A. Cover Page

Report Title:
Safe Harbor Local Evaluation Report: Implementation of a Hospital-Based Violence Intervention Program (HVIP)

Grantee:
The Lundquist Institute for Biomedical Innovation at Harbor-UCLA

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Introduction:

In 2020, the HVIP at Harbor-UCLA Medical Center was awarded the state's CalVIP grant to bolster its work supporting victims of violent crime. Together with an in-kind contribution from the Lundquist Institute and Los Angeles County Department of Health Services, the grant was used to support a three-year expansion of the program and its capacity to address the risk factors that contribute to involvement in community and other forms of interpersonal violence. With a new input of human resource, an extension of the length of short- and long-term provision of service, and an enhancement of case management capabilities, the aim was to grow the program's capacity to address social determinants of health and reduce rates of re-injury and criminal legal involvement among program clients.

The following report provides an overview of the expansion that was supported by our CalVIP grant and the subsequent process and patient focused outcomes that were collected during the grant period. It uses our original evaluation plan as a starting point of discussion. It overlays this with additional narrative about the structural challenges our program experienced during the implementation of our CalVIP grant and the adjustments we had to make to our plan to accommodate some of these challenges. The report ends with a brief narrative one of the more impactful cases our case managers were able to oversee during the grant period that highlights the kind of impact our program can have when properly resourced.

B. Project Evaluation and Background:

The burden of violence in Los Angeles County

Despite important gains made over the last two decades in the way of crisis intervention, outreach, and upstream violence prevention programming, interpersonal violence continues to bear a significant burden upon the youth and adult populations of Los Angeles County. In 2019, despite a 3% reduction over the prior year, the rate of violent crime across the county far exceeded state and national averages with 554.6 per 100k experiencing a violent crime compared to 379.4 per 100k nationally and 447 per 100k at the state level. Of this crime, aggravated assault comprised the bulk of incidents with a rate of approximately 326 per 100k population, followed by robbery with a rate of 192.9 per 100k, rape and homicide with 5.0 per 100k and 41 per 100k, respectively. The latter continues to rank among the top 5 leading causes of premature death for all ages in the county, and last year jumped to the number one cause of premature for those between the ages of 15 and 24.

Disproportionately affecting poor, underserved BIPOC (black, indigenous, and people of color) communities, the distribution of violence in LA County, and specifically South LA, across race, gender, class and ethnicity mirrors unsettling nationwide trends. From 2004-2013, for example, despite African Americans comprising less than 10% of the county's population, the homicide rate for African American men in LA of 50 per 100k was 8 times greater than the countywide average. For Hispanic/Latino men, during the same period, the rate of 9.3 per 100k -- was almost twice the county average and almost 3 times greater than the next ethnic/racial group. As a corollary, between 2008-2017, the onerous burden of these homicide rates among African Americans and Hispanic/Latinos corresponded with age-adjusted rates of 829/100k and 266/100k respectively of productive life lost—which was nearly four times the county average among African Americans, and 1.25 times the county average among Hispanic/Latinos.

The burden of violence in South Los Angeles

In South Los Angeles, majority BIPOC communities continue to endure the worst of this violence. For perspective, between 2013-2017, in the county's service planning areas (SPA 6) and (SPA 8), which serve the South LA and South Bay, respectively, the LA Department of Public Health Office of Violence Prevention reported rates of violent crime that were almost 1.5 times greater than the county average (685 compared to county 428.2 per 100k). In SPA 6, alone, the 502.9/100k rate of assault and the 427.6/100k rate of robbery were both almost four times higher than LA County averages for the same category. Homicide rates reported out of the catchment paint a similarly grim picture. To wit, over a five-year period between 2012-2016 the 16.1 per 100k and 7.4 per 100k homicide rates reported out of SPA 6 and SPA 8 were almost three and 1.5

times greater than the county average. Between 2008-2017, homicide remained the leading and second leading cause of premature death in the SPAs as the years of productive life lost age-adjusted homicide rate in SPA 6 and SPA 8 reached a staggering 647/100k and 291/100k respectively (statistically greater than the overall LA County rate of 238/100k).

Like other major urban areas, the phenomena of violence in South LA is born out of decades of exclusion, underinvestment, heavy policing, incarceration, gentrification, and unequal access to services and resources like housing and health care – all resulting in community trauma and deterioration of social supports that are known to be protective factors against violence. As a corollary, residents of South LA are some of the poorest in LA County with 48.9% living at or below 100% of the federal poverty level and 75% at or below 200%. South LA is also home to five communities with the highest economic hardship indices in the county while over half of children in the area live in poverty. Unemployment and education levels mirror these statistics with more than 10% of adults living in the area either unemployed or looking for work and approximately 40% of adults having never completed high school.

These same communities have been heavily impacted by a dearth of services (regional service gaps). In South LA, where healthcare access is limited, approximately 30% of non-elderly residents across South LA are uninsured, and 45% endorse difficulty accessing healthcare. The closure of King Drew Trauma Center in the mid-2000s increased the burden of trauma care at HUMC and other centers across he county, further limiting access to healthcare and other services for underserved communities and exacerbating the impact of violence in the area.

HVIP at Harbor-UCLA

To intervene upon the behavioral and environmental factors that influence violent crime and interpersonal violence in South LA, the Los Angeles County Department of Health Services in collaboration with the Lundquist Institute and the community-based organization Southern California Crossroads established a hospital-based violence intervention program at the DHS's Harbor-UCLA Medical Center (HUMC) in the spring of 2017. The HVIP at Harbor-UCLA implements an important "care-first" alternative to systems of punishment, focusing on linking victims of interpersonal and community violence - including justice-involved youth, patients with gang affiliation, and individuals who struggle with housing/food security, substance abuse and/or chronic mental illness - with hospital- and community-based services that address the underlying risk factors associated with violent victimization. A lifetime of structural vulnerability places many victims of violent crime at risk of reinjury and subsequent criminal legal involvement. Harbor-UCLA's HVIP works to address this vulnerability by employing community-based intervention specialists whose lived experience and ties to local communities allow them to engage victims in longitudinal case management and facilitate essential wraparound services (financial assistance, housing vouchers, skills training, employment opportunities, mental health and substance use services, mentorship, and legal advocacy) that promote important behavioral transformations.

Harbor-UCLA Medical Center serves the residents and communities of LA County's 2nd and 4th Districts and Department of Public Health Service Planning Areas (SPA) 6 & 8. The catchment extends over 230 square miles from the South Bay and port of Los Angeles to north of the 105 Freeway into Inglewood and from the Pacific Ocean to near the 710 Freeway. It includes the neighborhoods of South LA, Southeast LA, South Bay and the Los Angeles Harbor and a racially and ethnically diverse patient population of nearly 1 million with over 60% of patients self-identifying as Latino, 13% Black, 10% White, and 6% Asian and over 50% indicating speaking a primary language that is not English.

