Key Components of Hospital-based Violence Intervention Programs

Summarizing the discussions of:

The National Symposium of Hospital-based Violence Intervention Programs

Oakland, California

March 2 – 3, 2009

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Funded by Kaiser Permanente's Northern California Community Benefit Programs

Participants of the 2009 Symposium of Hospital-based Violence Intervention Programs

We gratefully acknowledge the following individuals who shared their valuable time, insights and expertise as participants in the National Network of Hospital-based Violence Intervention Programs Symposium:

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*Note: The program names listed next to each individual represent the program that they either are employed by or are linked with.

Introduction

On March 2-3, 2009 Youth ALIVE! (a nonprofit public health agency dedicated to preventing youth violence and generating youth leadership) convened the first ever National Symposium of Hospital-based Violence Intervention Programs in Oakland, California with the goal of opening a dialogue on key program components and best practices and beginning to establish a national network of hospital-based programs. The Symposium was funded by Kaiser Permanente's Northern California Community Benefit Programs.

After conducting a national search of hospital-based violence intervention programs that had been operational for at least one year, nine programs were invited to participate in the Symposium—all nine programs accepted the invitation. Representatives from the following programs participated in the event:

- Caught in the Crossfire, Oakland/Los Angeles, CA
- CeaseFire, Chicago, IL
- Healing Hurt People, Philadelphia, PA
- Out of the Crossfire, Cincinnati, OH
- Pennsylvania Injury Reporting and Intervention System, Philadelphia, PA
- Project Ujima, Milwaukee, WI
- Violence Intervention Advocacy Program, Boston, MA
- Violence Intervention Project, Baltimore, MD
- Wraparound Project, San Francisco, CA

The key components to the effective implementation of a hospital-based violence intervention program identified over the two days were:

- Secure Hospital Buy-in
- Select Target Population
- Establish Goals and Objectives
- Streamline Referral Process
- Determine Structure of Service Provision
- Engage Resource Networks
- Make Informed Direct Service Staff Hiring Decisions
- Support Direct Service Staff through Training and Supervision
- Conduct Effective Evaluations
- Set Funding Goals for Sustainability

Symposium participants provided extensive advance materials on their programs, including operating manuals, forms, evaluation results and published articles. Representation from the programs included Medical Directors, Clinical Directors, Executive Directors, Program Directors, line staff, and members of Boards of Directors. The goal was to solicit as much information as possible from our range of participants to begin to identify key components for effective hospital-based violence intervention programs, not to reach consensus on every item.

The primary purpose of this document is to summarize and synthesize the discussion that occurred during the course of the two-day Symposium. As expansion and replication of these programs continues nationwide, the hope is that this document will be helpful for individuals and organizations that are considering starting their own programs, as well as emerging programs and established programs across the country.

At the end of the two days, participants decided to formally establish a network, the *National Network of Hospital-Based Violence Intervention Programs*, which will continue to work in small working groups to expand and refine these key components and best practices, collaborate in research and evaluation, explore opportunities for funding program sustainability, identify opportunities to collectively impact policy, and re-convene annually. The five working groups are: Research and Evaluation, Funding, Workforce Development and Staff Training, Policy and Systems Interface, and Network Steering Committee.

Key Components of Hospital-based Violence Intervention Programs

1. Secure Hospital Buy-in

Overview:
Hospital-based violence intervention programs operate from the premise that there is a unique window of opportunity to make contact and effectively engage with victims of violent injury while they are recovering in the trauma center or hospital. In order for these programs to be effective and run smoothly, ongoing engagement from all levels of stakeholders is critical. Everyone from the CEO to the ER and trauma doctors and nurses, as well as the medical social workers to the Injury Prevention Coordinators needs to understand the program, how it works, what their various roles are in facilitating its success, and why it makes a valuable contribution to their own work.

Key Recommendations:

- Secure buy-in from various levels of hospital staff and administration before the implementation of the program. Engage partners and stakeholders early in the process. Make sure that they are actively involved in the planning process, and continue to keep them involved during program implementation.
- Assess carefully hospital readiness and capacity to effectively support a hospital-based violence intervention program. One program had success with making participation in the

program a competitive process for hospitals within their network, which helped to stimulate interest and identify those hospitals most ready and able to implement a program.

- Sell the program from the perspective of building the reputation of the hospital within the community. These programs can serve as part of the community benefit requirement of nonprofit hospitals, or be a part of a mission-driven hospital, creating a sense of seamlessness between the hospital and the communities it serves.
- Provide compelling statistics on the fiscal savings a hospital-based intervention program may create by reducing trauma recidivism due to violent injury among non-insured patients as a means of generating buy-in from hospital administrators.
- Institutionalize the program to help change the culture of the hospital and make it a standard of care, by implementing hospital-wide policies and procedures to support the program. Examples include regular presentations at new staff orientation, monthly in-service trainings for trauma staff, presenting at Grand Rounds, and scheduling a time/multiple times each day for a particular hospital staff member to check the trauma log for new referrals.
- Conduct frequent in-services to remind hospital staff about the program and referral protocols. Both new and veteran staff can benefit from in-services that reinforce the program goals and procedures, and offer an opportunity for a dialogue on what is working and areas for improvement.
- Highlight to hospital staff that the program brings new resources and services, and is not an attempt to replace existing ones. As with any work environment, employees can get territorial about their turf; it is crucial to understand the roles and responsibilities of existing hospital staff in order to accurately describe how services enhance or work in tandem with what already exists.
- Staff should hear about the successes of the program in order to reinforce its value. Optimum forums for updates include regular department staff meetings, such as the Department of Social Services, Trauma Department, Emergency Department, etc. Ask to be put on as a regular agenda item so that updates can be given regularly. Have data ready to illustrate the problem, and research that shows the impact of the program design. Also, once the program is established, engage former clients to continue to market the program through personal testimonials. They can be an effective voice of the program, so that staff can see the personal impact of the program.
- Identify opportunities to change staff misconceptions and/or biases around violently injured youth/patients. There is often still a stigma attached to this population, and some staff may feel that they are undeserving of services. While some victims of violence are also perpetrators of violence, the hospital-based intervention can be an opportunity to break the cycle of violence, or the "revolving door." Including clients in some of the meetings when updates are presented can be valuable, so that staff see firsthand the positive changes that results from program participation.

- If program staffing permits, include the provision of field instruction or clinical supervision to medical and/or social work students at the hospital-based intervention program as a way to bolster administrative buy-in.
- Work toward the broader goal of integration of programs into health care delivery by making hospital-based violence intervention a standard system of care in trauma centers; work with key members of the trauma community, such as the American College of Surgeons Committee on Trauma, to accomplish this.

