anyone to attend the meetings can be fruitful.

When identifying key partners, those involved should reflect the strengths and creativity of their community. And, those who are actively involved in the intervention should absolutely be

involved in the meetings (e.g. Probation, Street Outreach Organization, Hospital Security, Nursing, Hospital Social Work, etc). The meetings should be held to determine how things are going in the intervention, but also as a place to use the resources offered up by the community. For example, with RYVP it was through members of the partnership that the video was created, which is now an integral component to the intervention. Thus, utilize your community members wisely.

Recommendations
- Recruit and identify key partners through both word of mouth and because they have a stake in reducing youth violence.
- While all groups will have varying agencies and departments represented, through our experiences we would recommend that the following be present in some capacity:
    - Law enforcement (Probation, Police, District Attorney):
      <u>Probation</u> – who have access to all files and can share information within Probation as well as with the hospital as appropriate
      <u>Police Administration</u> – this representative can explain to line officers the intervention and share data on recent trends
      <u>District Attorney</u> – this representative can help so that the prosecutors are aware of the intervention and to share relevant information.
    - School District (who has access to support programs, to data on the youth, to assisting with relocating students)
    - Street Outreach Organization (who has credibility with the community)
    - Child Protective Services (this was critical to RYVP, though may not be to other programs depending on how the program is aligned)
    - Mental Health Service Provider (who has on the ground knowledge – access to services, overcome wait lists, etc)
    - Research Partner

  Further, it's recommended that the following be present from the hospital:
    - Hospital Security
    - Hospital Champion
    - Social Work
    - Child Psychiatry
    - Injury Prevention Coordinator
    - Nursing
    - Childlife Specialists (professionals who help care for children while in the hospital)

- Send out an agenda prior to the meeting, have a standing meeting time, establish who will run the meeting, be mindful of the time, identify who will take the minutes and share the minutes with all the partners.
- Identify a place to hold the meeting. One place that may be the best for this program is right there in the hospital. The hospital serving as the host has many advantages, an obvious one is that all the medical players are able to attend the meeting, while there will likely be pagers going off and phone calls made throughout the meeting, it allows the medical partners to be participants. A second advantage is that it gets other agencies to

the hospital, a place where violence prevention agencies and others involved in reducing violence in the community have not traditionally been present.

Consider Possible Obstacles

For RYVP it was difficult to consistently engage the faith community. For many partnerships, there may also be others who are difficult to engage. First, make sure that the prospective partner is aware of what the intervention is, what the goals and objectives are, what role this particular partner could play, and the benefits to them working with this partnership. Relationship building is key to this step. While all the partners are likely busy with daily work schedules, it will be necessary to highlight the benefits of collaborating around the issue of youth violence. From speaking to the numerous partnership participants it was clear that a number of things kept them returning other than passion and an interest in the issue, these included: regular meetings which included minute keeping, a meeting facilitator, and some consistent reporting out of activities. This can be helpful to get buy-in from specific agencies.

11. Changing the Culture within the Hospital

Explanation

This program should help hospital staff to rethink the "treat 'em and street 'em" mentality. When a child burn victim is treated in any medical facility, there is established protocol that is followed in order to determine whether the incident was accidental or that something else was at play (criminal involvement or parental neglect). The protocol then also ensures that the child is discharged to a *safe* place. Creating a hospital-based violence intervention that is imbedded in the hospital should involve an approach similar to that of addressing the needs of a child burn victim. Thus, the culture of the hospital where 'treat 'em and street 'em' might be the usual response to violent victimization will be changed, if successful. This approach puts in place a new way of addressing these pediatric victims of violent injury, beginning with the ED and carrying all the way through to safe discharge and service connection. Giving support and guidance to the hospital staff at all levels, is crucial, and if done successfully, will change the culture of the hospital. Making documented changes to the hospital protocol ensures that the new way of doing things will continue long after the original program champion is no longer present.

Recommendation
- Understand the process to establish protocol and follow it, pushing the agenda of child safety from violent injuries and get formal protocol established within the hospital.