The trauma center at Harbor-UCLA treats about 3,500 victims of traumatic injury annually, of which 20-30% are victims of interpersonal and community violence. Victims of violence are screened daily for program eligibility, and when able, individuals are engaged at the bedside by a member of the team (social worker or case manager). During this initial phase, the case manager engages with the prospective client at bedside to introduce the idea of intervention/program services and to offer immediate psychosocial support to the

patient and their loved ones. With the consent of either the patient or a loved one, the trauma care team and case manager assess immediate risks to the individual and community, and begin to conduct a risk and needs assessment for the patient. Individual risk for reinjury and subsequent poor outcomes, such as arrest and incarceration, are assessed using variables such as previous violent victimization, gang association or involvement, presence or lack of family and social support, unstable housing, and physical disability due to the trauma. Once this intake is completed, case managers work with enrolled clients to develop an individual service plan (ISP) aimed at addressing social determinants of violence (SDoVs). Team members also refer to the patient's medical record and gather additional information about the client's life and the circumstances of their injury, which they use to coordinate service and support with existing care teams. For patients that are not engaged in the hospital, team members use an assertive outreach protocol to try and make contact with patients in order to provide program education and enroll them into services.

After hospital discharge, emphasis is placed on maintaining close follow up with case-managers and frequent reevaluations of service needs which include individual counseling, job readiness, parenting support, work and volunteer opportunities, and GED assistance. Linkage to integrated mental health services and therapy is made through an on-campus Trauma Recovery Center. To coordinate the work outside of the hospital, the program draws upon the expertise of our case managers who have an intimate understanding of local social dynamics. Leveraging the knowledge and connections of our case managers, Harbor's HVIP works to meet and support clients where they are in the community and to ensure that they have access to the essential place-based resources they require to heal from their injuries and allow for self-determination and inner resilience.

In this way, the program works through a system of community-based service providers, including its CBO partners Southern California Crossroads which provides the case management component of the program, to address social determinants of violence and structural vulnerability. Effort to maintain sustained engagements with clients leverages this vast community-based network to organize an iterative process of individual service planning that constantly reevaluates evolving patient needs and corresponding community-based services.

The impact of HVIPs

Although long-term and robust evidence has not been collected, preliminary data suggest that HVIPs like Harbor's are effective at reducing future violence and criminal legal involvement among program participants. A randomized study of 100 patients admitted with violent injury over the age of 18 who had been admitted for violent injury and had both been hospitalized for violent injury and had a record of involvement with the criminal legal system found a threefold reduction in violent crime (1.7% v. 5.9%), a twofold reduction in any type of conviction (1.5% v. 3.6%), and a fourfold reduction in convictions for violent crime (2.1% v. 9.2%) in the intervention group compared to controls. in the intervention group.6 In Oakland, 12–20-year-olds hospitalized for violent injury randomization to HVIP reduced arrests for any offence by 70% (OR = 0.257) and reduced criminal justice involvement by 60% (OR = 0.356) relative to control.6
There is evidence that also suggests that HVIPs are successful in reducing trauma injury in a cost-effective manner. One hospital-based study found a reduction in the 1-year trauma reinjury rate from 4 to 2.5%.7 Other evidence shows a 5-year trauma reinjury rate decrease from 16% to 4.5%.8 Simulation evidence suggest that even assuming modest 20-30% reductions in trauma reinjury rates, the high cost of trauma related hospitalizations render HVIPs very cost effective.7,8

The California Violence Intervention and Prevention (CalVIP) Grant

To achieve these broader aims, the program set three specific programmatic goals for the new BSCC/CalVIP inputs it received, which focused on addressing gaps in service, deepening the practice of case management, and strengthening the accompaniment of wraparound services.

Goal One

To serve a growing population of violent crime victims, address service gaps including gaps in coverage over weekends, and improve the depth of service accompaniment. To realize these goals, Harbor proposed a series of programmatic interventions which included:

1. Hiring four additional community health workers with lived experience, familiarity with local resources, and social dynamics in local violence "hot spots."
2. Extending the hours of hospital-based coverage
3. Expanding the program's community-based accompaniment by offering a longer period of case management.

The objectives of the proposed activities were to:

1. Increase the number of enrollments of violently injured patient.
2. Extend the duration of case management accompaniment for high-risk clients.
3. Improve the depth of community-based accompaniment and support by increasing the number of touches between program staff and victims.

Based on the volume of patients seen at HUMC for violent injuries during the first three years of the HVIP program, and the number of patients the program had managed to engage via its case managers and community outreach during the same period, the program projected that it would contact approximately 40 high-risk individuals per month, anticipating that one-half to two-thirds of individuals would eventually enroll in the program. The projection was based on the assumption that an additional four case managers would allow program to capture patients lost due to limited hours of service coverage and that this would increase the enrollment, and eventually lead to an annual caseload of 240-300 individuals.

In addition to increasing enrollment, the program projected that the hiring of additional staff would free up the program to engage clients in a longer, more intensive period of case management from 3 to 3-6 months for low-risk patients and 6-8 to 6-12 months for high risk clients. The expectation was that the extended period of case management and additional human resources would eventually lead to more touches between staff, case managers in particular, and client/victims and thus a more impactful process of managing service planning and identifying and addressing the social determinants that contribute to the vulnerability of client/victims.

Goal Two

To address the social determinants that contribute to and increase the likelihood of an individual's involvement in interpersonal violence. Recognizing the interrelationship between risk factors of substance use, mental health needs, housing, employment and food insecurity, and an increased risk of violent reinjury and criminal legal involvement, the HVIP at Harbor UCLA proposed to:

1. Ensure that all clients received individualized service plans.
2. Ensure that a coordinated substance use and mental health screening and subsequent treatment including medically assisted treatment (MAT) was incorporated across all levels of programmatic activity.
3. Implement a youth summer program.

The aim of the three initiatives were to:

1. Identify, address, and add nuance to the understanding of SDoVs that negatively impacted protective factors of enrolled clients.
2. Identify, address, and add nuance to the understanding of substance use disorders and mental health needs.
3. Intervene upon early SdoV risk factors by providing financial stipends, mentorship and education to young patients at risk of potential reinjury and criminal legal involvement.

Recognizing the importance of SdoV, the program projected that an enhanced emphasis on recognizing and addressing substance use, mental illness, housing instability, food insecurity, employment would positively impact victim/client recovery and assist with the effort to reduce rates of reinjury and criminal legal involvement. The program also projected that these could potentially lead to a series of correlated impacts including but not limited to improved mental health, social functioning, and sense of safety and resiliency, in particular, among younger groups when properly mentored and given the opportunity to participate in age specific education and life skills training activities.