2. Select Target Population

Overview:

Selecting a target client population to serve helps determine the kinds of services the program will offer and where intervention efforts will be focused

The majority of existing programs focus on adolescents and young adults; however, some programs do not have any exclusionary criteria based on age. Many programs also extend services to family members and friends of the primary client.

Key Recommendations:

- Define the problem of violent injuries in the target community or hospital service area. Use existing data sources to determine the target population. Common data sources used include the local or state Department of Health, hospital trauma registries, and the local police or probation department. Obtain data on the number of individuals treated for a violent injury each year at a particular hospital (ideally for the past few years in order to reveal trends), with a breakdown by injury type, gender, ethnicity, time and day of admission, etc.
- Determine inclusionary and exclusionary screening criteria, as often the demand will exceed the available resources. This can include restricting the age range and the geographic area. Some programs exclude cases resulting from sexual assault, family violence and/or domestic violence, and some programs begin by only offering services to patients who are admitted to the Trauma Department and not to patients treated and released by the Emergency Department without being "admitted" to the hospital. Additionally, many programs exclude based on offender status, self-injury, psychiatric diagnosis or brain injury.
- Decide whether to extend services to family members and friends of the primary client. Recognize that clients are nested in families and communities, and determine the extent to which support will be extended to them as well. Programs need to be prepared for of the impact of other violence issues within the family, such as domestic violence and child abuse. Social service agencies and community-based organizations that deal specifically with these issues should be part of the resource network to which staff can refer.

- Monitor and assess the target population and whether it needs to be modified, such as lowering the age, etc. The public health model of violence prevention promotes this on-going assessment of whether the services are addressing the need and effectively reaching the intended target population.

3. Establish Program Goals and Objectives

Overview:

The majority of existing programs have similarly large programmatic goals around violence prevention, namely reducing and preventing retaliatory violence, and reducing and preventing re-injury. Each program has different levels of support, services, and resources from within and outside of the hospital to support those goals. The program goals and objectives are defined more specifically by the nature of the client base/target population and the capacity of hospital staff. Hospital administrative policies, state and/or federal regulations, and local public health priorities may also shape program goals and objectives. Finally, broad theoretical and conceptual frameworks, such as the Trauma-informed Approach or Social Learning Theory may guide program goals.

There should be a distinction between the broad mission of the program (e.g., reduce re-injury and criminal involvement) and measureable goals (e.g., percentage of youth enrolling in school, getting jobs, receiving services) and the activities that support them. Establishing benchmarks can be helpful for tracking individual progress through the program, as well as tracking how well the program is meeting its overall goals. Sample benchmarks for these long-term goals include obtaining a G.E.D. or High School Diploma, completing a job training program, getting a job, or engaging with an afterschool program. As clients make progress, there should be a shift from short-term, crisis-driven needs (e.g., obtain Victims of Crime funding, getting medical bills paid, securing safe housing, increasing school attendance) to other benchmarks that relate to more long-term goals, such as improving educational attainment, employability, health status, social and professional skills, and building a sustainable support network. Initial benchmarks, however, are important and should not be minimized. The medical director from one program stated that even "getting the client out of the house for the first time after an event might be an important benchmark." (*Please see Appendix D for an example of benchmarks/phases of program services, Appendix E for an example of one program's mission, goals and objectives*, *and Appendix G4 for a sample case planning form)*

Key Recommendations:

- Set goals based on data, establishing baselines and trying to establish change targets. Aggregate data can hide successes and problem areas. Disaggregating can show areas of success and shatter myths about certain client populations.
- Consider some goals to be based on attitudinal changes, such as determination to find a job or complete education, etc. In these difficult economic times, some of the more concrete

goals may be more difficult to achieve (e.g., obtaining employment). However, it is important to document effort the client makes toward achieving the goal.

- Establishing goals related to fostering strong individuals and healthy communities and not just preventing re-injury can help reframe the program as a health promotion model and not only a risk reduction model.
- When measuring goals, be sure to report process outcomes (e.g., number of youth enrolled in school or completing probation) as well as larger goals assessed by any impact evaluation (e.g., reduction in hospital's reported rates of re-injury). An internal checks and balances system is needed to ensure that the team is on track with the provision of services per the program's stated goals and objectives (i.e. review of documentation, random chart audits, and team discussions). Enlisting the help of an outside consultant to help evaluate the program's congruency with specified goals and objectives could be beneficial.
- Use qualitative data (e.g. client notes, interviews) to document progress in addition to quantitative data. These data points are useful to funders to highlight the progress of a program through success stories, not just numbers. Also, document barriers to success within overlapping systems (juvenile justice, child welfare, etc).
- Demonstrating "evidence-based" success of a program may take 10 years or more. It is useful to set surrogate or proxy measures instead of trying to measure direct effects.
- Individual case plans should be developed with clients, with completion of case plan precipitating graduation from or successful completion of the program. Individual case plans should meet the client where they are at and be tailored to their particular goals and personal objectives. (*Appendix G4*)
- Recognize that parents, guardians, and other family members may need support as well in order to help facilitate client progress. For example, parents may be fearful of their child leaving the house after a violent injury and case managers may need to address those fears around safety. Similarly, clients are nested in families, social networks and communities that may sometimes, intentionally or unintentionally, sabotage their progress. Engaging those families and friends to help support client progress is an important part of keeping the case on track.

4. Streamline Referral Process

Overview:

Most hospital-based and all hospital-linked programs will need to set up a referral protocol by which prospective clients are referred to a case manager. Without an efficient and organized referral process, clients will not be able to participate in the program and get the services they need and deserve. There are some conditions regarding the referral process, such as federal legislation such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, hospitals are required to protect patients' medical information. Thus, the referral process must conform to hospital HIPAA regulations. Some programs, particularly those in academic settings, may also need

to follow human subject protection guidelines as established by their Institutional Review Boards. Patients must sign a release of information form to allow any information from their medical files to be shared. Programs that are hospital-based and staffed with hospital employees may bypass the referral process entirely and be able to see prospective clients directly. Determine which position is the best referral source is at the hospital. Most existing programs utilize social work staff, trauma outreach coordinators, and nurses to make referrals, but one program in Chicago successfully uses chaplains to make referrals. Level I Trauma Centers are often required to have a Community Injury Prevention Coordinator on staff; this individual is often optimum for providing referrals.