12. The Five No's

Explanation

The final point to be made here is one that is addressed in every step of implementation and it reflects the overall framework used by the Rochester Youth Violence Partnership. The three key leaders behind the Program came up with five critical components to the program and refer to them as the "Five No's." These are explained below, as adapted from Chapter 5 in Workplace Violence in Mental and General Health Care Settings (Privitera, 2010).

1. No Budget

The no budget has continued to be identified as a strength by program founders. They argue it allows the partners and hospital staff to truly guide the evolution of the program. While the hospital staff think of this program as no budget, it does draw on a variety of resources both within and outside of the medical community (staff training, video production expenses, etc). Having no direct budget, then, also comes with its drawbacks, such as relying on outside organizations (i.e. street outreach organizations) for integral parts of the intervention and, perhaps limiting control and oversight of the program. It is important that there is, at a minimum, discussion as to whether there should be a budget attached to the program or that it should move forward with no direct budget. Either way, costs associated with the program should be documented. This unique program feature merits careful consideration.

2. Know Your Community

No community is the same as the next which is the reason for understanding the specific assets that your community brings to the problem of youth violence. These assets are essential to a successful program. It is not useful to reinvent the wheel when all the stakeholders may be active, but simply need a place to convene and coordinate around the issue. Providing that space to convene in the hospital can be crucial. Further, bringing together the resources that the agencies provide allows a place to formally coordinate service provision. It also is a space to get the partners to communicate with one another.

3. No Boss

While leadership is required in order to ensure accountability and program continuation, the root of this "No" is that there is a sense of community ownership. This belief is that there is authentic, productive collaboration amongst all partners involved. The partner members are all able to contribute and develop the program. This way, while some may be facilitating the meetings and the intervention, there are meaningful contributions from all of the partners.

4. Don't Take No For an Answer

This was especially important when a critical role was identified by the partnership members but they were initially unsuccessful at filling that role. The partnership was respectful and persistent in making sure that the necessary new partner eventually made it onto the partnership.

5. Don't Say No to an Invitation

It is important to get the message out and to inform the community about what work is being done. Openness can result in a number of new opportunities. It was evident for this community that youth violence is an issue and there are many community members who want to be involved, but do not know how to be. Being present at events, conducting presentations, and participating in roundtables helps to educate others about the work that is being done.

CHAPTER 5: Rochester Youth Violence Partnership: Lessons Learned

Lessons Learned

RYVP has evolved over the years with critical discoveries made along the way. This chapter highlights some of the adjustments made while still acknowledging that development is an ongoing process. As previously explained, there are many parts which are critical to the overall program, but there are also components that can be tailored to your community's identified strengths and resources. The lessons outlined below highlight some of the more important lessons we have learned over the duration of the program.

Case Review Meetings

1. Over time we thought it was important to have follow-up case review meetings for specific individuals who went through the intervention. These monthly meetings were held at the hospital with only those who had direct involvement with the individual invited. The status, progress, and current needs of the individual would be discussed. These meetings allowed for a fuller picture of the person of and what changes we could make to enhance the intervention. It also helped greatly with service collaboration. Those meeting participants included: the street outreach workers, the School District representative, and hospital staff.

2. We found it helpful to identify data sharing policies and issues around confidentiality when holding these case review meetings. Confidentiality and protection of the patient's rights are central to the medical field, so outlining and ensuring that the meetings are held within the patient's rights, is crucial. Thus, prior to the first meeting, establish protocols around confidentiality and sharing information amongst service providers.

No Budget

1. We recommend that you thoroughly weigh the pros and cons of running a program on no budget. While no budget can be very intriguing, there are issues that can come up, such as what happens if the champion no longer is involved, or the program may not be viewed as "serious" without an operating budget, or there may be an increased opportunity for different interests to compete. If operating on "no" budget, then the hospital administration should be aware that the intervention does take both time and training for hospital staff.

Prevention

1. While this program does not include a strong prevention component, other programs may be interested in enhancing the prevention component. RYVP used its partnership to enhance the prevention component, for example, through working with the School District to create a violence prevention poster contest for the students. While this is not a direct service prevention effort, it is a start. Other hospitals may find that using the injury prevention coordinator in this role may be very beneficial.