Goal Three
To reduce rates of violence and justice involvement among patients/clients enrolled in its program services. To achieve this programmatic endpoint, the program proposed three primary programmatic interventions:

1. Extending of the duration of community-based accompaniment and engagements with clients
2. Hiring of social work support to develop iterative individualized service plans after hospital discharge
3. Providing legal aid services to clients dealing with the criminal legal system

The objective of these interventions was to:
1. Decrease rate of repeat violent injury
2. Improve perceived safety of clients
3. Reduce the rate of justice Involvement

The introduction of CalVIP funded interventions, specifically the hiring of case management and social work support, the subsequent development of a more intensive iterative process for managing individualized service plans after hospital discharge, and improved linkages to legal services would result in a reduction in rates of both repeat violent injury and criminal legal involvement compared to historic and contemporaneous control populations. At least two different studies show that when clients receive services and participate in a case management period of at least 6 months, intervention participants were 60% less likely to be have any criminal involvement and 70% less likely to be arrested for any offense. Given these rates, and extrapolating from local baseline, the program expected to see a significant reduction in rates of criminal legal involvement through the implementation of CalVIP funding. Given that re-injury rates are usually reported over a five-year period the program also projected a series of corollary outcomes including an improvement in self-efficacy, resilience, mental health and most significantly the perception of safety among clients.

Harbor-UCLA Hospital Violence Intervention Program
Local Evaluation Plan
To monitor its progress towards these overarching goals and how it realizes the individual and programmatic outcomes it proposed in its CalVIP application, the HVIP at Harbor UCLA will implement an iterative evaluation plan that assesses the program's provision of services and utilization of related CalVIP inputs. Using a mixed method, multi-level approach, the proposed evaluation will track and report back upon key processes and outcomes defined in Harbor's CalVIP proposal including the new input of human resource/staff (four case managers) catered for by the grant, the extension of the length of its short- and long-term provision of service for low and high-risk patient/clients, and the related enhancements of the program's ability to address social determinants of violence. As a part of its design, the plan will also collect data on the critical outcome measures of reinjury and criminal legal involvement and perceptions of safety the program at Harbor proposed to evaluate as a part of its self-monitoring process. Tracking these key processes and outcomes, the evaluation plan will explore a series of interrelated questions about the program's process of implementation and the subsequent progress it has made towards achieving its stated programmatic and client-centered outcomes.

Question 1:
Process level evaluation and analysis

What progress has program made towards realizing process outcomes of Goal 1?
How has the HVIP at Harbor-UCLA been able to expand its programming and deepen its service accompaniment with inputs from the CalVIP grant? What are the process level outcomes that have resulted from the expansion of Harbor's programming? For example, was the program able to secure and onboard the additional staff/human resource (four case managers) it proposed to the BSCC, and extend its hours of hospital-based coverage? If it was, did this result in the expected increase in the volume of clients enrolled in the program? What about the community-based accompaniment and support it provides for high-risk patients via additional staff? Was the program able to deepen this accompaniment and increase the number of touches staff had with high-risk clients in the community after discharge? Or were there challenges/barriers in the implementation of this program component?

Question 2:
Process level evaluation and analysis
What progress has program made towards realizing process level outcomes of Goal 2?
What are the primary SDoV and related needs the program continues to identify among Harbor HVIP clients that place them at risk of re-injury and/or criminal legal involvement? What does the program do to address these SDoV and related needs? For example, what services does the program offer to clients with substance abuse issues or who are dealing with mental health issues, housing instability, and food insecurity? And was the program able to coordinate individualized service plans for all of these clients? What about the youth summer program it proposed in its initial submission? Was Harbor able to implement this program and provide the mentorship and education services to at risk youth that were proposed as a part of the summer program? What were primary process level and client-centered outcomes that resulted from this intervention?

Question 3:
Descriptive quasi-experimental outcome level evaluation
What progress has program made towards realizing the individual client-centered and program outcomes of Goal 3?
What are the principal client centered and programmatic outcomes Harbor's HVIP observed during its three year expansion of intervention services and case management? Specifically, what were the rates of repeat violent injury and criminal legal involvement among patient/clients as the program extended the duration of community-based accompaniment, number of touches or engagements, and its capacity to provide a more iterative process of service plan management? How do these compare to the rates of these two primary categories prior to the implementation of the CalVIP grant? Did the program observe a reduction in the rates of re-injury and justice involvement during the extension of duration of community-based accompaniment, number of touches or engagements, capacity to provide a more iterative process of service plan management as it anticipated in its proposal to the BSCC? Or did these stay the same? What were clients' perceptions of services and outcomes rendered by the program during the implementation of the grant? Did they report an improvement in their perception of wellbeing and safety or did these remain the same?

C. Project Logic Model *(Original plan, though with amendments as explained in LER text)*

Inputs	Activities & Services	Outputs

Program Staff
Program leads
• 1 Trauma Surgeon/co-Administrator
• 1 Emergency Medicine Doctor
Front Line Staff
• 1 Program Coordinator (Clinical Social Worker)
• 1 Program Manager (via Southern California Crossroads)
• 4 Violence Intervention Specialists at total 3.5 FTE (via Southern California Crossroads)
• 4 Violence Intervention Specialists at total 4 FTE (via Southern California Crossroads) to hire
 	
Service Partners
• Southern California Crossroads
• Safe Harbor Trauma Recovery Center (TRC)
• Harbor-UCLA Summer Urban Health Fellowship
• Workforce Development Aging and Community Services
• Los Angeles Hospital Based Violence Intervention Consortium
 	
Referral Partners
• Harbor-UCLA Clinical Services (Trauma, Emergency Medicine, Social Work, Primary Care)
• Safe Harbor Trauma Recovery Center (TRC)
 	
Program Materials
• Shared office space with Safe Harbor TRC and Harbor-UCLA Trauma
• Southern California Crossroads office space
• Intake questionnaire
• Service plan worksheet
• (PRAPARE) Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences Social Determinants of Violence (SDoV) Screener
• (PROMIS) Patient-Reported Outcomes Measurement Information System Self-Reporting Health Tool
 	
Funding
• Whole Person Care Rollover (6/30/2022)
• California Community Foundation (6/30/2021)
• Measure B Supplemental Funding (6/30/2021)
 	
IT & Data
• Client database (Civicore)
• Harbor-UCLA Trauma Registry
• Electronic Medical Record (Orchid)
	Engagement and Enrollment
	Identify, engage, and enroll high + low-risk patients
	• Daily trauma census list and clinical referrals used to screen eligible patients.
	• Bedside engagement of patients treated at Harbor UCLA Level 1 Trauma Center for gunshot wound, stabbing, or OIPI (other interpersonal injury) excluding incidents of domestic violence and child abuse, level one mental health emergencies, and self-inflicted injuries.
	• Engage patient referrals made by physicians, nurses, TRC staff, and social work department.
	• Enroll patient in HVIP services and administer intake questionnaire.
	
