

2008 Innovations Awards Program APPLICATION

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ID # (assigned by CSG): 08-E-27PA

Please provide the following information, adding space as necessary:

State: Pennsylvania

Assign Program Category (applicant): Health Services (Use list at end of application)

- 1. Program Name:** Pennsylvania Injury Reporting and Intervention System (PIRIS)
- 2. Administering Agency:** Pennsylvania Department of Health
- 3. Contact Person (Name and Title):** Leslie A. Best, Director, Bureau of Health Promotion and Risk Reduction
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- 7. E-mail Address:** lbest@state.pa.us
- 8. Web site Address:** www.piris-pa.org;
- 9. Please provide a two-sentence description of the program.**

The Pennsylvania Injury Reporting and Intervention System (PIRIS) is a hospital-based injury surveillance and intervention system that collects information on injuries, specifically firearm-related injuries and provides a multi-system intervention for the victim and family that will provide specific services designed to prevent future violence. The real time multi-system intervention component for the victim and family is designed to prevent and reduce violent crime, and reduce the chances of continued participation in violent, gun-related activity.

10. How long has this program been operational (month and year)? Since April 2006

11. Why was the program created? What problem[s] or issue[s] was it designed to address?

Firearm injury is the second leading cause of death among persons aged 15 to 24 years old in the U.S. In 2004, the firearm homicide death rate for this age group was 10.0 per 100,000 for the U.S., 11.1 per 100,000 for Pennsylvania, and 37.7 per 100,000 for Philadelphia. According to the Centers for Disease Control and Prevention's Web-based Injury Statistics Query and Reporting System, the national estimate for 2004 for the rate of nonfatal injuries from firearm assaults in this age group, based on hospital emergency department reporting is 46.7 per 100,000. A Pennsylvania study, entitled "Firearm-related Injuries in Pennsylvania" published by the Pennsylvania Health Care Cost Containment Council in 2005, found that hospital charges for firearm injuries have risen dramatically, now averaging \$127 million per year. The study found that young adults, blacks, and males had the highest hospitalization rates. Clearly, firearm injury is a significant and costly public health problem.

In March 2005, Governor Rendell established the Commission to Address Gun Violence. The charge of this Commission was to recommend changes that emphasize prevention, community focus and collaboration to reduce gun violence. An extensive report included a recommendation to develop and implement a hospital-based injury surveillance system that is actively connected to social service and intervention providers.

In June 2005, the PA General Assembly designated \$1.3 million in state funds to be used to implement the Pennsylvania Injury Reporting and Intervention System, also known as the PIRIS project. The planning phase for the PIRIS project began in the Fall of 2005, with implementation scheduled for April 2006.

The PIRIS is being piloted in Philadelphia through a partnership of the Pennsylvania Department of Health, the Philadelphia Department of Public Health, three university-based trauma centers, a not-for-profit public health agency, community agencies, and an expert advisory group.

The specific aims of PIRIS are to: 1) reduce the risk of recurring youth violence; 2) provide victims and their families with case management and other social and trauma-related services; and 3) provide community-based programs with information to better target, develop, and evaluate prevention activities.

12. Describe the specific activities and operations of the program in chronological order.

Referrals: Hospital staff complete a brief referral form which includes basic demographic information and the patient's signature for consent to participate in the program. Referrals are faxed to a secure fax machine in the supervisor's office. The supervisor calls the referring hospital to confirm receipt of the referral and to obtain additional information if available. The supervisor assigns the case to one of the three case managers. Every effort is made to contact the participant and/or their family within twenty four hours of receipt of the referral from the hospital, and staff has been able to do so in 80% of cases to date. This initial contact may be a telephone call or a face-to-face visit in the hospital or the participant's home. At this time arrangements are made for a face-to-face visit in the hospital or participant's home.