Follow-up

1. If including follow-up as part of the intervention, then ensure that there is a designated person doing this and what is expected of them. Follow-up includes a defined time period, method of

contact, services available, and purpose of the contact. This program continually thinks about follow-up contact and who should be making that contact and what should be offered.

Paperwork and Documentation
1. While the paperwork will likely evolve over time, it can be very helpful if there is already paperwork in place prior to the first patient. Also, determine whether paperwork related to the intervention will have any legal ramifications if kept in the medical file and proceed with caution. The victims treated for these kinds of injuries often are involved in the criminal justice system in some way, so the hospital has a responsibility to adhere to the patient's legal rights. Specific to RYVP, there were concerns around the Document of Understanding being signed and placed in the medical file. To resolve this issue, we placed it in a separate file, one that is not part of the medical record.

Evaluation
1. Evaluation is extremely important but it must occur in the context of confidentiality rules under HIPAA. One possibility is to have a non-medical entity collect data separately from the medical record for evaluation. This can be done by the street outreach worker responders who are part of the initial safety assessment conducted for the intervention. If this is not possible, engage with your Human Subjects Review Board to design the program evaluation prior to collecting data in order to identify what and how data can be shared for research purposes. Be familiar with HIPAA law prior to engaging an outside institution in evaluation. Remember, nothing in HIPAA law states that research and evaluation cannot be conducted, it just must be done under the purview of the law.

2. If trying to contact a participant for research purposes, have a Medical Doctor make the initial contact. We found that more potential subjects responded to a call made by a doctor than made by a non-medical professional.

3. Ensure that the participants sign confidentiality agreements early on in the intervention to allow for future sharing of information.

4. Ensure that there is opportunity early in the intervention for the participants to sign releases of information forms for evaluation purposes. Trying to track down the participants retrospectively will prove to be quite difficult with low response rates.

Age of participant
1. This is a youth violence intervention. As time has gone on, we have begun to expand the intervention to older victims of penetrating injuries. There are clear benefits of working with the youth (such as working with child Protective Services on the intervention), but it makes sense to engage older victims as well. Adults have different legal rights, so become aware of those and create a clear plan if the decision is made to include older victims. While many of the same processes and paperwork can be used, there are some that will need to be altered as well as some agencies who may not have a place, such as the School District, when engaging older clients. Also, increasing the age increases the staff time associated with the interventions, so be mindful of this and any ramifications this may have.

Loss of funding for critical component of intervention
1. Relying on a no budget intervention can be seriously handicapped if the street outreach organization operating as a component of the intervention loses or has its funding reduced.   The intervention program must be positioned to continue regardless of another agency's loss of funding. A contingency plan should be developed, as relying on soft money is not ideal. Whether another agency is approached to do the job, funding is sought by the program, or the intervention continues without certain components, the program must be prepared for that situation.

There are always lessons to be learned and while only a few were highlighted above, it is important to recognize when change is necessary and to make those changes. We can't emphasize enough the importance of regularly assessing the intervention and getting feedback from the partnership members to inform the intervention. Services, programs, and resources evolve, dwindle, expand, and so on, making re-assessment all the more critical.

CHAPTER 6: Conclusion

Conclusion

Intervention programs housed in the hospital have the unique opportunity to play a strong role in reducing violence retaliation and future violence prevention. Implementation requires a powerful champion who can promote, monitor, and guide the intervention. While the implementation steps were outlined here, there will continue to be lessons learned, program alterations, and ongoing evaluation of the effectiveness of the intervention. While RYVP learned much on the way to becoming a full-fledged program, there is much to be gained from both the process as well as the longevity. While this intervention is conducted in-house, it is greatly enhanced with the inclusion of partners. These partners can take on various roles, some more critical than others, which can range from support to production of intervention materials to conducting follow-up services to victims.

