

LEADING TO HEALTH



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**HEALTH SYSTEM
TRANSFORMATION**

days, weeks, or even months earlier—one of the hundreds of people in D.C. who were shot or stabbed or assaulted with a blunt instrument in 2019.

Wiggleton has five CVIP colleagues: another navigator and a violence intervention specialist—their job descriptions are fluid, but they are essentially case managers—as well as two social workers and a trauma surgeon. The team has an overarching imperative: to keep their clients from being shot or stabbed or otherwise violently assaulted again.

To do that, Wiggleton and his co-workers effectively befriend those clients, becoming their de facto support system and helping them take care of their most immediate needs—from getting an insurance card, a driver's license, or their GED to making a follow-up appointment at the hospital. Their model is intensive, hands-on, individualized case management. The result, if done right, is an improvement in a host of risk factors that should reduce the patient's risk of reinjury.

Figuring out what those needs are and having the doggedness and knowledge to address them are key to the success of the country's growing number of hospital-based violence intervention programs (HVIPs).¹ The Health Alliance for Violence Intervention (HAVI)—based in Jersey City, New Jersey, and known until recently as the National Network of Hospital-based Violence Intervention Programs—now counts forty-three member hospitals nationwide and nearly twenty more “emerging” programs, according to Fatimah Muhammad, executive director of the HAVI.

The concept is based on the idea that the circumstances of a patient's long-term postoperative life are as vital to overall health as the trauma surgeon's split-second decision making, a notion that requires a systemic reorienting of the hospital and trauma surgeon's traditional worldview.

Response: Members of Medstar's Community Violence Intervention Program team work closely with trauma patients who arrive at Medstar Washington Hospital Center, in Washington, D.C. From left to right, Tionna Pierce, James Wiggleton, Gary Durant, and Darrell Givens.

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Interrupting Violence From Within The Trauma Unit And Well Beyond

Hoping to reduce the number of repeat visitors, one Washington, D.C., hospital is providing short- and long-term support to victims of violence.

BY T. R. GOLDMAN

What's going on, brother? What's up with you? I want to chop it up with you," says James Wiggleton, talking into his work cell phone one Wednesday afternoon at his desk at Medstar Washington Hospital Center, in Washington, D.C.

"When you think is a good time to get

you up here and speaking with you? Sometime this week?" he says, repeating the answer and responding in the same breath: "What about tomorrow?"

Wiggleton is a treatment navigator at Medstar's Community Violence Intervention Program (CVIP). His client, the person whose visit he's trying to nail down, had been delivered to Medstar's seven-day Level I trauma unit either



Intervention: Medstar Washington Hospital Center’s Level I trauma unit is one of the busiest in the region and is the first point of contact between victims of violence and members of the Medstar Community Violence Intervention Program. Standing on the hospital’s helipad are (from left to right) Tionna Pierce, Darrell Givens, Erin Hall, Gary Durant, and James Wiggleton.

Repairing a damaged patient so they can leave the hospital alive—referred to as having a heartbeat at the door—“that’s been the thing we can reliably track, and that’s been our success and pride,” notes Erin Hall, the trauma surgeon who heads up the Medstar CVIP.

The problem, explains the hospital’s chief of trauma surgery, Jack Sava, is that “the deeper you get into what happens after serious injury, the more you realize that leaving the hospital alive is not necessarily a rousing success—not from a physical point of view if you’re dealing with daily pain and disability, nor in a broader sense if you’ve lost your job and you have PTSD [posttraumatic stress disorder] or you’re severely concussed or it’s a brain injury, and now your relationships are falling apart and you’re out of school.”

“There’s an increasing recognition,” he says, “that ‘dead, not dead’ is not an adequate way to describe trauma outcomes.”

As a result, Hall says, there’s “a huge push throughout the trauma community to start figuring out how to track these outcomes and how to impact them” and make this obviously unintended trip to the hospital “an inflection point towards better health.”