Key Recommendations:

- Ideally, prospective clients are met at bedside and assessed for eligibility before they are discharged from the hospital. If they are discharged before they can be assessed, persistent telephone follow-up can often result in uptake of services.
- Timing is important. The bedside after trauma provides for a "teachable moment" during which time a potential client is more likely to be amenable to change given that he/she just went through a major life event.
- The program's case manager should make the determination of eligibility. If the medical provider has to determine eligibility it can create barriers to referral.
- Some participating programs have set up a system where an eligible patient has to actively refuse services (i.e., consent to services is implicit unless the patient actively refuses services). Without consent, program staff cannot do any follow-up with the patient. In cases where delivery of services is connected to a research protocol, there may be certain IRB (institutional review board) restrictions around the protection of human subjects, including documentation of informed consent. Part of the informed consent process may include providing information to the prospective client about a Certificate of Confidentiality.[1]
- Some programs may accept referrals directly from the community. Each program needs to develop protocols on how these referrals are made and subsequently followed up on.
- If a patient is categorically ineligible for program services, such as living outside the geographic area served, they would still ideally receive an initial in-hospital visit whenever possible (with the purpose of providing emotional support and helping to prevent retaliatory violence), as well as appropriate referrals to agencies that are in their geographical area or would better suit their particular needs.

[1] A Certificate of Confidentiality is defined by the National Institutes of Health as protections "issued to institutions or universities where the research is conducted. They allow the investigator and others who have access to research records to refuse to disclose identifying information in any civil, criminal, administrative, legislative, or other proceeding, whether at the federal, state, or local level."

5. Determine Structure of Service Provision

Overview:

The structure of service provision depends on the program's goals and objectives, reinforced by hospital policy and guided by regulatory principles. All existing programs have tiers of services, clarifying which services are offered by program staff and which services clients are referred to; however, some are formalized while others are more informal. Having tiers of services helps appropriately assess the progress of the client and determine their level of need so that the appropriate level of services can be offered. Assessing the risk factors and needs of a client is crucial for determining level and length of service. Case managers should have appropriate tools for assessment risk level/needs of clients. (*Please see Appendix G4 for sample needs assessment/case planning form*.)

Key Recommendations:

- Define tiers of service (if appropriate), and the dose (i.e., frequency of staff contact) and duration (i.e., length of participation in the program) of services within each tier.
- Demonstrate flexibility with tiers of service as a client's needs change. As a client moves through the system, the level of services will change.
- Locate both internal and external resources for intervention. Once these resources are identified, develop the activities and materials that the program will provide, provide the necessary training for program staff, and determine the services that will require an external referral.
- After making referrals to outside agencies, continue to follow up with client and agencies to document success. Foster collaboration between agencies for coordination.
- Understand that clients may drop off from services for a length of time and then re-engage. Keep an inactive client file in the event that critical events bring clients back into the program.
- Peer support is an important social mechanism for clients and opportunities for bonding as a group may be encouraged, such as bringing clients together on a regular basis for discussion of specific topics and "coaching". Additionally, opportunities to remain involved in the program post-graduation can be therapeutic for former clients. One program with a strong youth development model has several mechanisms for graduate involvement, including: a youth advisory group to help new clients, provide input on services, and promote the program; a summer camp for current clients where graduates work as counselor mentors; and field trips where current clients and graduates can hang out socially. Another program uses a client bulletin board to mark important events in clients' lives, such as pictures of their kids, snapshots from events, and certificates of achievement. This offers a visual display of clients and their benchmarks that is viewed not only by the program participants but by other hospital staff, providing an opportunity for them to see the clients in a positive light.

EXAMPLE: Tiers of Service *One program has identified 3 tiers of services. These separate tiers help case managers determine the level of need for each client and the corresponding level of service they will initially receive.*

Level 1: Clients at low risk of re-injury or retaliation based on information gathered during the assessment who are not in need of case management services. These clients receive advocacy, such as help with Victims of Crime or Medicaid paperwork, and referrals to outside agencies for services.

Level 2: During the assessment, multiple needs are identified, such as the need for social services, mental health counseling, or job training, but determined to be not at high risk for retaliation/re-injury. On-going case management is still necessary and clients remain in the program an average of 3-6 months.

Level 3: These clients are at high risk of re-injury/retaliation based on their involvement in multiple systems, the drug trade and gangs. They require intensive case management services and are typically in the program 6 months to a year.

6. Engage Resource Networks

Overview:

Typically, hospital-based violence intervention programs provide a combination of case management (professional or paraprofessional) and mentoring to support clients' progress toward healthier lives. Referrals to outside agencies for services are an integral part of case management; it is critical to understand what services are available in the wider community for clients to access. As opposed to merely handing the participant a sheet listing available resources, it is important that the case manager is actively involved in making the referral to an outside agency and accompanying the youth on initial visits/appointments. The case manager will ideally have a strong relationship with the outside agency that may help to expedite the process of getting the participant enrolled in that agency's services, and the participant is more likely to become firmly engaged with that agency if the case manager actively facilitates the initial linkage to that service.

Key Recommendations:

- Some commonly used outside resources include job training and placement, mental health and substance abuse counseling, GED preparation, legal advocacy, tattoo removal and housing assistance. Check out resources first hand, building personal relationships with partnering agencies and assessing their stability and competence. The agencies should be visited periodically to continue to assess quality and appropriateness to clients.

- Have resources/partners present an overview of available services at staff meetings. Not only does this increase awareness of these services for program staff, but it also serves to build and maintain relationships between the program and this resource organization.
- Develop relationships before they are needed. It is helpful to establish a contact person at each agency so that there is an individual with whom to work and exchange information. Just as it is important to secure buy-in from hospital staff, securing buy-in from outside systems and agencies will help with the referral process and the coordination of services. Memorandums of Understanding can be a useful tool for specifying how the programs and systems will work together.
- Beyond traditional social service delivery agencies, it is important to develop relationships with individuals representing other systems, including schools, the juvenile and criminal justice system, and immigration services. Many clients will be involved with these systems already, making coordination of services an important part of the case manager's role.
- It is important for the Case Manager to follow up with providers after a referral has been made, in addition to providing transportation for the client to the first few appointments, until the client is able to manage keeping their own appointments. In order to assess client readiness to manage making and keeping appointments, one program offered the conceptual frame of functional independence measures, commonly used in rehabilitation practice. Establishing relative independence for clients can be folded into their benchmarks and into the larger evaluation components of a program.
- Engage hospital and medical staff to help advocate for ancillary programs that help support the overall violence prevention mission. For example, hospital staff may advocate for more job training centers if they know there is a gap in services for their clients.