A planning period is integral to the success of such an intervention. It is during the planning period that program description and process are outlined, paperwork is drafted, MOUs and releases of information are agreed on, data collection and evaluation are identified and scheduled, key players are identified, and partner outreach begins. The implications of a sound, continuously evaluated hospital-based violence intervention program include:
1. Enhanced identification of at-risk victims of violence
2. Greater connection to accessible, appropriate services for victims once released from the hospital
3. More rigorous in-hospital assessment
4. Cultural shift in the hospital for care of victims with penetrating injuries
5. Improved system collaboration
6. Identified measures on how to monitor and improve a hospital-based violence intervention
7. Reduction in violent retaliation in the community

In conclusion, the implementation of a hospital-based violence intervention program, if done methodically and based on best practices, can be a tool used to reduce violence in your community. Reducing violence is a success in and of itself.

Appendix A

Retrieved September 1, 2012 from
http://assembly.state.ny.us/comm/Children/20011016/htmldoc.html#link9
From, A Guide to New York's Child Protective Services System, 2001 Revised Edition

Definition of Child Neglect[1]

<u>"Neglected Child" means a child less than 18 years of age:</u>

   ii.   <u>whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of the child's parent or other person legally responsible[2] for the child's care to exercise a minimum degree of care:</u>

        a.   in supplying the child with adequate food,clothing,shelter,education in accordance with Part I of Article 65 of the education law, or medical, dental, optometrical, or surgical care though financially able to do so or offered financial or other reasonable means to do so; or

        b.   <u>in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm or substantial risk of harm</u> including the infliction of excessive corporal punishment; or by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that the parent or other person legally responsible for the child's care loses self-control of his or her actions; or by any other acts of a similarly serious nature requiring the aid of the court. However,where the person legally responsible for the child's care is voluntarily and regularly participating in a rehabilitative program, evidence that he or she has repeatedly misused a drug (or drugs) or an alcoholic beverage (or beverages) to the extent that he or she loses self-control of his or her actions shall not establish that the child is a neglected child without evidence that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as set forth in paragraph (i);or

   iii.   who has been abandoned.[3]

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[1] See N.Y. Family Court Act, Section 1012. According to the NY Social Services Law, Section 412, the definition of a "maltreated child" includes the definition of a "neglected child" as well as 1)a child who has had serious physical injury inflicted upon him or her by other than accidental means and 2)a child in residential care who is a "neglected child" (click here for a definition).

[2] For a definition,see Other Person Legally Responsible.

[3] New York State's law defines abandonment only after a child has been placed in foster care. An "abandoned child" is defined as a child whose parent or other person legally responsible for the child's care shows an intent to give up his or her parental rights and obligations as manifested by his or her failure to visit with the child and communicate with the child or the agency with which the child is placed or from which the child is receiving care although able to do so. This definition does not apply to parents or other persons legally responsible for the child's care who are prevented or discouraged from visiting or communicating with the child by the agency with which the child is placed or from which the child is receiving care. Without evidence to the contrary, the ability to visit and communicate with one's child is to be presumed.See NY Social Services Law, Section 384-b, Subdivision 5.

Appendix B

Recommended Data Collection fields

LAST NAME	FIRST NAME	DOB	AGE	RACE	ETHNICITY	INJURY TYPE (GSW/SW/BLUNT)	E-CODE	DATE OF INJURY	DATE OF TREATMENT	DAY OF INJURY

HOSPITALIZED (Y/N)	DATE OF DISCHARGE	LENGTH OF STAY	LOCATION OF WOUNDS (DESCRIPTION)	INJURY PROGNOSIS (DESCRIPTION)	PREVIOUS VIOLENT INJURY DATE (N/A)	HOME ZIP CODE	HOME STREET NAME

HOME CITY	HOME COUNTY	GANG MEMBER (Y/N/UNK)	INTERVENTION COMPONENTS RECEIVED (LIST)	AGENCIES REFERRED TO (DESCRIPTION)	PERSON TO MAKE REFERRALS (NAME)	CIRCUMSTANCES AROUND INJURY	OTHER INFO

Appendix C

Research

45 CFR 164.501, 164.508, 164.512(i) (See also 45 CFR 164.514(e), 164.528, 164.532)
(Download a copy in PDF)

Background

The HIPAA Privacy Rule establishes the conditions under which protected health information may be used or disclosed by covered entities for research purposes. Research is defined in the Privacy Rule as, "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge." See 45 CFR 164.501. A covered entity may always use or disclose for research purposes health information which has been de-identified (in accordance with 45 CFR 164.502(d), and 164.514(a)-(c) of the Rule) without regard to the provisions below.