No ‘Quick Fix’

Medstar, the largest hospital in the D.C. area, is a not-for-profit, 912-bed academic medical center. Its violence intervention program, currently in the midst of a randomized controlled trial to gauge its effectiveness, is paid for in part by a grant from D.C.’s Office of Victim Services and Justice Grants. In addition to salaries, the grant also includes money to provide patients with wound care kits, new clothes for a job interview, Uber rides, and replacement IDs—which are sometimes taken by the police during an investigation and kept for an indefinite period (and occasionally lost, according to Medstar patients). The Uber rides not only help ensure that clients get to where they’re supposed to go but also are a boon to those patients for whom riding public transportation after a violent injury is suddenly fraught with fear and anxiety.

Such services are the opposite of a traditional hospital discharge scenario—in this case, the “standard of care” control group in the Medstar randomized controlled trial—where patients leave with a few sheets of postoperative instructions and a referral list of various social service agencies, with no one to help them navigate those agencies or make sure that patients even contact

them.

The enhanced or experimental arm of the Medstar randomized controlled trial, following the template of other HVIPs, both addresses patients’ immediate goals and emphasizes long-term relationships with patients, the community, and the resource centers patients might need.

“We by no means are a quick fix, nor do we want to be a quick fix,” explains Millie Sheppard, Medstar’s CVIP manager and, along with Tionna Pierce, one of two licensed clinical social workers on the team. Yet at the same time, Sheppard says, “we want what’s going to help you from today to tomorrow. Like, what is the biggest barrier that you have right in front of you at this moment?”

Often the obstacles are basic and physiological: For victims of gunshot wounds, for example, it could be getting an ostomy bag to work. “You have to address whether or not you’re pooping on yourself, literally, before you can start addressing what your goals are going to be in your life,” Hall says. “Dressing and wound care or getting in and out of your apartment or just having a safe place to go—all of those are such basic needs that it’s really part of our job, I think, to help people address those.”

However, Hall continues, doing so also allows case managers to form that crucial relationship with a patient, to say to them: “Look, we do care. We get that this is an issue and why it’s such an important issue.’ And then we can start talking about the other things with them that perhaps would lead to longer-term improvements.”

Often, the program can help clients handle their most urgent needs using services they never knew existed. “If you have a D.C. ID you can get...free GED classes, you can go to UDC for free almost,” says Gary Durant, referring to the University of the District of Columbia. “There are a lot of resources people don’t know about that we just bring to light,” adds Durant, who is the other Medstar CVIP navigator.

While the concept of an HVIP is straightforward, it requires case managers who possess an unusual combination of intangible qualities: empathy, street savvy, persistence, and the sort of sagacity that is often the by-product of having lived through the same ad-

verse circumstances as their clients. Getting the right intervention specialist for a hospital-based program is “incredibly important,” says Rochelle Dicker, the vice chair for surgical critical care at the University of California Los Angeles and founding director of one of the oldest HVIPs, the San Francisco Wrap-around Project. But she says it’s deceptively difficult to pull off—requiring the type of person who, for example, knows that your client “might be safe in one tattoo removal place and not the other.”

“I went to prison at an early age, from seventeen to twenty-three, so I was kind of like raised in prison,” says Durant, who also serves on Medstar’s Workplace Violence Intervention Committee. “Just my environment and growing up the way I grew up, you had to learn how to study people. It’s a helpful trait that I can sit down and feel the person out and relate, because I can relate to almost anybody.”

“Pride is very dangerous,” he continues. “You have to explain to some people, ‘OK, who are you proving something to? Are you proving to yourself that you’re a man and not a punk? Or are you trying to prove something to people who are just going to be like: “He was a good dude. May he rest in peace” or “He was a dummy, he should’ve let it go. It wasn’t even that serious?”’”

“Some of these guys can’t even tell you the reason they got shot, or the reason they were stabbed,” Durant says, referring to his Medstar clients. “That lets you know alone that it probably wasn’t worth it.”