	Case Management
	Initial Needs Assessment/Individualized Service Plan
	• Administer PRAPARE screen to assess needs and level of risk across SDoV and mental health axes.
	• Work with patients on individual service and treatment plan that prioritizes mental health and social determinants/needs identified during initial PRAPARE screening: e.g. housing/food insecurity, substance abuse/use, unemployment, PTSD, depression, anxiety.
	
	Long-term intensive case management
	• Provide mentorship and assistance with service navigation for 6-12 months and 3-6 months for high- and low-risk patients, respectively.
	• Facilitate warm handoffs and meaningful connections to mental health, substance abuse, economic, legal, and peer resources including housing/food/daily living/transportation assistance, victim's compensation fund advocates, counseling and psychotherapy, medical follow up service, continuing education.
	• Re-evaluate evolving patient needs to ensure an iterative service plan that maximizes community-based accompaniment and mental health services provided through service/referral partner Safe Harbor TRC.
	• Assist with transition to natural resources and social supports in the community.
	
	Youth Summer Program
	• Annual 6-week summer fellowship
	• Provides participants with 6-weeks of mentorship and life skills training.
	• Model/partner: Harbor-UCLA Urban Health Fellowship
	
	Supports
	• Summer fellowship stipends
		Enrollment and Demographics
		Monthly process level report
		• # of eligible patients (low- and high-risk victims of interpersonal violence) and family members
		• # of referrals to HVIP
		• # of eligible patients engaged (bedside vs. after discharge) and family members
		• # of eligible/engaged patients enrolled
		• # of eligible patients that decline services
		• # of patients lost due to lack of follow-up and reason
		• # of patients discharged and reason
		• patient demographics, including zip codes
		• mechanism of injury (firearm, stabbing, assault)
		
		Identified SDoVs, Needs, and Services
		Monthly outcome level report
		• SDoV/needs identified via PRAPARE screening
		  ○ Economic stability
		  ▪ Annual income, employment status, food insecurity, housing instability
		  ○ Education
		  ▪ Level of education, language and literacy, early childhood education and development
		  ○ Health and Health Care
		  ▪ Physical/mental health history, access to health care, health literacy
		  ○ Neighborhood and Built Environment
		  ▪ Access to healthy food, quality of housing, exposure to crime and violence, environmental conditions
		  ○ Social and Community Context
		  ▪ Networks of social support/cohesion, experiences of discrimination, history of criminal legal involvement and incarceration
		3 and 6-month process level report
		• Report of services requested
		• Audit of services delivered
		
		Self-reported Health – Perception of Safety
		Pre-, post-, 3-month outcome level report
		• Descriptive outcomes of PROMIS screening for safety, life satisfaction, self-efficacy, social support, and mental health.
		
		Rates of reinjury and criminal legal involvement
		Bi-monthly and annual outcome level audit
		• Rates of reinjury calculated using trauma registry information and Harbor program ledgers
		• Rates of criminal legal involvement (felonies and/or misdemeanors) calculated using self-reported information in case management notes and individual service plans

Outcomes	Impact
Short-term Outcomes Client-focused • Stabilization of physical mental emotional wellbeing of patient/clients • reduction in short term rates of reinjury among low-risk clients • reduction in rates of reinjury among high-risk clients • reduction in rates of criminal legal involvement among low-risk clients • reduction in rates of criminal legal involvement among high-risk clients Programmatic • successful identification and treatment of social determinants • increased number of eligible patient/victms enrolled in HVIP • increase number of touches between case managers and victims in community after discharge • increased period of case management **Long-term Outcomes** Client-focused • reduction in rates of reinjury among low-risk clients • reduction in rates of reinjury among high-risk clients • reduction in rates of mortality among low-risk clients • reduction in rates of mortality among high-risk clients • reduction in rates of criminal legal involvement among low-risk clients • reduction in rates of criminal legal involvement among high-risk clients • positive change in client perception of health and safety Programmatic • successful identification and treatment of social determinants • increased number of eligible patient/victms enrolled in HVIP • increase number of touches between case managers and victims in community after discharge • increased period of case management	**Program level & Organization Outcomes** • Organizational culture change • Improved awareness of social determinants of violence and needs of victims of violence among healthcare providers and community stakeholders • Improved capacity to provide services for victims of interpersonal violence • Improved capacity to facilitate emotional recovery and reintegration into society for victims of violence **System Level Outcomes** • Establish foundation for HVIP services to be installed as a component of essential healthcare. • Sustained and embedded standard of care for victims of violent crime • Reduced rates of hospital re-admission • Reduced rates of criminal legal involvement • Reduced costs for medical legal systems **Community level** • Positive community perception of program and hospital • Reduced Implicit bias and improve relationships between hospital and community • Reduce violence related outcomes in community

D. Process Evaluation Method and Design

Case Management

To evaluate Harbor's progress implementing its proposed CalVIP inputs and the ways in which the inputs have supported the expansion of the program's ability to address the social determinants of violence, the program proposed to collect data on a series of basic demographic and process variables. The following is a list of data with indication on whether they were actually collected or not:

- the onboarding of new staff/human resources ***(collected)***
- client hospitalization
  - date of admission/injury ***(collected)***
  - zip code for location of injury and residence ***(collected)***
  - hospital length of stay ***(collected)***
  - mechanism of violent injury gunshot wound, stabbing, other interpersonal injury (OIPI) ***(collected)***
  - diagnosis, treatment, post-operative complications ***(collected)***
  - insurance type ***(collected)***
  - morbidities ***(collected)***
  - mortalities ***(collected)***
- patient demographics
  - income ***(collected)***
  - housing status ***(collected)***
  - employment status ***(collected)***
  - race/ethnicity ***(collected)***
  - sex/gender ***(collected)***
  - age ***(collected)***
- program participation (including Youth Summer Program)
  - source and number of referrals eligible patients ***(collected)***
  - number of eligible patients engaged ***(collected)***
  - number of eligible patients enrolled ***(collected)***
  - number of eligible patients who declined services ***(collected)***
  - number of eligible patients lost due to lack of follow up and reason ***(collected)***
  - number of eligible patients discharged and reason ***(collected)***
  - duration of patients' enrollment ***(collected)***

Program will also continue to gather data about the process of case management including:

- number and types of needs identified by case managers and clients, as documented and followed individual service plans ***(collected)***
- Number and types of needs met/successfully completed ***(collected)***
- number and type of community touches with clients after discharge ***(collected)***
- SDoV identified including mental health problems, substance use/abuse, employment status, access to health care, education opportunities, income, housing and food insecurity, recurrence of involvement with violence, neighborhood and/or school safety, gang involvement, family and social support network ***(collected)***
- number and types of services provided to address need/SDoV ***(collected)***

Information about program participation and demographics was collected on a monthly basis via regular audit of the Harbor UCLA EMR (ORCHID), as well as the trauma and HVIP registries. We proposed comparing program participants to non-participants, as well as successful graduates vs non-successful program participants, but were not able to do so, as there was not a reliable comparison group able to be created in adequate detail.