Recruitment and intake: The initial visit with the participant (and their parent if under the age of 18) is conducted by the assigned case manager and an outreach worker from PAAN. At this time the program is explained, including the roles of the PHMC case manager and PAAN outreach worker. The case manager explains that on-going clinical intervention and specific supportive services will be provided to the participant and their family with the overall goal of preventing future incidents of violence

Ongoing supportive services: Case managers have a minimum of one weekly contact with each person on their caseload. Length of contact is dependent upon presenting issues for each case. Face-to-face visits are conducted at least twice a month, at the participant's home, at PHMC or as part of accompaniment to a medical, employment or court appointment. Specific case management services include:

- Assessment: A comprehensive psychosocial assessment is conducted using GAIN-Q, a standardized assessment tool. The GAIN-Q is administered within two weeks after the client agrees to participate in the intervention, and then repeated every three months. Each participant receives twenty dollars on completion of the assessment.
- Individual service-planning: An individualized plan with realistic goals and objectives is developed with input from both the case manager and the participant.

- Referrals: Referrals are made as needed for a variety of supportive services for the youth and the family, including housing, counseling, legal assistance, parenting, transportation and others. Referrals are followed-up to assure that needed services are actually obtained. Staff members assist clients to advocate for the receipt of services if problems arise.
- Monitoring and follow-up: Staff regularly update and revise the service plans to make sure that the outlined goals are accomplished. New goals are added as others are accomplished or as new needs arise.

Work with family members: As appropriate, staff members assist other family members with needs, such as housing, income or transportation needs. PAAN staff members also engage family members in anti-violence events occurring in the community, such as rallies, hearings or community vigils.

Documentation and data entry: Initial referral and contact information, ongoing case management notes and assessment outcomes are entered into the MIS in a timely manner. Data entry tasks are accomplished with relative ease and are an integral part of case record documentation.

13. Why is the program a new and creative approach or method?

PIRIS combines an injury reporting system with targeted prevention strategies to help reduce the impact and repercussions of violence on youth, families, and communities. The unique aspect of PIRIS is the multi-system interventions. It is designed to address the impact of these injuries and reduce the risk of recurring violence, whether through re-injury or retaliation. Referrals are tailored toward the needs of the victims and their families. Referrals may be made to community services, such as drug and alcohol treatment, job training, education programs (general education diploma and vocational education), and mental health treatment and services help to address the needs of victims and family members. Most needs have included assistance in maintaining health status, completing education, and obtaining employment.

14. What were the program's start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

- Initially through an existing grant agreement with a local health department, funds were made available to the Philadelphia Health Management Corporation (PHMC) to manage the PIRIS pilot. The funds supported existing management staff and the recruitment of four new case managers. PHMC internally developed the Management Information System (MIS) being utilized by PHMC case management staff. One fax machine, four computers, and office supplies were purchased for the case managers.
- PHMC developed contracts with the three trauma centers, the Philadelphia Anti-Drug/Anti Violence Network (PAAN), the Pennsylvania Trauma Systems Foundation (PTSF), the Firearm & Injury Center at Penn (FICAP), and the Center for Clinical Epidemiology and Biostatistics at Penn.
- All grantees continue to receive funds annually to continue the pilot through a sole source grant to PHMC.
- Funds allotted to the three trauma centers support human or material resources for the referral process.
- PAAN supports case management activities with community engagement.

- PTSF has the Pennsylvania Trauma Outcome Study (PTOS), which provides the data related to the provision of healthcare to the victims. This was an existing system for data collection from all Pennsylvania trauma centers. Funds allotted support minimal personnel and technology resources to support data sharing for the purpose of PIRIS surveillance.
- To support evaluation of PIRIS, FICAP collaborates with partners of PIRIS: to establish and utilize a PIRIS Advisory Group; provide advice on best practices; utilize the experience and expertise of the Advisory Board; and consult on system development protocols and review encounter data.
- To support evaluation and quality assurance, CCEB has developed the framework for a data acquisition system to integrate PIRIS partners' databases, which allows for future expansion as more databases are made available.

15. What are the program's annual operational costs? \$1,300,000

16. How is the program funded? State Revenue Funds

17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number. No.

18. What equipment, technology and software are used to operate and administer this program?

PHMC created the PIRIS secure, web-accessible Management Information System (MIS). Case Management staff members maintain hospital referral and contact information in the MIS in addition to detailed data on case management activities with PIRIS participants. Specific data reflecting these activities include: demographics; assessments administered; monthly service plans; critical events (both positive and negative) during a participant's tenure in the program; types of assistance provided; group service activities; date, type and duration of Case Managers' contacts with participants, family members, and/or collaterals (i.e. participant's doctor, probation officer etc.); outcomes related to participants' health, education, vocational, and emotional status; and reason for discharge from the program. PHMC programming staff members are constantly creating reports to look at the case management data in different ways. These reports are critical to the evaluation process because they enable staff members to identify program progress and/or areas that require additional scrutiny or improvement.