Despite widespread agreement that mitigating negative social determinants of health is key to building a healthy society, there is no consensus on how to tackle the vastness of a problem that involves a host of interlocking issues, from chronic violence to substandard housing and education and inadequate public transportation—and certainly not enough public or private financial commitment to make any permanent improvements.

“That’s the story of preventive medicine in America,” Sava notes. “We’re more jazzed generally about throwing money at the late sequelae of severe terminal illness than we are about preventing it up front. And of course, the thing about injury is that a lot of the time it

There is no more “teachable” moment than when someone is lying in a hospital bed after having undergone trauma surgery the day before.

occurs at the intersection of everything that’s difficult for human beings and society—meaning problems with crime, mental illness and emotional regulation, family structures, education, the justice system. All these things come together at a flash point of injury. That’s what we see every day.”

‘There’s Nothing Else’

The term *recidivism* normally refers to a relapse into criminal behavior, and it has long been a major social challenge. A Department of Justice study published in 2018 found that an extraordinary 83 percent of state prisoners released in 2005 had been rearrested within nine years—with 82 percent of those arrests occurring within the first three years after release.²

But hospital recidivism is just as real. One might think that experiencing a lead bullet entering your body at the speed of sound or a knife blade slicing through your soft tissue would be once-in-a-lifetime events. But in many communities the same endemic gun-saturated violence that regularly puts ex-offenders back into the criminal justice maw just as consistently sends people back to the trauma bay. Numbers vary widely, but estimates for a violence re-injury rate can range as high as 45–50 percent.³

It is at this moment of entry—or reentry—that an HVIP finds its narrow window of opportunity. The concept is raw and unsentimental: There is no more “teachable” moment than when someone is lying in a hospital bed after having undergone trauma surgery the day before. In place of a toxic neighborhood environment, one is now surrounded by a neutralizing institutional starkness and perhaps the inkling of a blank slate.

And there is no better teacher for this teachable moment than someone who grew up in the same environment as

the patient in the hospital bed and experienced many of the same things they did, from being shot to incarceration—a connection that is a bedrock tenet of any HVIP.

Medstar CVIP staffer Darrell Givens is the team’s violence intervention specialist and, like Wiggleton and Durant, makes initial patient contacts. “Telling them what we can do for them is nothing they never heard before,” and as a result, he explains, “they’re...still kind of closed off.”

But Givens says that once he starts talking to patients and lets them know he can relate to them—“I’ve been locked up before, I’ve been shot at”—they respond, in turn: “Oh, you’re not that much different from me, let me open up.”

This moment of susceptibility is even more fraught in a population where many people are not only used to going it alone with little or no familial help but are not in the habit of verbalizing deep-felt emotions. Wiggleton says that in his experience, a lot of people “engaging and acting out in violence don’t know how to act out or articulate their feelings. A lot of them don’t have a strong vocabulary, so they couldn’t word their feelings—they can’t tell you how they’re feeling.”

Lying in a hospital bed or a recovery room creates, almost by definition, a certain fragility, Durant adds: “Some of these guys have cried, just cried about how they feel they have to carry all the weight. They tough with their girlfriends, but when you get them one-on-one they just want to tell you how they feel about every little thing: how you aren’t supposed to be doing this, and they know better, but it’s like, ‘There’s nothing else.’ It’s definitely the most vulnerable stage for them.

“A lot of times people don’t have enough time to sit down and talk because they got things going on,” he says. “But this time, you’re stuck in a hospital bed, trying to get yourself together, so why not talk to somebody?”

‘You Become Numb To It’

While residents of the United States are twenty-five times more likely to die from a shooting than those of other high-income countries, the risk is even greater for African American males. For those

ages 15–34, homicide is the leading cause of death. Black men account for 52 percent of gun homicide victims in the US, yet they make up less than 7 percent of the total population.⁴

It's hard to overstate the social and cultural isolation of many African American assault victims who are mired in the cyclic violence of their communities. "You become numb to it," says Davon Benton, age twenty-three, who's been shot on three separate occasions. Benton eventually moved out of the D.C. neighborhood where he grew up and today talks about his experiences to youth groups and in schools.