Data on the progress of case management for individual clients was gathered and input in real time alongside the daily implementation of the program and provision of services. Data collection began as soon as an individual enrolled in the program and started with the intake process, which includes a needs assessment and evaluation of the individual-, community-, social-, and structural-level factors that will shape the patients' experience of recovery from injury. Through this intake process, the program collected baseline process metrics on SDoV and demographics that also served as the foundation for each clients ISP. The tool used for this intake process was planned to be an adaptation of the current intake tool used by our CBO partner Southern California Crossroads that borrows from the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) Social Determinants of Health screener developed by the National Association for Community Health Centers and guidelines from the HAVI (Healthcare Alliance for Violence Intervention) database codebook, and San Francisco Wraparound Project's data dictionary. As will be detailed later in this report, our pre- and post- screener was developed, but not successfully implemented. We continued to obtain SDoV data from our participants using the intake tool that was familiar to our team via our community partner.

Over the course of case management – estimated to be 3-6 months for low-risk clients and 6-12 months for high-risk clients – the evaluation leveraged the program's iterative process of service planning, which requires check ins at regular bi-weekly intervals to continue to update the audit of social determinants/needs identified, and services rendered. Data was collected and stored using Southern California Crossroads' case management database, Civicore. Managers re-evaluating needs/SDoV were asked to provide an updated ledger of needs/SDoV identified and report on progress of service including services provided, and needs met by service.

Youth Summer Program

Adolescents impacted by interpersonal and community violence who are at increased risk of recurrent violent victimization or other poor behavior health outcomes, such as arrest and incarceration, and who show interest in participating were identified and invited to attend a summer fellowship program focused on leadership development, political education, skills training, and resilience building. The evaluation of this annual summer fellowship included feedback from our community partner and fellowship participants, to help shape the curriculum and content of the summer project for future years, and to evaluate whether participants gained valuable experience by attending the fellowship.

For the two summers during the grant period (2021 and 2022), we partnered with the Harbor-UCLA Summer Urban Health Fellowship (SUHF) run by the Department of Family Medicine. Participants from our cohort joined this six-week pipeline program that aims to introduce high school- and college-aged students to the importance of community-based health. During the program, participants learned skills in community needs assessment, while implementing and evaluating innovative programs to accompany local communities in their struggles for justice. Furthermore, participants attended trainings and engaged in discussions regarding health policy advocacy and community health education. Throughout, program participants received mentorship from fellowship staff, including college students, medical residents, and community professionals and physicians.

Youth participation and progress through the fellowship was to be evaluated quantitatively and qualitatively. For youth who were also enrolled clients in our case management program, we continued with our process and outcome evaluation outlined above. Summer program process measures were tracked, but unfortunately did not distinguish between our HVIP participants and the regular SUHF program members. Informal focus group discussions were conducted with the program participants after their participation and led to better understanding the successes and barriers to their participation, their perceptions on community support and resilience, the relationships created with program staff, mentees, and other youth participants, as well as the potential benefits to completing the summer fellowship curriculum. Program participants were then followed prospectively through the time course of the CalVIP grant to evaluate for any future incidents of violent victimization or arrest/incarceration.

E. Outcome (and Impact) Evaluation Method and Design

To evaluate the primary outcomes and impacts of its HVIP, the Harbor program planned to conduct a quasi-experimental impact study measuring changes in reinjury and criminal legal involvement of clients over time. We also set out to measure pre- and post- intervention differences in behavioral health outcomes measures and perceptions of safety and wellness. As explained, however, there were infrastructural and rollout-related barriers that we were not able to overcome to successfully complete this aspect of our evaluation.

We did begin with a review of a baseline retrospective assessment Harbor conducted of reinjury rates among clients prior to its CalVIP proposal/application, which used the county's trauma registry and program ledger to determine the proportion of patients enrolled in HVIP services between 2017-2020 who returned to the trauma unit with a repeat violent injury. We were unable to proceed to a retrospective assessment of rates of criminal legal involvement among clients Harbor's program served from 2017, the first year of the program and October 2020, the month that implementation of CalVIP grant began.

After confirming baseline rates, our program was able to conduct prospective evaluation only via self report from our program participants, as reported below in section H. We did track this information through the duration of case management with our clients, and this was discussed during case review meetings with evaluators, the program coordinator, and the cross-functional team of case managers and medical case workers who implement HVIP at Harbor. This was done iteratively through the time period of the grant.

As outlined in our LEP, we were unable to provide a comparison rate for our CalVIP participants because we were not able to access the same data sets to look for regional or county-wide incidences of recurrent violent injury. Los Angeles County has a large, mature trauma system and network of acute care hospitals from which clients could seek care for violent injury. Without a data set that could reflect this network, any rate of recurrent violent injury we could establish with our single center trauma registry would certainly not be accurate and potentially underreport true reinjury. Furthermore, our follow-up of patients did not reach out to 5 years, and so may not reflect a participant's true risk of reinjury.

As a part of the client -entered outcomes it seeks to understand, we also proposed to conduct a separate evaluation of clients' perception of safety and self-sufficiency before, during, and after the provision of HVIP services. To do this, the program developed a self-reported health questionnaire that was to be administered to program participants and standard time intervals. Using the self-reported health screening tool, the program's evaluation of safety and self-sufficiency outcomes was to focus on collecting descriptions of patients' perceptions of physical, mental and social health with an emphasis on victims' responses about safety, life satisfaction, self-efficacy, social support, and mental and emotional wellbeing. As will be detailed in Section H, though the tool was developed and tested with our team, we were not successfully able to implement it with our clients and gain consistent data. As such, we were unable to complete this portion of our proposed evaluation.

F. Timeline and Reporting

Data collection and evaluation procedures began after hiring of new, CalVIP-funded case managers in 2021. Enrollment and demographic data are compiled monthly by the Program Coordinator and discussed with the leadership team. Other evaluation was done quarterly in conjunction with the submitted Quarterly Progress Reports (QPR), and the final local evaluation is being submitted in December of 2023. Furthermore, evaluation of the annual summer program was completed yearly at the end of the project.

Participant intake was done with client enrollment into case management services. This was done via client interview and completion of a needs assessment and screen, culminating in the creation of an individualized service plan (ISP). As the program case managers work with the client in moving through their ISP, data will be iteratively inputted into our local database. Data will include results of the initial intake and needs assessment, number and form of client contacts, service goals identified and met, duration of case

management, etc. Quarterly evaluation of data was discussed with the program leadership team, our community partner, and reported via our QPRs.

G. Appendices
N/A

H. Evaluation Results

Program Overview and Description
The Safe Harbor Hospital-Based Violence Intervention Program and Lundquist Institute received the CalVIP grant and started operations in November of 2020. As described in Section B. above, the HVIP had been established at our trauma center with previous foundation and local grants, and we had planned to scale services up with the use of CalVIP funding while also transitioning over current case management staff at the completion of existing grant funding in June 2021. Over the course of the first year and a half of the grant period, the program was successful in building out a large team to receive the volume of patient need at our trauma center, though with some barriers in the pandemic environment that will be detailed.