7. Make Informed Direct Service Staff Hiring Decisions

Overview:

All staff hiring decisions are important and help create a functional, productive work environment. Particular attention should be paid to the hiring of the case managers—the employee who will have the most interaction with and influence on the clients the program serves. Recruiting the right individuals for this work may mean exploring alternatives to traditional job posting sites, particularly if the program is searching for paraprofessional interventionists with direct experience with or knowledge of street culture (note: nearly all programs participating in the Symposium employ a peer-based model, hiring case managers who are from the communities they serve). Workforce Investment Boards, community colleges, religious institutions and other local resources may be helpful in identifying prospective employees. Fully vet potential employees, taking into consideration things like body language during the interview, how long it takes to return a call, overall demeanor. The interview establishes whether the prospective employee will be able to communicate effectively

with clients, understand them, and serve as effective mentors. Include current Case Managers in the new hire vetting process; one seasoned program manager talked of knowing whether someone is right for the position within 5 minutes of the interview. Hiring panels can also be a useful tool, and can include a member of the Board, other hospital employees, and outside members of the community.

Key Recommendations:

- When hiring paraprofessionals with little formal workforce experience, it may be difficult to screen for acclimation to workforce (e.g., professionalism). The expectations of the position need to be clearly established during the hiring process (e.g. being on time, the protocol for calling in sick, etc.). In other words, the employee should not be set up to fail by assuming that they have experience working in a professional environment. Develop guidelines around work expectations that can be used for both prospective and current employees. Hold all employees to high professional standards to foster accountability and trust.
- Standard workplace policies, such as probationary periods and clear, detailed job descriptions, can help establish the expectations of the job and the consequences of not meeting those expectations.
- Staff salaries should be competitive. Research the salary range for case manager positions with similar qualification requirements at other agencies in your community.
- Hiring program graduates to serve on staff requires additional staff resources and training. It may be necessary to establish a guideline for employees around how much time has passed since program graduation or any traumatic injury or criminal involvement.[2] Prospective employees who are still too connected to the street culture or who have recently left can jeopardize the credibility and reputation of the program, as well as the safety of clients.
- In term of matching clients to staff, life circumstances and then gender are often more important than ethnicity. However, one exception may be particular ethnic/cultural groups that are less acculturated to United States or a more insular community. In cases where the client and/or their family members are non-English speaking, it is preferable to match by common language.
- Credibility and knowledge of the street were cited by current program staff as crucial for case managers in order to gain the trust of clients.
- In terms of ideal age of line staff, one program established a general rule of thumb that the minimum age should be 3-5 years older than the oldest client, and no maximum age. In other words, programs should make sure that staff will be able to effectively serve as mentors for youth and young adults while also being relatable. It should be noted, however, that the risk factors may change quite significantly with older clients, particularly those in their 40s and 50s, which may necessitate staff familiarity with risk factors for older adults.

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[2] Some hospitals may be prohibited from hiring any staff with a criminal background. This may be a barrier for hiring outreach staff with knowledge of and prior experience with street life.

8. Support Direct Service Staff through Training and Supervision

Overview:

Staff members at existing programs receive a range of trainings and supervision activities (*see Appendix H*). Training for staff typically includes initial program and agency/hospital orientation as well as ongoing opportunities for professional development and skills building. For the first three months, employees at most hospital-based and hospital-linked programs receive training on hospital protocols, program-specific policies and procedures, confidentiality and privacy, ethics, case management, safety issues, trauma, Post-Traumatic Stress Disorder (PTSD), self-care, victims' compensation, substance abuse screening and intervention, mandated reporting, and cultural competency. One program requires new staff to complete Introduction to Counseling for Paraprofessionals and Introduction to Case Management for Paraprofessionals courses at a local community college during their first year of employment (the program pays for tuition and books and counts class time as work hours). Additional training to new employees includes shadowing a more experienced case manager. Case managers typically do not transition from shadowing to their own caseload for 1-2 months. Case managers at most of the participating programs have weekly supervision meetings with their direct supervisor to review all cases, in addition to having their supervisor review their documentation/conduct folder reviews at least monthly. Intensive regularly scheduled supervision and support is crucial for these programs.

Key Recommendations:

- Employees in this field need tremendous support, both in terms of professional development and therapeutic supervision. Working with violently injured youth, particularly for staff members who have experienced violence in their own lives, can lead to significant emotional stress and sometimes burnout. Service plans, or self-evaluation tools, can be useful for staff professional development and ongoing supervisory support around cases is crucial. Other components such as job shadowing, new employee buddy systems, updated policies and procedures manuals, and case management manuals can reinforce training for new employees as well.
- Team morale is an issue when a staff member is not held accountable; there must be a balance between employee support/development and accountability to the program. Procedures for handling poor performance, violations, and other employee issues should be clearly defined and explained to employees. If staff are employees of the hospital, the Human Resources Department may be a part of these procedures, and they may have specific guidelines and policies of their own that must be incorporated into any disciplinary process.
- Ongoing training of participating programs includes weekly staff meetings, in-services on topics such as PTSD, burnout, mandated reporting, sexual abuse, Victims of Crime procedures, book clubs, and outside conferences and symposia.

- Encourage staff to pursue certifications through training (e.g. conflict mediation, substance abuse counseling). Workforce Investment Boards may offer funds for certification trainings.
- Look for opportunities to build morale, camaraderie, and trust between staff. This could involve formal activities, like staff retreats, as well as more informal activities, such as serving food at staff meetings.

9. Conduct Effective Evaluations

Overview:

Clearly, evaluation plays a critical role in establishing whether a program is successful in meeting its goals and objectives. Stakeholders such as funders and hospital Boards of Directors are interested in knowing whether the program is cost-effective. Existing programs are interested in tapping into the evidence-base in order to improve their programs, while emerging programs would like to have best practices to help guide their implementation. Existing programs have used evaluations in a number of ways, including: promoting their model of service delivery to funders, hospital administrators, and other stakeholders; making programmatic changes; standardizing service provision; identifying and examining intermediate outcomes; identifying areas for professional development of staff, such as in-services to build capacity; determining what partners are needed for collaboration; presenting results to local government and other funders and leveraging results to retain or obtain funding, and; estimating the cost of the program for cost-benefit analysis.

However, evaluation is not an easy task and requires a commitment from all levels of staff, which includes a willingness to participate in data collection and to comply with reporting requirements. Evaluation should be built into regular program activities. It is useful to think of evaluation on three levels: formative evaluation, process evaluation, and summative/outcome evaluation. Formative evaluation is conducted as the program is getting started to make sure that targets are being met and that implementation is running smoothly; process evaluation tracks progress toward larger agency goals, and; summative/outcome evaluations attempt to measure what worked in the program and whether agency goals were met.