"The work I do now, I see that it's totally different on the outside world," says Benton, who was treated at Medstar and helped by Sheppard. "But if you're stuck in the neighborhood all day, this becomes your reality. I stayed at my grandmother's—me, my little brother, my two little sisters, and my oldest brother—because my mother was killed when I was two."

That's the sort of fatalism that is common to clients in any HVIP, notes HAVI executive director Muhammad. "Imagine what kind of life it is to have a bullet [in you] and be like: 'It is what it is,'" she says.

Transformation, Muhammad says, "takes people noticing you're in pain—not to fix it for them, just to be alongside them as they articulate what their needs are."

Many potential clients, Wiggleton says, can't conceive that help is available just for the asking.

"We had a kid come in here yesterday, randomly just shot in February, he didn't know these services were available, and he came up to the hospital and met with us, and he pulled me to the side...and said, 'Hey, look, man, I need some help, man, because I'm trying to finesse this situation,'" Wiggleton recalls.

"And I had to stop him right there because in his mind he's so stigmatized and so traumatized, he feel as though he has to finesse his way—cut corners, go under the table, cut the rug, that's finessing—into getting help. He didn't know he was speaking that to the help. Like, 'You're not finessing the help. The help is there for that. To help.'"

When there are family members wait-

It's hard to overstate the social and cultural isolation of many African American assault victims who are mired in the cyclic violence of their communities.

ing for the patient to come out of surgery, the case managers will often approach them first to talk about the Medstar program, and they can be valuable allies in convincing someone to join.

However, many patients have to recover on their own, at least in the initial days, with no visitors (family or otherwise)—a fact that's clear when CVIP members make their daily rounds. "The room is empty," Wiggleton says, referring to one patient he had just visited, and he can usually tell if someone has come by earlier. "They would have brought you something. You either have a different type of juice that's not sold in the hospital, a different bag of chips.... You see these things that indicate that someone came to check on him.

"We offer these services, and even if he doesn't take the resources, he's taking camaraderie and companionship," says Wiggleton about the patient. "He gave me an active phone number, he's thirty years old. You really don't want to overwhelm them. You just get an initial contact, let them know you're here, tell them about the program, and tell them, 'As long as you're here, we'll check back with you.'"

The personal engagement is critical, Sheppard notes, "because a lot of guys—if we don't catch them or we don't have the right contact number and they're supposed to follow up, the return rate is almost zero."

That includes people who leave the hospital with a bullet or two still lodged in their body. "In our communities nowadays, a lot of people—youth, kids, African Americans—they get shot, they get released from the hospital, they feel as if they're walking again, they're OK," Durant says. "They don't see the long-term health implications."

That's one of the cautionary points

that Hall makes to her gaggle of residents one autumn morning as they sit in a small, crowded room at one end of the trauma unit reviewing their patients, including one recently arrived male with a single gunshot wound. "One hole, right chest," Hall tells the residents, who sit diligently taking notes, water bottles at their sides. "Holes and bullets should be even," she adds with emphasis, then points to an x-ray of the patient's chest, where two bullets are clearly visible—one plainly from a previous shooting.

"How many holes did he have?" she asks rhetorically. "Right now, I see two slugs. So one thing you can ask in the trauma bay...is: 'Do you know if you have a bullet in you?'"

A Rigorous Study

The results of Medstar's randomized controlled trial will be combined with data from Howard University Hospital's violence intervention program for eventual publication as part of Project Change, which is one of twelve programs at different sites across the country in a larger research study—the Supporting Male Survivors of Violence Initiative, funded by the Department of Justice's Office for Victims of Crime and its Office of Juvenile Justice and Delinquency Prevention.