The three trauma centers upload data for the Pennsylvania Trauma Outcomes Study to maintain their trauma center accreditation. Minor changes were made to the software for the purposes of PIRIS with no impact to non-participating trauma centers and minor impact to the front-end users.

19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address, telephone number and e-mail address.

Yes. Calvin B. Johnson, M.D., M.P.H., Secretary, Pennsylvania Department of Health, Health and Welfare Building, 7th & Forster Streets, Harrisburg, PA 17120, 717-787-6436, calvjohnso@state.pa.us

20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ? No

21. Has the program been fully implemented? If NO, what actions remain to be taken?

No. Based upon pilot findings, system will be expanded to other jurisdictions based upon the incidence of firearm-related hospitalizations among the targeted population and the availability of additional funding.

22. Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.

The program is designed to have an impact on violence and its repercussions at the individual, family, community and systems levels. For example, at the individual level, recovering from a gunshot wound involves much more than physical healing. Case management to help reduce repercussions for young gunshot wound patients since exposure to trauma can have both an immediate impact on health and daily activities and long term impact on healthy physical, emotional, social and economic development. At the family level, this program can help preserve household stability for fragile families, where caregivers may face a loss of productivity. Communication and parenting support can help reduce adverse affects on siblings or the children of injured youth. On a systems' level, the program's longer-term follow-up and feedback to healthcare providers has fostered a broader wellness perspective and expands focus beyond wound healing. PIRIS also has provided trauma centers with a way to contribute to their community's health through an outreach and prevention program.

The program began identifying and referring patients in April 2006. As of February 29, 2008, 226 gunshot victims have been referred to the PIRIS Intervention (94.7% Black, 4.9% Hispanic; 92.5% male, ages 15 to 25). Case managers indicated that about 70% of the youth were relatively easy to engage in the program. These youth tended to be younger, have stable living situations and relationships, had identified and were working toward goals before they were shot, were victims of random shootings, and had the more severe medical outcomes. Case managers worked with youth to identify problems and needs. The most common needs identified by youth early in their involvement in the program were accessing medical insurance and transportation. Out of 1,035 needs identified among 142 participants with a needs assessment, 26.6% were health related, 15.9% were education related, 13.4% were employment related, 7.9% were legal related, 3.6% were mental health related, and 8.3% housing related. Case managers had the most difficulty linking participants to behavioral health services primarily because of insurance issues.

Although less than two years old, some of the outcomes of the assistance provided to the individuals and families resulted in 98 victims that received financial assistance (Victims Compensation, SSI, DPA); 112 secured health insurance; 28 secured or returned to employment; 28 enrolled in education programs; seven earned their GED or high school diploma; six secured housing or were relocated to a safe environment; and five completed their probation or parole.

23. How has the program grown and/or changed since its inception?

Regular review and feedback on program coordination and operations has helped the data collection and referral process fit into each different institution, while also improving accuracy, consistency and comparability across the entire system. This interactive and iterative review process has resulted in improved data collection forms and expanded eligibility criteria. Triangulation between the PIRIS data and other data sets, such as the Philadelphia Weapons Related Injury Surveillance System has been useful in assessing and improving referral rates.

23. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

In relation to patient recruitment and flow, each trauma center has inherent organizational differences but the social workers and/or trauma outreach coordinators are notified of all gunshot wound victims. Enrollment location may differ because of inherent differences in trauma center setup; however, sites have been utilizing their resources to catch patients that are transferred from the trauma unit to other services. After lengthy testing of the referral process for full needs assessment, trauma centers are now using the same form for referrals. Given organizational differences, patient recruitment and flow have been fairly successful.

In implementing PIRIS in the City of Philadelphia, the Department recognizes that there are some challenges in expanding PIRIS to other locations with significantly high rates of firearm-related injuries. Community resources may vary significantly and access to multi-system interventions may be limited in other locations. Given that reality, other states may also find the variance a challenge in system development.