Table of Contents

Introduction 3

The Epidemic of Violence 3

State of Violence in San Francisco 3

Addressing the Epidemic of Violence 3

Theory and Concepts 5

Theory Base 5

Conceptual Definitions 7

Staff Roles and Responsibilities 10

Case managers 10

Weekly lead case manager 11

City Hall representative 12

Monthly NNHVIP call representative 13

WIMP Facilitator 13

Director/Principal Investigator 14

Injury Prevention Coordinator 15

Research Staff 15

Hospital Leadership 16

Weekly Schedule 17

Identifying and Enrolling Clients 18

Client Follow-Up/Intensive Case Management 21

Meetings 22

Crisis Response Plan/Protocol: multiple casualties or high risk case 22

Client Referrals to External Resources/Services 23

Development, Implementation, and Referrals to In-House Programs 25

Closing a Case 26

Trainings, seminars, and conferences 27

Data Entry 29

Safety in the community 31

# Introduction

## The Epidemic of Violence

Interpersonal violent injury is pervasive in the United States and trauma centers stand on the front lines of the epidemic. Homicide is the second leading cause of death in people 15-24 years of age and the third leading cause of death in people 25-34 years of age. Fatalities from assault represent the tip of the iceberg: non-fatal injuries are believed to outnumber fatal injuries on the order of *100 to one*. As a result of the tremendous societal effects of violent injury, violence prevention is considered a fundamental goal of “Healthy People 2020.”

## State of Violence in San Francisco

San Francisco has not escaped the toll of interpersonal violence. In 2013, 477 people were killed or severely injured due to violence in San Francisco. Major findings from San Francisco’s Violent Injury Surveillance System indicate that non-fatal violent injury is highest among youth and young adults, primarily involving assaults that result in hospitalization. Over 80% of patients at SFGH presenting for violence-related injuries are from minority populations. Homicide is the number one cause of death in African Americans aged 10-24 years old and numbers two among Hispanics. African Americans make up about 6% of the population in San Francisco but represent 60% of the gun violence victims.

Though the homicide rate in San Francisco is slowly declining, gunshot wounds remain the leading cause of traumatic death at SFGH. For those who do survive their violent injury, approximately *8%* of assault victims are reinjured from another assault badly enough to require hospitalization. In addition to the impact these injuries have on individual and their communities, healthcare charges to assault victims exceeded $23 million dollars, with more than 60% of these charges covered by public funds.

## Addressing the Epidemic of Violence

Wraparound works with individuals who have sustained a violence-related injury, and their families, with the goal of prevention a re-injury, taking a “wraparound” approach to address multiple risk factors for violent injury.

* 1. *Goal*

a. The overall goal of Wraparound is to reduce interpersonal violent injury in San Francisco by providing comprehensive risk reduction services.

* 1. *Purpose*
     + - 1. Institute a model for sustained partnership between SFGH and affected communities in order to provide a complete approach to the care of violently injured individuals.
         2. Provide a “reentry” program for violently injured individuals in a manner similar to the criminal justice system.
  2. *Aims*
     + - 1. Develop a new paradigm for a Trauma System’s care of interpersonal violent injury victims to minimize risk of future injury, or recidivism.
         2. Institute culturally sensitive case management from the affected communities during the acute care to facilitate improved Health Communication.
         3. Decrease activities associated with violent injury by linking acute care to community and municipal risk reduction resources.
         4. Increase activities that act as protective factors again injury and incarceration.
         5. Adapt public health evaluation measures historically applied to unintentional injury and substance abuse to a violence prevention protocol.
         6. Decrease modifiable risk factors, evaluated as intermediate indicators associated with interpersonal violent injury, using Comprehensive Rehabilitation with culturally sensitive Case Management and links to resources.

1. Method

There are three foundational components of Wraparound that outline the phases of our program:

1. Providing culturally competent case management, beginning at the bedside, allowing the process to begin during the “teachable moment”. Cultural competency can lead to vast improvements in health communication and reduce health care disparities.
2. Shepherding clients through risk reduction resources in the community through strong ties to city and community based organizations that offer these services.
3. Long-term intensive case management. Evaluation of these individual programs has been conducted demonstrating significant promise of these principles.

The common guiding principles of Wraparound include the public health model of violence prevention, an appreciation for the social indicators of health, and trauma informed care.

# Theory and Concepts

## Theory Base

### Social Ecological Model (from the CDC)

1. *History and Orientation*

The socio-ecological model considers the interplay between individual, relationship, community, and societal factors. It allows us to understand the range of factors that put people at risk for violence or protect them from experiencing or perpetrating violence. Factors at one level influence factors at another level. The model suggests that it is necessary to act across multiple levels of the model at the same time.