"We're trying to understand, across all these grantee types, what they are doing to meet the biggest hurdle—reaching these young men," says Stephanie Hawkings, a program director at RTI International who is the principal investigator of the cross-site, national evaluation. The D.C. program is the only randomized controlled trial and the only hospital-based program among the twelve sites, Hawkings says.

Compared to community-based programs, she continues, hospitals have "really solid legs for funding" because they are permanent institutions that everyone uses, are run with a certain scientific rigor, and are less subject to fallout from political changes than smaller community groups are.

The Medstar randomized controlled trial began in the fall of 2018. Between August 2018 and early March 2020, nearly one thousand violently injured people arrived at the hospital's trauma unit. Four hundred sixty-two people had been shot, 290 stabbed, and 228 vio-

lently assaulted with a blunt weapon, according to figures provided by the program.

Of that total, 415 people met the criteria to take part in the trial: they were male, at least age eighteen, and proficient in English; not under arrest; and either living or injured in D.C. As of March 5, 2020, eighty patients had been enrolled in the study: forty-four in the experimental group that receives the intensive, individualized case management; thirty-five in the control group, whose members receive the same referral services that Medstar has always provided on discharge; and one who wants neither intervention nor referrals but has agreed to take part in follow-up surveys and an exit interview.

Those entering the program commit to participating in an initial research survey; a lengthy psychosocial and risk assessment intake interview that asks a variety of medical, legal, and life satisfaction questions; two shorter telephone follow-up surveys at three and six months; and a final, more rigorous one-year exit interview.

Only after patients are enrolled are they randomly assigned to either the control or the experimental group. Staff members make the assignments by blindly choosing an envelope that contains either a blue card for the control group or a purple card for the experimental group with the enhanced services.

The study will track participants for one year from their date of injury, comparing the control and experimental groups in terms of everything from violent injury recidivism, predisposition to violence, and substance abuse to whether PTSD symptoms have subsided and life satisfaction has improved.

Rigorous randomized controlled studies of HVIPs are unusual; there are only about half a dozen in the literature, notes Michael B. Greene, a senior fellow at the Rutgers School of Criminal Justice.^{5,6} And while “they yield a conclusion that these types of programs are very promising, we don’t have sufficient data at this point to really accurately assess them.”

The same conclusion was reached in a 2016 systematic literature review that looked at four randomized controlled trials and six observational studies. While acknowledging the “strong theo-

Rigorous research helps gain that all-important buy-in from the data-obsessed surgical community that is key to a successful HVIP program.

retical underpinnings for HVIPs,” the authors cited “insufficient evidence” as the reason they could not make a recommendation. “There was a relative paucity of data,” they wrote, “and available studies were limited by self-selection bias and small sample sizes.”⁷

Large-scale randomized controlled trials are difficult to carry out for several reasons: People who end up at urban hospitals with penetrating trauma are not typically patients who want to take part in a research study. And aside from usually recording violent injury and criminal recidivism, there is no consensus among different HVIP programs about what other outcomes—which range from “better coping strategies” to “improved self-esteem”—should be measured.⁸

In addition, many practitioners eschew randomized controlled trials of HVIPs because there is no clinical equipoise—that is, no genuine uncertainty about which of the two methods, control or intervention, are best. Indeed, to many people, it defies logic to believe that providing individualized case management to injured people does not result in better outcomes than a “treat and release” protocol does. Randomly assigning people to a control group, Hall says, is “incredibly morally difficult for all of us because we believe so much in this program—that it has to be better than just giving someone a piece of paper with some phone numbers that may or may not be accurate.”

Yet the reality is that giving hospital executives and other funders the statistical rationale they need to support HVIPs requires a “community of studies,” says Christopher St. Vil, an assistant professor at the University at Buffalo School of Social Work and the evaluator of the Medstar and Howard University programs. Only with such

rigorous research would most system leaders and investors trust the cost-benefit analyses that quantify the program’s positive dollar impact^{9,10}—and help gain that all-important buy-in from the data-obsessed surgical community that is key to a successful HVIP program.