Our preexisting program coordinator and social worker was brought on to oversee the CalVIP staff that were subcontracted through our community partner, Southern California Crossroads. Crossroads has been a leader in the violence prevention space for decades, with a focus on youth development and empowerment, and a strong presence on our hospital campus. In the first quarters of the CalVIP grant, we experienced infrastructure constraints that prevented us from hiring. Members of our leadership team transitioned out from their hospital responsibilities to new jobs or areas, and there was a COVID-19 related hiring freeze. Starting in 2021, however, and through the rest of the grant cycle, staff were hired to provide case management to victims of violence seen at our trauma center. As planned in June 2021, original staff of our HVIP were moved on to the CalVIP grant as full-time employees. We then hired additional case managers in the following months: two case managers in 7/2021, 2 case managers in 10/2021, one case manager in 5/2022, one case manager in 7/2022, one case manager in 8/2022, and our last case manager in 1/2023. With staff turnover, we had opportunity throughout the entirety of the grant period to hire and fill out our team. At its fullest, our team consisted of 8 case managers in July of 2022, a significant increase from our pre-CalVIP team, and a welcome addition to the trauma center that was experiencing pandemic-related increases in trauma volume and violent injury. As will be described, this allowed for increased coverage and enrollment of potential clients into our program.

The overall program structure included a mix of in-kind donation and grant supported staff. An in-house social worker program coordinator, as described above, and a program manager from the community partner created a close supervisory relationship to oversee the day-to-day operations of the case management staff, which also included a lead case manager. This core team met weekly for clinical case conference to discuss caseloads and specifics of ongoing case management. Physician champions on the leadership team met routinely with community partner leadership to provide additional visioning and oversight to the entire program. The presence of an in-house program coordinator has shown itself to be a best practice position, particularly for hospital-*linked* violence intervention programs like ours that rely on community partner subcontracting, as opposed to hospital programs that hire directly, to provide continuity between the institution and the community, and the acute inpatient stay with longitudinal outpatient and community accompaniment. This bridging, along with transparent leadership and aligned visioning between the medical center and the community partner, allowed for thoughtful expansion and program implementation.

Participant Demographics and Process Measures
At the outset of the grant period, our program estimated that it would serve 240-300 individuals. In total, we served **156 unduplicated clients**. Our original estimation was based on the daily trauma census in the hospital, a goal of 40 potential client engagements per month, and a target ratio of 1 enrollment for every 2 client engagements. As outlined above, because of hiring barriers and a delay in reaching our anticipated full

case manager complement, program enrollment required time to ramp up. Prior to our CalVIP grant in 2020, our program averaged 66 referrals a month. From these, there was a 29% engagement and 6% enrollment rate. Though total referral numbers did not change significantly throughout the grant period, there was a large increase in the percentage of potential clients our program was able to reach and serve. For example, in 2021, we had an engagement rate of 39% and an enrollment rate of 8%. In 2022, the engagement and enrollment rates went up to 60% and 19%, respectively. For the first half of 2023, engagement and enrollment rates dipped to 40% and 12%, respectively. This was an expected decrease in 2023, as we began to lose case management staff to job turnover as well as grant transitions within the organization. Despite that, the 2023 engagement and enrollment numbers were still an improvement from the pre-CalVIP time period.

Pertinent demographic information for our CalVIP participants are as follows. 77% of enrollees were men and 23% were women. The largest age group served was 35 years or older (49%), followed by 25-34 years old (29%), 18-24 years old (15%), 13-17 years old (6%), and under 12 years old (1%). The majority (62%) of clients served were Black or African American, followed by Latinx (35%), White (2%), and other or multiple (1%). We were not able to consistently collect demographic data on educational attainment, employment, or housing. For example, 72% of clients did not provide educational level on survey. For those who did, there was a mix of educational attainment: some high school or less (N=23), high school diploma or GED (N=16), some college or vocational training (N=4), and college degree (N=1). Regarding employment, 49% of data was missing. Otherwise, 37 participants were employed, 10 were looking for employment, 16 were unemployed but not looking for employment, and there were 9 students. In terms of housing, 51% (N=80) were living independently in stable housing, 16 clients were living with parents, and 15 clients had unstable housing.

All unduplicated participants received case management services, culturally responsive and culturally competent services, life skills, healthy choices, and family management counseling, and assistance with accessing victims of crime (VOC) benefits. Other services included pro-social, leadership skills and activities (88%; N=138), mentoring (83%; N=129), mental or behavioral health counseling (45%; N=70), housing assistance (17%; N=26), facilitated linkage to medication-assisted treatment or substance use disorder counseling (17%; N=26), de-escalation or violence interruption services (16%; N=25), and linkage to legal services (12%; N=18). We also provided the opportunity for paid summer internships through our collaboration with the annual Summer Urban Health Fellowship at Harbor-UCLA. This is a student-led health justice initiative aimed at empowering young people to pursue careers in community health and medicine. Through this initiative, we supported 7 students over two summers to complete this program, with 5 students doing so full-time.

Program Goals

The first goal of our program was to increase the case management team complement to scale up the wraparound services provided to our community with documented need from the trauma center. As described above, we were able to successfully do this, though more slowly over time than anticipated due to changing leadership team composition and hiring barriers. We reached our goal of 8 case managers on the team 1.5 years into the grant period. This allowed us to expand service coverage hours by shifting a case manager in August 2022 to the weekend. Indeed, 2022 was the best year for our HVIP in terms of engagement and enrollment numbers, increasing enrollment threefold from pre-CalVIP numbers. The full case management team also allowed for more depth in client participation as reflected in weekly case conference discussion. Quantitatively, for those clients who exited our program with a successful outcome, they underwent a range of 1 to 24 months of services, with a median of 7 months.

The second goal of our program was to provide a structure to potentially address social determinants of violence for our clients. To that end, all clients met the first target, which was to develop individualized service plans with their case managers. When applicable, clients were referred to our on-campus trauma recovery center for mental health evaluation and counseling. Likewise, we developed a partnership with our on-campus substance use disorder counselor and medication assisted treatment team to automatically

screen any participant with a history of substance abuse. With these direct connections, we were able to provide mental and behavioral health services to 70 of our 156 participants, and furthermore facilitate linkage to substance use treatment for 26 clients. Lastly, as described previously, we partnered with the Harbor-UCLA Department of Family Medicine to plan their annual Summer Urban Health Fellowship and sponsor 7 students to participate. Sessions facilitated by HVIP leadership during the summer fellowship included a history of medicine and community organizing, introduction to trauma recovery and trauma-informed care, community stop the bleed training, and simulation center exposure to medical and surgical techniques. Throughout their participation in the summer program, enrolled clients continued to receive mentorship from their case managers who recruited them for the fellowship due to their leadership and change potential. Upon completion, they received a stipend, helping give them a prosocial activity to participate in. Through conversations with our summer fellowship participants, we identified the following themes and barriers to success, respectively: applicable and stimulating curriculum, opportunity to get to know peers with different interests, belief set forth with their case manager, lack of transportation and everyday lunch options, unfamiliar educational setting, and long days.