1. *Core Components*
   * + 1. Individual: The first level identifies biological and personal factors, such as age, education, income, substance use, or history of abuse. Prevention strategies at this level are often designed to promote attitudes, beliefs, and behaviors that ultimately prevent violence. Specific approaches may include education and life skills training.
       2. Relationships: The second level examines close relationships, such as a person's closest peers, partners and family member’s behaviors that contribute to their range of experience. Prevention strategies at this level may include parenting or family-focused prevention programs, and mentoring and peer programs designed to reduce conflict, foster problem-solving skills, and promote healthy relationships.
       3. Community: The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings. Prevention strategies at this level typically address the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighborhoods, as well as the climate, processes, and policies within school or workplace settings.
       4. **Societal: The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.
2. *Conceptual Model*

### Health Belief Model

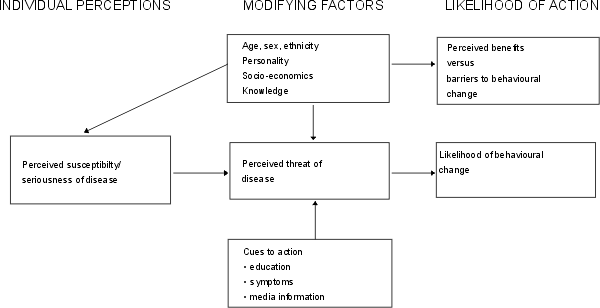
1. History and Orientation

* The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS.

1. Core Components

* The HBM is based on the understanding that a person will take a health-related action (i.e., use condoms) if that person:
  + - * 1. Feels that a negative health condition (i.e., HIV) can be avoided
        2. Has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., using condoms will be effective at preventing HIV), and
        3. Believes that he/she can successfully take a recommended health action (i.e., he/she can use condoms comfortably and with confidence).
        4. The HBM was spelled out in terms of four constructs representing the perceived threat and benefits: perceived *susceptibility,* perceived *severity,* perceived *benefits,* and perceived *barriers.* These concepts were proposed as accounting for people's "readiness to act." An added concept, *cues to action,* would activate that readiness and stimulate overt behavior. A recent addition to the HBM is the concept of *self-efficacy,* or one's confidence in the ability to successfully perform an action. This concept was added to help the HBM better fit the challenges of changing habitual unhealthy behaviors, such as being sedentary, smoking, or overeating.

1. Conceptual Model



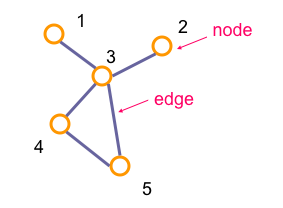
### Social Network Theory

1. History and Orientation

Social network theory views social relationships in terms of nodes and ties. Nodes are the individual actors within the networks, and ties are the relationships between the actors. There can be many kinds of ties between the nodes. In its most simple form, a social network is a map of all of the relevant ties between the nodes being studied. The network can also be used to determine the social capital of individual actors. These concepts are often displayed in a social network diagram, where nodes are the points and ties are the lines.

1. Core Components

Traditional sociological studies assume that it is the attributes of individual actors -- whether they are friendly or unfriendly, smart or dumb, etc. -- that matter. Social network theory produces an alternate view, where the attributes of individuals are less important than their relationships and ties with other actors within the network. This approach has turned out to be useful for explaining many real-world phenomena, but leaves less room for individuals to influence their success; so much rests within the structure of their network.

1. Conceptual Model

### The Public Health Approach to Violence Prevention

1. Core Components

* The complexity of an issue like violence mandates a comprehensive approach for solutions. There are four key components to the public health model:

|  |
| --- |
| * + - * Defining the problem       * Identification of potential causes       * Designing, developing and evaluating intervention strategies       * Exportation of a successful program |

* + - * The following general risk factors that contribute to violent behavior and injury include:

|  |  |
| --- | --- |
| * + - * Substance abuse       * Injury recidivism       * Physical aggression/school fights       * Low socioeconomic status/poverty | * + - * Ties to antisocial peers or gangs       * Antisocial parents       * Involvement in criminal acts       * Poor education |

* + - * Risk factors rarely occur in isolation. The more risk factors present, the greater the likelihood of involvement in violence. Individuals exposed to the risks also do not live in isolation. For this reason, it is critical that any attempt at violence prevention should target at-risk individuals by reaching into the greater community in which they reside in order to appropriately address the cadre of contributing environmental factors.

