

Leveraging Hospitals to Stop the Cycle of Violence – Webinar Follow-up Q&A

1. Does the UJIMA program partner with police agencies?

Marlene Melzer-Lange (MML): Yes, we work through the Milwaukee Homicide Review Commission to assist those families who have lost a family member through a homicide. The police department refers the next of kin for services. We have also worked with members of the police department in providing crime victim services.

Joel Fein (JF): We access Victims Services, and have partnered with the officer in charge of that section in order to help our clients navigate that system.

2. Q for Marlene: Wondering how/if Project Ujima has addressed the issue of increased risk for violence when youth are brought together with delinquent peers? While project Ujima focuses on youth who have been victims (vs. perpetrators) of violence, was wondering if this has come up at all and if so how it's been addressed?

MML: Fortunately, this is a rare event. In Milwaukee, for those youth who have contact with the juvenile justice system, we have the Wraparound program that does case management and mental health services. ...so those youth would be served by Wraparound, and we would not duplicate those services. As far as our youth development activities, our community liaisons expect that youth will act appropriately toward each other in a respectful way--with this expectation set, we find that we have peaceful, respectful interactions at our sessions.

3. Is the community intervention specialist (csi) and hospital social worker the same person or is that two positions?

MML: In Milwaukee, we utilize the hospital, emergency department social worker (who also has other duties) and community liaisons who are hospital employees. They are separate people. The community liaisons are college graduates in a variety of disciplines but are not social work trained.

JF: For The Children's Hospital of Philadelphia (CHOP) VIP the ED social worker is just that, and while informed of the program for referral purposes does not work for us. The Violence Intervention Specialist who does community visits is a Social Worker but works only for our program.

4. How do hospitals learn of these programs? Is info sent out to them?

MML: In Milwaukee, Project Ujima was developed by Children's Hospital of Wisconsin. You may want to consider starting a program at your hospital-- the National Network of Hospital Based Violence Intervention Programs would be a good place to start for recommendations.

JF: Similarly our program started at the hospital. For other programs that are hospital linked rather than hospital based, the community organization (such as Youth Alive!) would reach out to local hospitals to offer partnership.

5. How does law enforcement generally respond to these efforts?

MML: We have positive experiences with law enforcement in Milwaukee. In some cases, courts will also be more benevolent to a youth who is involved in Project Ujima. Project Ujima, though, is completely voluntary and is never "court ordered".

JF: We have had varied responses from law enforcement. At times the individual precincts or officers are glad that we are involved and trying to assist, and at other times we have encountered everything from skepticism to outright obstructive behavior. We also act as advocates in the court system, within which our role is not fully understood by the judges and other administrative folks.

6. Can you describe the type of evaluation methods used for these programs? How do you track and measure the effectiveness of your programs?

MML: In Milwaukee, we examine repeat injury and process evaluation such as number participating and number of youth reached in the ED.

JF: Outcomes within the NNHVIP programs vary. Most collect process outcomes but some are looking at violence-related outcomes and costs. NNHVIP has a Research Workgroup that is currently working on defining salient and measurable outcome through a Delphi process, and also looking towards common data collection methods through computerized web-based programming. CHOP VIP is currently in a re-design of our outcome measures and research plan.

7. Does this work, done successfully, impact overall violent crime by preventing or reducing it in a community?

MML: Because there are so many different interventions, from so many different disciplines (health, mental health, legal, educational) it is hard to know the specific effects of our work. Certainly, we are very hopeful that we are making an impact on violent crime.

JF: One study by Dr. Carnell Cooper and colleagues has demonstrated reduced arrest rates in program participants compared to non-participants. No studies have measured community-level impact of a specific program, with the knowledge that these programs would work best in the context of comprehensive, multi-disciplinary approach as Marlene suggests.

8. You mentioned that the average cost of injury is \$25,000 per person. Is that for each incidence of violence or over a lifetime?

Ted Corbin (TC): This estimate was developed based on the cost of each incident of violence, and the lost productivity associated with it. "Average cost per case for a fatal assault was \$4906 in medical costs and \$1.3 million for lost productivity. Average cost per case for a nonfatal assault resulting in hospitalization was \$24,353 in medical costs and \$57,209 in lost productivity. Average cost per case for a nonfatal assault treated in a nonhospital setting (either an emergency department visit, an office-based visit, or a hospital outpatient visit) was \$1002 in medical costs and \$2822 in lost productivity."

Citation: Corso PS, Mercy JA, Simon TR, Finkelstein EA, and Miller TR. Medical costs and productivity losses due to interpersonal and self-directed violence in the United States. *American Journal of Preventive Medicine*. 2007; 32(6): 474-482.

9. Is it possible to get a copy of the questions you use in your EMR? And/or get copies of the materials that you use with your patients?

JF: None of our three programs use the EMR for data collection or repository – the information is too sensitive. It is unlikely that a program would be placing answers to their intake forms directly into an EMR. NNHVIP has a training core that would work toward formulating and implementing a new program, if you are interested. Through this modality you can likely obtain the forms and documents from specific programs that are similar to what you would be designing. Contact Linnea Ashley from Youth Alive! at lashley@youthalive.org

10. How does the system accommodate multiple hospitals from the same city? Is there an expectation of local collaboration in addition to the participation in the HVIP?

MML: Currently in Milwaukee, we are serving primarily youth at Children's Hospital of Wisconsin. We occasionally receive referrals from other hospitals and are able to care for those clients as well. If the number of clients from other hospitals grow, further collaboration amongst the hospitals would be important.

JF: All NNHVIP member organizations work both within and outside of the hospital setting. Similar to Milwaukee we only currently acquire referrals from CHOP. However, as mentioned in a response above, some locales such as Oakland and Chicago have the community agency as the NNHVIP member organization and therefore accept referrals from multiple hospitals and youth serving agencies.

11. Is there a role for predictive analytics across the intervention process?

JF: Older models use mostly self-reported risk factors and some have even begun to engage community-level factors such as data for individuals' residence block-face, etc. There is certainly a role to look at cross sectional responses to surveys and even initial responses to interventions that could predict risk for violent injury. This work, unique to post-discharge HVIP efforts, has yet to be done.

12. What is the real public health potential? if every person you worked with never was injured again, how would it impact on the total level of violence?

MML: It's still a very intense individual approach as opposed to population level interventions. I believe that if you look at these interventions, similar to immunization against infectious disease, you can imagine that if we were able to reach more youth with services prior to their being injured (primary prevention), we would be potentially more successful in diminishing violence. Yes, this is an intense intervention, but we are focusing not only on the injured youth but their siblings and families. Also, we are focusing on some of the highest risk youth in trying to prevent reinjury and violence.

JF: This HVIP model is intense but is working with the highest risk individuals based on their exposure to violence. In order to have a community-level effect the model would need to expand to include other sources of at-risk identification such as juvenile/criminal justice/family courts, schools, and Departments of Social Services within a locale.