The third goal of our program was to prevent recurrent violent injury and intersection with the carceral system for our clients. Our ability to report on this goal is hampered by a few issues. Using regional data from a period prior to the implementation of this grant, we calculated a recurrent violent victimization rate of 2% over 5 years. We were unable to provide a comparison rate for our CalVIP participants because we were not able to access the same data sets to look for regional or county-wide incidences of recurrent violent injury. Los Angeles County has a large, mature trauma system and network of acute care hospitals from which clients could seek care for violent injury. Without a data set that could reflect this network, any rate of recurrent violent injury we could establish with our single center trauma registry would not be accurate and potentially underreport true reinjury. Furthermore, our follow-up of patients did not reach out to 5 years, and so may not reflect a participant's true risk of reinjury. Nevertheless, with self-reporting from our clients during their duration of receiving program services (from above, a range of 1-24 months, with a median of 7 months), there were **zero reports of recurrent violent victimization** in our cohort. Similarly, we had anticipated being able to receive data from the criminal-legal system to assess whether our clients had any contact with the carceral system during or after participation in our program. We were unable to do this as planned and cannot report any data beyond self-report from our clients. Nevertheless, there were also **zero reports of arrest or incarceration** for our program participants. We do not have a baseline comparison rate for all comers or violently injured patients seen at our trauma center that did not enroll in HVIP services.

Outputs and Outcomes

This section describes the outputs and outcomes measured by our program for our clients who successfully completed and exited our services. There are also changes made to our outcome measurement plans as described above, with discussion describing the learning points taken away from our implementation challenges. The categories we measured outputs are: crime, housing, employment, victimization, and meeting basic psychosocial needs.

As described above, our collection of data to calculate violent reinjury or criminal-legal involvement outcomes was not achieved. As such, we pivoted to self-reported data to gain a baseline understanding of how our participants fared in these two arenas. During the CalVIP grant period, there was no incidence of recurrent violent victimization for our clients and likewise no incidence of involvement in the carceral system.

Interestingly, in our cohort, there was a small number of clients (10%; N=15) that indicated up front that they had unstable housing. There were a similar number of clients who lived with their parents, and many others who did not indicate any housing information. We were successfully able to provide positive change in this realm for 13 participants (87%) to exit our services with stable housing. Similarly, there was a small number of clients (6%; N=10) who were unemployed and requested assistance. There were many others who were not looking for employment or with missing data. Of these 10 clients, our program was able to successfully aid 5

of them (50%) into finding jobs. Lastly, all patients with successful program exits had basic needs identified and met through their individualized service plan.

We had originally planned to report client focused outcome data by using a client centered survey that focused on changes in key psychosocial measures including perceptions of safety, symptoms of depression and traumatic stress. With the help of our project consultant and an iterative process that involved our program coordinator, hospital-side leadership, and the staff of our community partner, we developed scales to be delivered to program participants. Screener development began in the Fall of 2021 and the case management staff was trained on how to use these instruments in May of 2022. Spanish translation was also done via our hospital interpretation service in October of 2022 for our clients that were monolingual or more conversant in their native tongue. Despite our best efforts, however, the uptake of survey delivery to our clients was not comprehensive and was unable to provide meaningful data to interpret. We found out that there were many barriers to implementation, and often the screeners were incomplete, or there were many difficulties in completing them. These barriers included case managers' unfamiliarity and discomfort with delivering the survey instruments, difficulty doing so over the phone with clients in the remote-work/social distancing pandemic era, as well as a lack of time available to case managers with full caseloads requiring in depth attention and other administrative responsibilities. As such, the lesson learned was to create separate infrastructure in the future to support research-like arms of the program to ensure a smoother rollout and better fidelity to the delivery protocol.

Discussion

Overall, expansion of our hospital-based violence intervention program with the support of the CalVIP grant was a successful undertaking, establishing several infrastructural improvements and best practices that can be maintained and improved upon moving forward. First and foremost, the in-house program coordinator position proved to be an essential piece and stabilizing force for the program's workflow, keeping constant connection between the medical center and the community partner, and the inpatient with the post-discharge community accompaniment. The expertise offered by our program coordinator through her experience as a social worker also boosted the clinical oversight of our case management team, some of which started out with less knowledge about patient and client care. As our program coordinator was on campus and often on the hospital wards and in the intensive care unit, her visibility elevated the presence of the entire program in the eyes of the hospital staff, creating a sense of integration for the case management team and facilitated their ability to start their work at the bedside. We recommend that all hospital-linked programs like ours with hybrid organizational leadership (ie. hospital and CBO partner) hire an in-house program coordinator to help the physician champions with administrative, project implementation, and visioning responsibilities.

A trusting relationship between our hospital team leadership and that of the CBO partner was also a strength of our program implementation. Fostering this connection was urgent through the early grant period amidst pandemic-related HR concerns, but continued throughout the duration of the grant due to shared principles of transparency, community empowerment, and care-first alternatives to the institutions that victims of violence often interface with during their recovery. This allowed our team to hire a full complement of case managers, thereby greatly increasing the reach of our program in the trauma center and community, as well as the depth of case management delivered to enrolled clients.

The collaboration needed to support our youth clients to successfully complete their summer program internships was also a highlight of our grant period. The Summer Urban Health Fellowship is designed for high school, premedical, and college students to expose them to a health justice perspective on health care delivery. The curriculum was challenging for many of our clients, particularly being in an environment that encouraged academic rigor alongside popular education on community engagement and empowerment. However, our youth participants all expressed gratitude in being exposed to this orientation on life and connection to a larger purpose. A specific success story will be shared at the end of this report. Furthermore,

having paid stipends allowed for the students to continue coming back to the fellowship program to learn and participate in activities, though some days were more difficult than others.

Alongside the aforementioned program successes, the program also encountered several key barriers. We already highlighted some of the challenges we experienced in implementing a pre- and post- psychosocial survey with our clients. Looking ahead, we will need to better support our case managers when we go to evaluate client-centered outcomes even as our program grows in its capacity to provide lifesaving services. To do this, we will focus on separating this aspect of the program from the case management team, so that it stands alone as its own fully developed arm of programming. Also, leadership oversight of the program would benefit from less reliance on in-kind donations of time from physician champions and other administrative staff. Dedicated leadership infrastructure is needed to ensure ongoing excellence in the administrative tasks of the program. Finally, as we move forward and potentially transition away from grant funded support like the CalVIP , our program will work on visioning and strategizing with local institutions and stakeholders to find ways of incorporating and integrating HVIP services into the standard operations of existing health systems.