Some lessons learned from programs that conducted fairly rigorous evaluations include: evaluations placed a higher than expected burden on line staff in terms of the amount of time staff had to be involved (in relation to documentation, recruiting participants for interviews and transporting them to and from these interviews, etc.); it can be difficult to balance data collection with intervention work; staff expressed anxiety that evaluation would show no effect, and; there was a threat of cross-contamination of services when trying to conduct a case/control study.

Key Recommendations:

- As with many health and human service interventions, there are major methodological issues associated with evaluating their effectiveness. These include the dose of the intervention

sometimes being difficult to measure; sample sizes are often small; threats to validity, including diffusion, regression to the mean, and loss to follow-up. Evaluation designs should be creative and methodologically sophisticated to counter some of these issues. Whenever possible, incorporate strategies such as triangulating data (i.e., obtaining data from more than one source) to strengthen the results of the evaluation. The integrity of the evaluation helps protect the integrity of the program and can be a powerful tool for program sustainability.

- Build accountability and set high expectations for reporting and data entry requirements for all levels of staff. Incorporate evaluation into program materials and staff training, and engage staff early in order to secure buy-in. Daily documentation and case notes are an important part of ongoing evaluation and should be kept up to date. Ensure that they understand that these processes are beneficial to them, the clients, and the potential for replication and expansion to serve more youth if results are positive, and improvement in the program for clients, otherwise.
- It is important for <u>all</u> program staff to understand case managers' level of services and to be knowledgeable about the "nuts and bolts" of the program. An example of how this relates to evaluation was related by a medical director of one of the participating programs. The director was concerned that certain forms were not getting filled out on the first visit with clients. After accompanying staff on a few initial visits, she realized that staff work hard to foster trust during this visit and that there was a significant amount of immediate crisis intervention that was needed initially before a case plan could be developed. She recognized that a more reasonable expectation would be that these forms be completed within 1-3 visits, as opposed to requiring them after the first visit.
- Engaging graduate students and university-based research departments in evaluations of the program can help share the burden of evaluation and bring additional expertise to the process. Many undergraduate and graduate students are required or encouraged to complete internships, and it may be possible to utilize this resource for evaluation activities. However, staff may see these people as "outsiders", and will need to have an understanding of the utility of evaluation for them, their clients and the program in order to facilitate trust and compliance between the evaluator and staff.
- When considering hiring an outside evaluator for an outcome evaluation, find an evaluator who will work well with the program and its staff, as well as the clients. This population can be difficult to follow-up with for multiple reasons, and the evaluator needs to fully understand this difficulty, be persistent, and be culturally competent. Including direct service staff in the hiring process of an outside evaluator is beneficial because they will have a good sense of who would work well with the client base, and including them in this process can increase their buy-in to the entire evaluation. Additionally, case managers will often assist evaluators—helping to set up interviews, accompanying the evaluator on follow-up visits—so trust and accountability needs to be fostered between staff and the evaluator as well. Outside evaluators should have what one clinical director termed "arrogant

humility"—the ability to be sensitive, a good listener, competent, and open to learning from staff and clients as much as being open to sharing expertise.

- In order to demonstrate long-term success of the program, evaluations need to measure the extent to which effects persist years after program involvement. In other words, it is important to be able to track down clients, even years after they left the program. This is true for clients who successfully completed the program, as well as those who self-terminated before program completion. Encouraging clients and even providing some incentives to notify the program when there is a change of address will help keep records current for when follow-up is needed. Offering a monetary stipend for completing follow-up interviews is another important tool to consider as well. Given the transient nature of the client population, this can be a significant challenge, and one that must be taken into account when planning any evaluation.
- Look at data to determine who benefited the most from services. Stratify the data to determine what dose/duration was most effective and for whom. This ongoing assessment of the program will help to refine and strengthen service delivery and identify areas for improvement.
- Creative research designs are necessary for addressing data limitations inherent in studies with small sample sizes. Programs should always be engaged in refining evaluation and research methodologies to capture successes of program in order to build the evidence base.
- Some concrete benchmarks may not always be reached, such as employment. However, it is important to measure attitudinal change towards a different lifestyle and continued efforts and determination to reach concrete goals.
- The evaluation process is circular, not linear. Stakeholders, and especially funders, will want to see results of an evaluation followed up on, expanded, and replicated.

10. Set Funding Goals for Sustainability

Overview:

In this tenuous economic environment, funding can be particularly challenging. However, there are still numerous avenues to pursue for initial and sustainable funding for hospital-based or hospital-linked violence intervention programs. (*Please see Appendix F for a list of Federal, State, and local funding sources existing programs cited.)*

Key Recommendations:

The following list was generated to provide an idea of what line items a new program would want to ideally include in a budget proposal.

Sample line items in budget include:

- Staff—direct services, management, administrative staff, clinical/medical director, social workers, grant writers, interns (stipends)
- Information technology, computers, notebooks, technology/IT consultants, database development/software licensing
- Evaluation and data collection
- Development and fund-raising
- Professional services, such as legal fees, accounting and auditing
- Public relations, media, program brochures, other printed materials
- Board insurance
- Discretionary fund for client needs (e.g., clothing, food, class registration fees, DMV fees)
- Transportation and mileage
- Travel
- Cell phones
- Food and petty cash
- Office supplies
- Office rent/overhead expenses
- Staff professional development (e.g., in-house and external training costs, conference fees)
- Indirect charges (for a non-profit agency)

Conclusion

Our hope is that the *Key Components of Hospital-based Violence Intervention Programs* handbook captures the essence of the discussion generated at the initial National Network meeting and provides support to existing and emerging programs. This document is intended to serve as a springboard for future discussions. This handbook draws upon the knowledge and experience of the March 2009 National Network of Hospital-based Violence Intervention Programs Symposium participants, and should be viewed not as an exhaustive list of the components of an effective hospital-based program, but rather as a compilation of the components that were identified during the course of the Symposium as being the most crucial.

Through the working groups that were created at the Symposium and through future meetings, the National Network of Hospital-based Violence Intervention Programs will continue to expand upon these key components and work toward developing best practices. We continue to work on securing funding to be able to support and expand the activities of the Network.

For questions about this handbook or to inquire about technical assistance for new hospital-based violence intervention programs, please contact Marla Becker, Associate Director, Youth ALIVE! at (510) 594-2588 x307 or mbecker@youthalive.org.