‘He Got Through It’

On a third-floor corridor at Medstar Washington Hospital Center, it’s 6:00 p.m. and there’s already an early evening calm. An occasional gurney rolls by, the patient staring into space. Residents in green scrubs, faces relaxed, drift down the hall. A chest-high robot named Arnold rolls along the corridor on a linen delivery. The pale, rectangular box, one of six robots at the hospital, senses people approaching, stops, then starts again.

Around the corner, in a small conference room, the Medstar CVIP’s monthly trauma survivors’ meeting is just starting. Wiggleton is presiding, his blue fleece Medstar jacket zipped up to his neck and the collar turned up. He is leaning over the table, asking each of the attendees to briefly tell their story.

“My brain is fumbling,” says Corey Peterson, who is still recovering after someone broke his jaw in two spots. “That little inch can take a mile.”

“I went in at seventeen for a crime I did not commit,” says the next person.

“I was shot in the neck two and a half weeks ago. I was in the ICU on a breathing machine. I just came home,” says the only woman in the group.

“I was shot in the back with an AK-47. It almost hit my spine, but it didn’t,” another person responds.

“I appreciate you sharing,” Wiggleton tells him, adding to the whole group, “When you set aside an hour to come up here and chop it up, kudos to you all.”

At the same group session a month earlier, Wiggleton had applauded Jawon Douglas, then age twenty-three, who had been shot on September 19, 2019, just twenty days earlier. Douglas had been caught in a barrage of automatic gunfire that killed one person and left five others wounded. “Wrong place, wrong time,” he said quietly, when asked how he came to be shot.

“Jawon made an accomplishment today,” Wiggleton told the group. “He got his bullet taken out.” The bullet had

been lodged in Douglas's knee since the first time he was shot a few years earlier, a shooting that Douglas said was the reason he dropped out of high school.

Douglas had gotten that bullet removed after he saw a flier about the Medstar program in the trauma bay the night he was shot for the second time in his life. He called the CVIP number. The team helped him find a surgeon to remove the bullet and fill out the D.C. Superior Court's six-page Crime Victims Compensation Program application for money to cover lost wages from his job as a barista in a Georgetown coffee shop and replace the clothing damaged by the two bullets that had entered his body. ("Clothing replacement limited to \$100," according to the compensation program application. "No reimbursement when victim is deceased.")

Later that evening, Wiggleton went around the room asking everyone about their immediate goals. "To get my GED within a year" was Douglas's reply.

Three months later, in early 2020, Douglas is back working at the coffee

shop and is enrolled in GED classes. He's also working with Durant, whom he considers a mentor, to get his driver's license. "He had an accident, too, and he got through it," says Douglas, admiringly, referring to Durant's incarceration.

"We came up with a goal that Jawon has to pass the written pre-test in front of me before we can go down and get the driver's license," Durant says. "No point in me sending him down there if he won't pass it."

Sometimes, what the Medstar CVIP team offers is more intangible, and possibly more important. Peterson's first memories after he was violently assaulted and brought to the Medstar trauma bay was "a big dude standing over the top of me trying to stick a tube down my throat." He'd been hurt so badly, he said, that the blood in his lungs "took four days to come out."

A few days after being discharged, and still traumatized, he started having thoughts of retribution. "It was the end of the day and I was going through my phone and his number popped up,"

he recalls, referring to Wiggleton's cell phone. Sheppard has encouraged her team to disengage from the job after hours, including not answering the phone. But Peterson called Wiggleton's cell several times, and around midnight Wiggleton picked up the phone.

"Somehow he got me to laugh, and my temperature gauge came down," Peterson says. "That's what really got me from red. He took my mind off of it, and from there gradually calmed me down. I went to sleep," he says, thinking, "I ain't going to dwell on it right now." ■

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NOTES

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