The Privacy Rule also defines the means by which individuals will be informed of uses and disclosures of their medical information for research purposes, and their rights to access information about them held by covered entities. Where research is concerned, the Privacy Rule protects the privacy of individually identifiable health information, while at the same time ensuring that researchers continue to have access to medical information necessary to conduct vital research. Currently, most research involving human subjects operates under the Common Rule (45 CFR Part 46, Subpart A) and/or the Food and Drug Administration's (FDA) human subject protection regulations (21 CFR Parts 50 and 56), which have some provisions that are similar to, but separate from, the Privacy Rule's provisions for research. These human subject protection regulations, which apply to most Federally-funded and to some privately funded research, include protections to help ensure the privacy of subjects and the confidentiality of information. The Privacy Rule builds upon these existing Federal protections. More importantly, the Privacy Rule creates equal standards of privacy protection for research governed by the existing Federal human subject regulations and research that is not.

How the Rule Works

In the course of conducting research, researchers may obtain, create, use, and/or disclose individually identifiable health information. Under the Privacy Rule, covered entities are permitted to use and disclose protected health information for research with individual authorization, or without individual authorization under limited circumstances set forth in the Privacy Rule. Research Use/Disclosure Without Authorization. To use or disclose protected health information without authorization by the research participant, a covered entity must obtain one of the following:

- **Documented Institutional Review Board (IRB) or Privacy Board Approval.**Documentation that an alteration or waiver of research participants' authorization for use/disclosure of information about them for research purposes has been approved by an IRB or a Privacy Board. See 45 CFR 164.512(i)(1)(i). This provision of the Privacy Rule might be used, for example, to conduct records research, when researchers are unable to use de-identified information, and the research could not practicably be conducted if research participants' authorization were required. A covered entity may use or disclose protected health information for research purposes pursuant to a waiver of authorization by an IRB or Privacy Board, provided it has obtained documentation of all of the following:
  - Identification of the IRB or Privacy Board and the date on which the alteration or waiver of authorization was approved;
  - A statement that the IRB or Privacy Board has determined that the alteration or waiver of authorization, in whole or in part, satisfies the three criteria in the Rule;
  - A brief description of the protected health information for which use or access has been determined to be necessary by the IRB or Privacy Board;
  - A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures; and
  - The signature of the chair or other member, as designated by the chair, of the IRB or the Privacy Board, as applicable.

The following three criteria must be satisfied for an IRB or Privacy Board to approve a waiver of authorization under the Privacy Rule:

1. The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:
   - an adequate plan to protect the identifiers from improper use and disclosure;
   - an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and
   - adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of protected health information would be permitted by this subpart;
2. The research could not practicably be conducted without the waiver or alteration; and
3. The research could not practicably be conducted without access to and use of the protected health information.

- **Preparatory to Research**. Representations from the researcher, either in writing or orally, that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purposes preparatory to research, that the researcher will not remove any protected health information from the covered entity, and representation that protected health information for which access is sought is necessary for the research purpose. See 45 CFR 164.512(i)(1)(ii). This provision might be used, for example, to design a research study or to assess the feasibility of conducting a study.