As our hospital-linked violence intervention program is similar to the makeup and structure of many other programs across the county, the results of our report should be generalizable to other hospitals and institutions that would like to partner with community organizations to address community and interpersonal violence as a public health problem.

I. Grantee Highlight

One summer afternoon, Robert[1], a 15-year-old boy, saw himself being rushed to Harbor-UCLA Medical Center after being shot. While the commotion of the emergency department ensued around him, Robert was able to communicate with a social worker about what precipitated the incident. Robert was walking along a sidewalk when a car drove up to him and someone began shooting at him. Even though he was shaken and was reassured by the medical team that his family was enroute to the hospital – it was our violence intervention case manager, Javier, that was on the move at bedside to provide emotional support and stabilization. When medical staff asked whether Robert was with anyone, he became nervous and did not say much. Javier understood this demeanor and the nature of the events that took place. He already started to think of supportive outlets that could help Robert on his road to healing and recovery. Robert was not alone.

Bedside engagements are tough and complicated, and given the level of crisis response needs, it's never fully known whether it will be successful or not. Javier's extensive experience working with at-risk youth and gang intervention and prevention services is advantageous in situations like this, when medical staff is rushing around and family is not there yet to provide that emotional hand. HVIP intervention at bedside, whether it be during emergency room rush hours or even post medical intervention, becomes vital to building a lasting relationship with victims of violent injury. Harbor's HVIP bedside engagement model highlights bringing no judgment to the table, but uplifting hope and healing to traumatized young individuals that are impacted by their own community violence. Whilst Javier worked on building rapport and trust with Robert, he learned that Robert lived with his mother in another town. To the medical staff and to Javier, Robert's mother shared that he had been spending time "with the wrong crowd" of friends. Javier learned that Robert was having a hard time at home as well, which resulted in him running away.

With the social support from the hospital team in assisting both mother and father with community resources, it was Robert's post discharge care and follow-up that was the primary concern for his parents. How would he go to back to school? How is his mental state as a young black man being shot? Was he targeted? Is there violent retaliation involved? Was he gang involved? Could their son fall into trouble after leaving the hospital? How do we move on from here? These questions and concerns would swirl in the minds of Robert's parents, creating a cycle of stress and despair.

Robert was a very shy kid and did not talk much, as Javier would describe him. However, with Javier's mentorship and true connection with him, Robert slowly became comfortable enough to mentally and emotionally accept program services and support from HBVIP. Mentorship and connection were key in providing ongoing intervention and long-term prevention goals. Javier began conducting one-on-one mentorship sessions with Philip – a particular strength of his – and soon realized there were familial concerns that required mediation. Robert had trouble maintaining a relationship with his father. He was also doing poorly at school and missing attendance. These issues, Javier came to learn, impacted Robert's mental stability and self-worth, and limited his confidence in achieving success in his life. As Javier witnessed a few verbal arguments between Robert and his father, Javier took the lead in maintaining boundaries. At the same time, he supported the parents in educating them about meeting Robert where he was at emotionally and mentally, and focusing their objectives in helping Robert reach his goals that he set forth himself.

While Javier provided education on Victims of Crime services to support Robert's parents in managing medical and hospital bills, his one-on-one mentorship with Robert motivated the shy student to work on himself and think about his long-term goals. With Javier's experiences of mentoring at-risk youth and victims of gun violence, Javier realized that the most important action was to connect Robert with gang intervention and prevention services. This support culminated in Robert accepting a referral to Job Corps, a program

[1] Name changed for anonymity.

administered by the United States Department of Labor that offers free education and vocational training to young men and women ages 16-24.

While these services were beginning to take form in Robert's life, he still had trouble with school. Javier helped keep him on the right track in focusing on school and completing necessary assignments. However, a lack of structure and motivation still impeded Robert's success, leading to a discussion of Robert needing alternative intervention in youth development services. To change his approach, Robert then enrolled into Sunburst Youth Academy, a residential youth academy "high school" for at-risk youth to earn and complete high school credits while developing leadership skills, job readiness, life coping skills, and community services. This also encouraged Philip to enroll into the Harbor-UCLA Department of Family Medicine's summer youth program, the Summer Urban Health Fellowship (SUHF). Our HVIP had recently partnered with the Department of Family Medicine to collaborate on this 6-week health professional pipeline program that introduces high school and college level students to community health, structural racism, heath disparities, and social justice advocacy. During this time, Javier also aided Robert in going through a tattoo removal process, to better his chances of finding stable employment after completing his educational endeavors. Robert successfully completed both Sunburst Youth Academy and SUHF, acquiring his certification, new skills, and knowledge that he plans to use for the good of his community.

Throughout Robert's recovery, he also faced symptoms of post-traumatic stress and flashbacks, leading to difficulties sleeping and managing day-to-day responsibilities. Javier connected Robert with the Safe Harbor Trauma Recovery Center, also on campus at Harbor-UCLA and a sister program to Harbor's HVIP that supports survivors of interpersonal violence and trauma through holistic, integrated, community-centered mental health and therapy services. Robert was reluctant at first to delve into therapy, but with Javier's guidance and education, he was enrolled into counseling with a therapist.

Because of his rigorous self-work and staying consistent with his program goals that he worked with Javier to develop, Robert was nominated for Harbor-UCLA Trauma Surgery's annual Trauma Survivors Celebration, an event where trauma survivors that endured life changing injuries are celebrated with their families and honored by the hospital staff. Robert was honored by his family, his doctors, nurses, and especially Javier who helped him find support and resources towards his journey of healing.

Robert's journey to recovery is still an ongoing process. Even after successfully completing our HVIP, he keeps in touch with Javier who continues to mentor Robert and provide guidance on emerging life issues. Oftentimes, the impact of firearm violence is closely correlated with reinjury. Firearm incidences are the leading cause of death for children and teens, ages 1-19, in the United States[9]. Youth exposure to gun violence has a lasting impact on the mental health and well-being of children and teens that can affect a myriad of their development in school performance, social activity, how safe they feel in their neighborhood, and relationship development.[10] Robert's story highlights the importance of community violence intervention programs such as our Safe Habor Hospital-Based Violence Intervention Program that build a connection of continued guidance and support so that clients feel less alone in their recoveries after injury. Programs such as these help in identifying the best practices and resources to support alternative avenues to resolve future conflict and ending the cycle of violence through a trauma-informed lens. This is attained specifically because HVIPs highlights the model of connecting community members who come from similar life experiences and backgrounds and bring trust and respect to those that are seeking support and healing from their post-traumatic life expectations. Cases such as Robert's, who experienced violence at such a young age, was able to find avenues to achieve his goals and find personal independence and strength through the support of his family, and of course, his case manager Javier.

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