## Conceptual Definitions

1. Teachable Moment

* For the violently injured individual at great risk for injury and criminal recidivism, interventions targeting risk factors immediately after injury and continuing upon discharge would amount to a much more comprehensive approach than is currently the standard of care and practice at trauma centers. The “teachable moment” that has been identified after other life-threatening events such as a heart attack, provides a unique opportunity to influence behavioral changes to reduce future risk. Acute care trauma centers today can seize this same window of opportunity for individuals injured from violence.

1. Health Communication

Health Communication is defined as “the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues”. Dr. Stephen Thomas of the Center for Minority Health at the University of Pittsburg points out that there is “credible evidence suggesting that cultural norms within Western societies contribute to lifestyles and behaviors associated with risk factors for chronic diseases.” He goes on to say that “group identity” acts as a powerful filter for receiving information. Application of these principles to violent injury, which can be regarded a societal chronic disease, is not traditionally implemented in Trauma Centers.

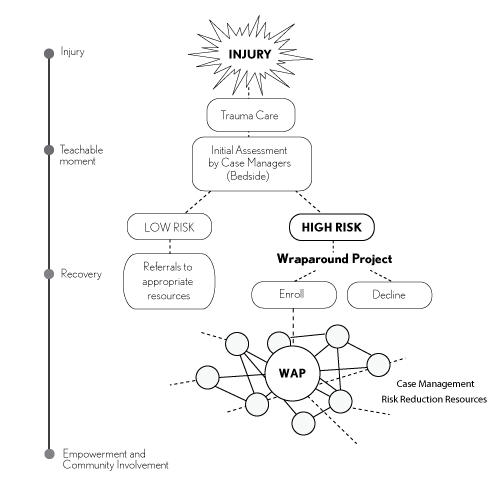
1. Self-efficacy

* Perceived self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave.
* A strong sense of efficacy enhances human accomplishment and personal well being in many ways. People with high assurance in their capabilities approach difficult tasks as challenges to be mastered rather than as threats to be avoided. Such an efficacious outlook fosters intrinsic interest and deep engrossment in activities. They set challenging goals and maintain strong commitment to them. They heighten and sustain their efforts in the face of failure, quickly recovering their sense of efficacy after failures or setbacks. They attribute failure to insufficient effort or deficient knowledge and skills, which are acquirable. They approach threatening situations with assurance that they can exercise control over them. Such an efficacious outlook produces personal accomplishments, reduces stress and lowers vulnerability to depression.
* In contrast, people who doubt their capabilities shy away from difficult tasks that they view as personal threats. They have low aspirations and weak commitment to the goals they choose to pursue. When faced with difficult tasks, they dwell on their personal deficiencies, on the obstacles they will encounter, and all kinds of adverse outcomes rather than concentrate on how to perform successfully. They slacken their efforts and give up quickly in the face of difficulties. They are slow to recover their sense of efficacy following failure or setbacks. Because they view insufficient performance as deficient aptitude it does not require much failure for them to lose faith in their capabilities. They fall easy victim to stress and depression.

1. Social support

* Social support refers to the various types of support (i.e., assistance/help) that people receive from others and is generally classified into three major categories: emotional, instrumental, and informational) support.
* Emotional support refers to the things that people do that make us feel loved and cared for, that bolster our sense of self-worth (e.g., talking over a problem, providing encouragement/positive feedback); such support frequently takes the form of non-tangible types of assistance. Case managers provide this support directly, and may work to foster emotional support for clients in their families, peers, and school or work settings.
* Instrumental support refers to the various types of tangible help that others may provide (e.g., help with childcare/housekeeping, provision of transportation or money). Wraparound provides this type of support in the form of transportation vouchers, gift cars, and workshops or seminars. Job placement and educational support also falls under this category.
* Informational support represents a third type of social support (one that is sometimes included within the instrumental support category) and refers to the help that others may offer through the provision of information.

Wraparound Program Model



# Staff Roles and Responsibilities

## Case managers

*Required Training:*

CITI (NIH training)   
Trauma Informed Care  
Therapeutic Communication

Violence Peer Counsellor Training

*Primary responsibilities:*

**Engage in a teachable moment:** Identify clients from the ED log and approach the client and/or their family prior to discharge. If a client could not be reached before discharge, case managers should make 3 attempts to reach the client by phone.

**Establish client’s commitment to services:** Provide Release of Confidentiality form, HIPAA, Patient’s Rights, and **current** consent forms to the client before providing services (see appendix). The consent form is not needed if the client doesn’t want to participate in research. Ensure consent to participate in Research or Program is noted in QuesGen.

**Needs Assessment:** Conduct an initial needs assessment **within one month of initial contact** with the client. Needs assessment should be revisited at 3 months and 6 months to keep track of client needs as their situation changes. There are example assessment forms in the appendix. All identified needs must be documented and tracked in QuesGen.