- **Research on Protected Health Information of Decedents**. Representations from the researcher, either in writing or orally, that the use or disclosure being sought is solely for research on the protected health information of decedents, that the protected health information being sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is being sought. See 45 CFR 164.512(i)(1)(iii).
- **Limited Data Sets with a Data Use Agreement.** A data use agreement entered into by both the covered entity and the researcher, pursuant to which the covered entity may disclose a limited data set to the researcher for research, public health, or health care operations. See 45 CFR 164.514(e). A limited data set excludes specified direct identifiers of the individual or of relatives, employers, or household members of the individual. The data use agreement must:
  - Establish the permitted uses and disclosures of the limited data set by the recipient, consistent with the purposes of the research, and which may not include any use or disclosure that would violate the Rule if done by the covered entity;
  - Limit who can use or receive the data; and
  - Require the recipient to agree to the following:
    - Not to use or disclose the information other than as permitted by the data use agreement or as otherwise required by law;
    - Use appropriate safeguards to prevent the use or disclosure of the information other than as provided for in the data use agreement;
    - Report to the covered entity any use or disclosure of the information not provided for by the data use agreement of which the recipient becomes aware;
    - Ensure that any agents, including a subcontractor, to whom the recipient provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the limited data set; and
    - Not to identify the information or contact the individual.
- **Research Use/Disclosure With Individual Authorization**. The Privacy Rule also permits covered entities to use or disclose protected health information for research purposes when a research participant authorizes the use or disclosure of information about him or herself. Today, for example, a research participant's authorization will typically be sought for most clinical trials and some records research. In this case, documentation of IRB or Privacy Board approval of a waiver of authorization is not required for the use or disclosure of protected health information. To use or disclose protected health information with authorization by the research participant, the covered entity must obtain an authorization that satisfies the requirements of 45 CFR 164.508. The Privacy Rule has a general set of authorization requirements that apply to all uses and disclosures, including those for research purposes. However, several special provisions apply to research authorizations:
  - Unlike other authorizations, an authorization for a research purpose may state that the authorization does not expire, that there is no expiration date or event, or that the authorization continues until the "end of the research study;" and
  - An authorization for the use or disclosure of protected health information for research may be combined with a consent to participate in the research, or with any other legal permission related to the research study.
- **Accounting for Research Disclosures.** In general, the Privacy Rule gives individuals the right to receive an accounting of certain disclosures of protected health information made by

a covered entity. See 45 CFR 164.528. This accounting must include disclosures of protected health information that occurred during the six years prior to the individual's request for an accounting, or since the applicable compliance date (whichever is sooner), and must include specified information regarding each disclosure. A more general accounting is permitted for subsequent multiple disclosures to the same person or entity for a single purpose. See 45 CFR 164.528(b)(3). Among the types of disclosures that are exempt from this accounting requirement are:

- o Research disclosures made pursuant to an individual's authorization;
- o Disclosures of the limited data set to researchers with a data use agreement under 45 CFR 164.514(e).

In addition, for disclosures of protected health information for research purposes without the individual's authorization pursuant to 45 CFR164.512(i), and that involve at least 50 records, the Privacy Rule allows for a simplified accounting of such disclosures by covered entities. Under this simplified accounting provision, covered entities may provide individuals with a list of all protocols for which the patient's protected health information may have been disclosed under 45 CFR 164.512(i), as well as the researcher's name and contact information. Other requirements related to this simplified accounting provision are found in 45 CFR 164.528(b)(4).

Transition Provisions. Under the Privacy Rule, a covered entity may use and disclose protected health information that was created or received for research, either before or after the compliance date, if the covered entity obtained any one of the following prior to the compliance date

- An authorization or other express legal permission from an individual to use or disclose protected health information for the research;
- The informed consent of the individual to participate in the research; or
- A waiver of informed consent by an IRB in accordance with the Common Rule or an exception under FDA's human subject protection regulations at 21 CFR 50.24. However, if a waiver of informed consent was obtained prior to the compliance date, but informed consent is subsequently sought after the compliance date, the covered entity must obtain the individual's authorization as required at 45 CFR 164.508. For example, if there was a temporary waiver of informed consent for emergency research under the FDA's human subject protection regulations, and informed consent was later sought after the compliance date, individual authorization would be required before the covered entity could use or disclose protected health information for the research after the waiver of informed consent was no longer valid. The Privacy Rule allows covered entities to rely on such express legal permission, informed consent, or IRB-approved waiver of informed consent, which they create or receive before the applicable compliance date, to use and disclose protected health information for specific research studies, as well as for future unspecified research that may be included in such permission.

Please review the Frequently Asked Questions about the Privacy Rule.

OCR HIPAA Privacy
December 3, 2002 Revised April 3, 2003

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