APPENDIX A: PROGRAMS PARTICIPATING IN NATIONAL SYMPOSIUM OF HOSPITAL-BASED VIOLENCE INTERVENTION PROGRAMS (March 2-3, 2009)

Caught in the Crossfire
Youth ALIVE! Oakland
3300 Elm Street
Oakland, CA 94609
Phone: (510) 594-2588
Fax: (510) 594-0667

Youth ALIVE! Los Angeles
P.O. Box 33521
Los Angeles, CA 90033
Phone: (323) 225-0401
Fax: (323) 225-2832
www.youthalive.org

CeaseFire
The Chicago Project for Violence Prevention
School of Public Health
University of Illinois at Chicago
1603 West Taylor Street, MC/923
Chicago, IL 60612
Phone: (866) TO-CEASE (866-862-3273)
Fax: (312) 355-0207
www.ceasefirechicago.org

Healing Hurt People
Center for Nonviolence & Social Justice
Drexel University, New College Building, 2nd Fl.
245 N. 15th St., Mail Stop 1011
Philadelphia PA 19102-1192
Phone: (215) 762-2372
www.cnvsj.org

Out of the Crossfire, Inc.
The University Hospital
234 Goodman Ave., Room 5201
Cincinnati, OH 45219
Phone: (513) 584-7867
Fax: (513) 558-3136
www.outofthecrossfire.org

Pennsylvania Injury Reporting and Intervention System (PIRIS)
Firearm & Injury Center at Penn (FICAP)
University of Pennsylvania
Division of Traumatology & Surgical Critical Care
3440 Market Street, First Floor
Philadelphia, PA 19104-3335
Phone: (215) 615-0161
Fax: (215) 349-5917
www.piris-pa.org
www.uphs.upenn.edu/ficap

Project Ujima
Children's Hospital of Wisconsin
MS 677
PO Box 1997
Milwaukee, WI 53201-1997
Phone: (414) 266-2647
Fax: (414) 266-2635
www.chw.org/display/PPF/DocID/20624/router.asp

Violence Intervention Advocacy Program (VIAP)
BNI-ART Institute
Boston University Medical Campus
715 Albany Street, 580 3rd floor
Boston, Massachusetts 02118-2526
Phone: (617) 414-8455
www.ed.bmc.org/sbirt/index.php

Violence Intervention Program (VIP)
R Adams Cowley Shock Trauma Center
University of Maryland Medical Center
22. S. Greene St.
Baltimore, MD 21201-1595
Phone: (410) 706-0550
www.umm.edu/shocktrauma/vip.htm

Wraparound Project
San Francisco General Hospital
Department of Surgery, Ward 3A
1001 Potrero Avenue
San Francisco, CA 94110
Phone: (415) 206-4623
http://violenceprevention.surgery.ucsf.edu/

APPENDIX B: SYMPOSIUM PROGRAM PARTICIPANT CHART

Title of Program	Hospital Affiliation	Year Established	Annual Clients Served	Total Clients Served to Date	Length of Services	Age Range	Average Caseload per Worker	Frequency of Client Contact
Caught in the Crossfire (a program of Youth ALIVE!)	Alameda County Medical Center/Highland Hospital, Oakland; Los Angeles County/USC Medical Center & California Hospital Medical Center, Los Angeles	1994 (Oakland); 2006 (Los Angeles)	180 (100 in Oakland; 80 in L.A.)	1,400 (1175 in Oakland; 225 in L.A.)	6 months	Oakland: 14-20 years; Los Angeles: 12-20 years	14-17	Weekly
The Chicago Project for Violence Prevention/ Ceasefire	Advocate Christ Medical Center	2005	400	1,400	In-hospital only	Any age; mostly under 35		
Healing Hurt People (HHP)	Drexel University College of Medicine	2007	44	44	Not yet available	12-25 years	20	
Out of the Crossfire	University of Cincinnati Hospital	2006	50	113	6 months-1 year	15-70	15-20	At least weekly
Pennsylvania Injury Reporting and Intervention System (PIRIS)	Hospital of the University of Pennsylvania; Temple University Hospital, Albert Einstein Medical Center	2006	97	183	5.38 months (average)	15-24 years	14	Average of 5.72 contacts per month (includes phone and in-person)

Title of Program	Hospital Affiliation	Year Established	Annual Clients Served	Total Clients Served to Date	Average Time in Program	Age Range	Average Caseload per Worker	Frequency of Client Contact
Project Ujima	Children's Hospital of Wisconsin	1994	300 victims (also serve family members)	4,500 (including family members)	8-10 months	7 to 18 years; also have an adult program for victims of crime	20-30	Daily to monthly depending on client
Violence Intervention Advocacy Program (VIAP)	Boston Medical Center, Baystate Medical Center (Springfield), Brockton Hospital, Lawrence General Hospital, Massachusetts General Hospital (Boston), UMass Memorial Health Care (Worcester)	2006	98	94 accepted services without follow up and 103 patients agreed to receive case management	Not yet available	15-41	7	Weekly
Violence Intervention Project (VIP)	University of Maryland Medical Center-Shock Trauma Center	1999	200	1500	No limit-average 2 years	14 and up	20-40	Active clients: weekly or biweekly; Inactive clients : once a quarter
Wraparound Project	San Francisco General Hospital	2001	80-100 intensive services	>300	6 months- 2 years	12-30 years	15	Daily, weekly, or monthly as client progresses through program

APPENDIX C: National Symposium of Hospital-Based Violence Prevention Programs Agenda

Monday, March 2nd:

8:30-10:00 Opening session

- Keynote Address: Deane Calhoun, Founder and Executive Director, Youth ALIVE!
- Vision and goals for Symposium: Marla Becker, Associate Director, Youth Alive!/Caught in the Crossfire
- Introductions

10:00-10:45 Target Population Identification & Staff Selection

- What are the necessary steps to take in identifying your target populations?
- What are the benefits and challenges of providing tiers of services?
- Do the demographics of your population influence your staff hiring decisions?
- Summary

10:45-11:00 Break

11:00-12:15 Setting Program Goals

- What are realistic goals & objectives for a hospital-based violence prevention program? How do you measure success in hospital-based interventions? How did you come up with your program goals and objectives?
- How do you measure how well you are achieving your program goals and objectives?
- How does length of time that you provide services to your youth impact your goal setting?
- Summary

12:15-12:45 Lunch

12:45-2:00 Conducting Effective Evaluations

- What are some of the lessons learned from evaluations you have completed? What would you do differently/the same for a future evaluation?
- What kinds of resources are needed to conduct an effective evaluation?
- How did you use the findings of your evaluation?
- What are your future plans for evaluation and are there opportunities for collaboration?
- Summary

2:00-3:15 Creating Sustainable Progress for Clients After Program Completion & Building Effective Resource Networks

- How does your program set benchmarks and goals for participants? How do you balance individualized needs with program goals?
- How do you prepare participants to exit the program and decrease their reliance on the case manager? What is the process for youth completing/exiting the program? Is there a graduation ceremony? What are ways in which you work to sustain progress beyond the program?
- How do you identify resources and establish effective partnerships? How do you hold resources accountable? How involved do/should staff stay once youth are linked with resources?
- Summary

3:15-3:30 Break

3:30-4:30 Securing Buy-in From Hospital Administrators

- What recommendations do you have from challenges and successes you encountered when you started the program that would be helpful to an emerging program?
- What local, state and national policies and regulations can help facilitate the successful implementation of a hospital-based program? How did you overcome policies and regulations that present barriers to starting a program?
- Who/what positions needs to be on board from the hospital to initiate this kind of program? What level of ongoing involvement of hospital administration and staff is required?
- Summary

4:30-5:00 Wrap-up

Tuesday, March 3rd:

8:30-9:00 Continental breakfast

9:00-10:30 Staff Training & Support

- How do you recruit staff from the community?
- How do you train new staff? What type of ongoing professional development is provided and who provides this?
- How do you provide emotional support for staff?
- What are some of the benefits and challenges of hiring community members for life experience vs. professional experience?
- What kind of training do you provide to in-hospital (non-program) staff?
- Summary

10:30-10:45 Break

10:45-11:45 Funding

- What are the costs associated with running a hospital-based violence prevention program?
- How did you get initial funding?
- How do you get funding for sustaining your program, expanding your program and evaluating your program?
- How can we engage funders in this process/network?
- Summary

11:45-12:30 Lunch

12:30-2:30 Best Practices/Key Components Summary

2:30-3:00 Next Steps & Closing Remarks

APPENDIX D: Program Benchmark Example

Phase 1: Engagement & Motivation

1. Prevent/discourage retaliatory violence & develop safety plan
2. "Hook" client into program (by helping with VOC, medical bills, etc.)
3. Build trust & establish relationship with youth & family members & assess family/home situation
4. Set short-term & long-term goals

Phase 2: Work toward goals & identify/build sustainable support network

Phase 3: Preparing case for close-out/Creating sustainable setting for continued success

1. Frequency of contact decreases as the youth is becoming increasingly independent in achieving their goals and/or more linked with other support services/individuals to achieve their goals;
2. Ensure that there is a stable adult in the youth's life (parent, relative, mentor, etc.) to continue to support the youth
3. Conduct exit/closing/graduation interview (reviewing accomplishments & discussing where the youth wants to be in 1 year, 5 years, etc.)

APPENDIX E: Example of Program Mission, Goals and Objectives

PROGRAM MISSION:

Promote positive alternatives to violence in order to reduce retaliation, criminal involvement and re- injury among youth injured by violence.

PROGRAM GOAL: Reduce risk factors and increase protective factors for violence.

OBJECTIVES:

- **Improve educational attainment**
    - Any client who does not already have a High School Diploma or GED should be enrolled in an educational program leading to a High School Diploma or GED
    - Any client who does have a High School Diploma or GED should be encouraged to enroll in college
- **Improve employability**
    - Link all clients identifying employment as a need with a job training program (ex: Job Corps, Conservation Corps/Civic Corps, Youth Employment Partnership, AmeriCorps, certification program for a vocational trade)
    - Assist all clients identifying employment as a need with job seeking & job readiness (ex: resume writing, job application completion, interview preparation)
    - Tattoo removal and removal of gold casings on teeth
- **Improve health status**
    - Link all clients and families with mental health support (ex: counseling for PTSD, anger management, general mental health, substance abuse, church-based counseling)
    - Ensure that client is linked with medical provider(s) to provide follow-up treatment of violent injury and ongoing health care
- **Improve social and professional skills & build sustainable support network**
    - Link all clients with at least one community, school-based or faith-based ongoing social group activity (ex: Boys & Girls Club, YMCA, sports, art, music, etc.)
    - Link all clients with a program that builds social & professional skills (note: possibly have IS provide this directly)
    - Link all clients with long-term mentoring to sustain progress after graduation from our program

**These goals relate to all youth who are qualified to receive these services. For example, undocumented youth may sometimes not qualify to receive certain services, & some objectives may unfortunately be N/A for these individuals.

APPENDIX F: Funding Sources

Initial funding

Private Funds	**Public Funds**	**In-Kind Contributions**
Insurance foundations State foundations Community-based foundations Hospital foundations	City and State Departments of Public Health Monies diverted from police/criminal justice system	ER staff time Volunteers Donations

On-going funding

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

APPENDIX G: Examples of Forms

G1: SAMPLE Initial Intake Form

Date of Referral: **Date of first contact:** **IS:**

Participant Name:				Social Security #:
Address:				English fluency? **Y N**
Phone #s (include name/relationship to the Participant): Participant living with:				
Age:	DOB:	Sex: **M F**	Race: **AA L A/PI W NA other**:	
Referred from: **HH CHO Probation District TNT School: SBHC: other:**				
Current school status:			Current employment status:	
Any previous violent injuries? **N Y** How many? Resulted in medical treatment? **N Y**				
On Probation? **N Y** For what?				

IF HOSPITAL REFERRAL

Referred by:	**MSW other**:	Medical record #:
Date admitted:	Seen in the hospital: **N Y** (date)	
Type of injury: **GSW SW Assault 261 other:**		Location of wound:
Geographic location of violent incident (intersection):		

IF PROBATION REFERRAL

REFERRED BY:	P.O. OTHER:	CASE PENDING? Y N

Additional Information:

G2: SAMPLE Consent Form

Participant Name: ________________________________ Date: _______________________

Parent/ Guardian: _________________________________ (if participant is younger than 18)

I, __________________________, hereby give my consent for ____________________________ to participate in *Caught in the Crossfire* (a program of Youth ALIVE!).

1. I have been informed of both the services provided by *Caught in the Crossfire* and the requirements to receive these services. I understand that the participant can be terminated from the program for lack of participation or for disregarding the safety and respect standards of the *Caught in the Crossfire* program.

2. I have been informed and I understand that the services the participant receive(s) from *Caught in the Crossfire* are confidential to the full extent permitted by State and Federal laws.

3. I have been informed that the participant may be asked to participate in group meetings, interviews and surveys for the purpose of evaluating the effectiveness of the *Caught in the Crossfire* program. I understand that all responses will be kept confidential and that the participant has the right to refuse to answer any questions that make him/her feel uncomfortable or embarrassed. I hereby give permission for the participant to participate in these evaluation activities.

4. I hereby give consent for:
   - Alameda County Medical Center
   - Alameda County Department of Probation
   - Alameda County Department of Public Health
   - Children's Hospital Oakland
   - Oakland Unified School District
   - Oakland Police Department
   - ____

to disclose requested information regarding the participant to *Caught in the Crossfire* staff for program evaluation purposes. I understand that the information obtained by *Caught in the Crossfire* staff shall remain completely confidential.

5. I hereby give permission for *Caught in the Crossfire* staff to provide transportation for the participant in their private automobiles. (All *Caught in the Crossfire* staff have a valid California Driver's license and automobile insurance).

6. I do hereby fully release and discharge *Caught in the Crossfire* and Youth ALIVE! employees and volunteers from all claims, demands and causes of action of any kind whatsoever which may be sustained as a result of the participant participation in the services and program of *Caught in the Crossfire*.

____

Date consent effective

____

Name of participant

____ ______________________

Signature of Parent/Guardian or Participant (if younger than 18) Date

____ Relationship to participant: Parent / Guardian

Name of Parent/Guardian (please print) (Circle one)

Emergency Notification Information

In the event of an emergency, please notify:

1. __________________________ __________________ _________________________

Name Phone Number Relationship to Participant

2. __________________________ __________________ _________________________

Name Phone Number Relationship to Participant

3. __________________________ __________________ _________________________

Name Phone Number Relationship to Participant

G3: SAMPLE Follow-up and Progress Form

IS:__________________ **Participant:**________________________

Date	**Contact by**	***NOTES*** *Include issues discussed, progress/outcomes, and next steps*

Chart key = phone = letter =visit

G4: SAMPLE Case Plan

Participant Name:	IS name:

Participant & IS: Check off all the short and long-term goals that you want to work toward.

Under the priority column, please number the priority of each goal using the following codes:

1=Immediate Need/Goal; 2=Secondary Need/Goal; 3=Long-Term Goal

GOALS:	*PRIORITY*	*LIST ANY RELEVANT SPECIFICS & RESOURCES TO CONTACT*	*DATE COMPLETED*
EDUCATION *UNIVERSAL GOAL: ATTAIN A HSD, GED OR COLLEGE DEGREE (Enroll all clients without a HSD or GED in an educational program leading to one; encourage all clients with a HSD or GED to enroll in college)			
• Reconnect w/ school system			
• GED program			
• Tutoring program			
• High School diploma			
• Assist w/ DHP			
• College Classes			
• Other			
EMPLOYMENT *UNIVERSAL GOAL: ATTAIN EMPLOYMENT (link all clients needing employment to job training, job readiness and/or job placement programs)			
• Clothes/tools for job			
• Job training			
• Computer training			
• Other vocational training			

• Resume/cover letters			
• Job interview preparation			
• Maintain current employment			
• Obtain employment			
• Other			
HEALTH (PHYSICAL & EMOTIONAL) *UNIVERSAL GOAL: IMPROVE HEALTH STATUS (link all clients & families with mental health support; ensure that client is linked with medical provider(s) to receive follow-up treatment of injury & ongoing health care)			
• Physical Therapy			
• Medical/hygiene supplies			
• Medical/dental appointment			
• Drug/alcohol rehab./counseling			
• Mental Health Counseling			
• Anger management			
• Conflict resolution			
• Prenatal care			
• SSI/MEDI-Cal/other			
• Other			
GOALS:	***PRIORITY***	***LIST ANY RELEVANT SPECIFICS & RESOURCES TO CONTACT***	***DATE COMPLETED***
SOCIAL/RECREATIONAL/ONGOING SUPPORT *UNIVERSAL GOAL: IMPROVE SOCIAL & PROFESSIONAL SKILLS & BUILD SUSTAINABLE SUPPORT NETWORK (link all clients with a community, school-based or faith-based ongoing social group activity(ies); a program that builds social & professional skills; and long-term mentoring to sustain progress after graduation from our program)			
• After school program			
• Support group			

• Link w/ community center			
• Mentor			
• Church/faith based connection			
• Sports			
• Improve communication skills			
• TNT			
• Volunteer work			
• Other			
LEGAL			
• Driver's License			
• ID card			
• Social security			
• Government assistance			
• Court advocacy			
• Legal aid/ lawyer			
• Report to probation			
• Naturalization			
• Victims of Crime			
HOUSING/ SHELTER			
• Obtain housing			
• Utilities assistance			
• Housing advocacy			
• Shelter/ Temporary housing			
• Other			
NUTRITION/FAMILY			
• Emergency food			

• Food stamps			
• Parenting classes			
• Childcare			
• Family planning/sex education			
• Other			
•			
•			
•			
•			
•			
•			
OTHER			
GOALS:	***PRIORITY***	***LIST ANY RELEVANT SPECIFICS & RESOURCES TO CONTACT***	***DATE COMPLETED***
•			
•			
•			
•			
•			
•			

I am interested in receiving the services checked off above and agree to do my part in accomplishing my goals with the help of my Intervention Specialist.

Participant Signature_____________________________________

Intervention Specialist Signature _____________________________________

Date ______________________________

G5: SAMPLE EXIT SHEET

Participant name: ________________________________

Intervention Specialist name:____

Date closed: _________________________________

Reason:

____

____

____

____

Overview of case (significant accomplishments/difficulties):

____

____

____

____

____

____

____

APPENDIX H: Supervision and Training Examples

Supervision

- Informal supervision occurs spontaneously and refers to staff offering and asking for support around client issues, or other job-related tasks. Concrete elements, such as communal space and desk arrangements within the one program's office, can help facilitate conversation and feedback throughout the day. Open-door policies can be another mechanism for encouraging informal supervision.

- Formal supervision: Formal supervision may include one-on-one meetings with supervisors, weekly staff meetings, and staff evaluations. One program offered a model of peer support that included the following 4 components:

  1) Case updates—go over caseload

  2) Case review—every case is reviewed

  3) Weekly case management—discuss areas of improvement

  4) Monthly meeting to discuss other topics

- Peer supervision: peer supervision can help foster teamwork and mutual support. Peer supervision can occur throughout an employee's employment, and may include activities such as job shadowing, a buddy system, assigning mentors, and team meetings.

Trainings

- In-services for staff on range of topics, such as self-care, burnout, mandated reporting, PTSD, etc.
- Hospital training which may include topics such as HIPAA, safety issues, hospital policies
- College or Extension classes and certificate programs on counseling, case management, substance abuse, and other human/social service topics
- Professionalism training
- Public speaking and media training
- Informal learning opportunities, such as book clubs
- Outside conferences and symposia