**Provide intensive case management:** Be available for their clients during work hours, and for crisis management. Maintain a low to moderate caseload (15-18 clients) to allow sufficient time with each client. Case managers are given autonomy in intake, assessment, care planning, and implementation, with ultimate delegation at the discretion of the Supervising case manager. Case managers should ensure they are communicative of their management plan with the Wraparound team.

**Provide culturally competent case management:** Plan care of the client according to individual need. When assigning cases, consider language and culture as making a meaningful connection with the client is a driving factor of success. Initial management plans must be vetted in the case management meetings.

**Provide direct connections to community resources:** Ensure that clients are sent to a CBO that is appropriate, reliable, and accountable. Hold clients accountable for their participation in programs with CBOs. Case managers are to maintain communication with CBOs. In the case of a breakdown in the relationship between a CBO and a client, case managers are to assess the reason for the breakdown and address it appropriately.

**Collect data for program evaluation and performance improvement:** Maintain an accurate and up-to-date database for program evaluation. Data entry will be assessed quarterly and a report provided to each case manager, case managers are expected to fill in all data fields. See the data entry section for details.

**Foster relationships with community partners**: continually work to expand the network of services for clients by building strong relationships with CBOs and government agencies. All team members must be aware of new community resources.

**In-house resources:** Case managers are to provide direct connections to available in-house resources. Case managers are to ensure that all clients have equal access to in-house resources.

**Professionalism:** Case managers are to comport themselves in a manner conforming with Wraparound and UCSF’s code of conduct (See appendix). Case managers are to document vacation and sick time in the Time keeping system and the Wraparound calendar, and assign their clients to other case managers for the time period that they will be away.

## Weekly lead case manager

To streamline the process of client identification and enrollment and reduce duplication of services or efforts, one case manager takes a lead role from Wednesday to Wednesday. The responsibilities of the lead CM can be summarized as: **screen, assess, enter information into screening page of Quesgen, disseminate information.**

**Review the trauma registry report** (via e-mail) daily to identify cases that presented to the emergency department. On Mondays, the lead case manager reviews the registry report for cases that presented over the weekend.

**Review the ED logbook** daily to identify cases that presented to the emergency department but may not have been captured by the registry report. On Mondays, the lead case manager reviews the ED logbook for cases that presented over the weekend.

* 1. Cross-reference trauma registry report with ED log
  2. Investigate names/MRNs through LCR, the electronic medical record system
     1. Research patients to determine their eligibility (e.g. is it actually a violence related injury? Is it self-inflicted?).
  3. Review the Charlie Morimoto report as necessary for additional relevant information.

**Enter ALL screens into QuesGen** after researching patients and note their eligibility status.

Lead case manager is to ensure referrals are made as appropriate and documented in Quesgen.

**Go to the bedside to make initial contact** throughout the week for new / potential clients and conduct an assessment

* 1. Assessment informs seriousness of case and which case manager is most appropriate. Lead case manager may also provide urgently needed services during initial contact.

**Inform Supervising case manager of new cases** daily. After initial contact and assessment, the lead case manager is to notify the supervising case manager of all new cases on a daily basis. Based on this assessment, a point person will be appointed by the supervising case manager to follow up with the patient. This point person provides services or referrals as needed until the client is discussed at the Monday/Tuesday meeting and the patient is either referred to an appropriate CBO or assigned to a case manager.

**Disseminate information** gathered through the assessment in Monday’s meeting with CRT and DPH. Based on this information, decisions will be made as to which patients Wraparound will take lead on and offer intensive case management.

**Touches base with** the social workers and nurses to inform them if screened clients will be offered Wraparound services.

**Report out a** census for the week’s clients, and highlights and lowlights at the weekly Wednesday staff meeting.

**Keep all CMs informed** so that services and support can continue even if a case manager leaves or is unavailable.

1. Keep track of all referrals, initial assessments, etc. in the QuesGen database.

## City Hall representative

One case manager represents Wraparound at the weekly City Hall street violence reduction team meeting. This is a mandatory meeting for Wraparound. The meeting is **Wednesday at 9:30am**.

**Prepare the Point of Entry form** and be up-to-date on any pertinent issues or topics.

**Review current cases**, specifically those that are noted in the agenda.

* 1. E-mail from city hall/mayor’s assistant will contain names (initials) of clients to be talked about.

**Obtain relevant information from community partners** and other case managers at the Monday community partners meeting and the Tuesday case management meeting.

a. Note the confidentiality clause—Only report information included on the form – initials, point of contact, case manager assigned or not assigned, or referred to external organization/any referrals out

**Make note of new information from the meeting:** anything new that was previously unknown about the client or situation, who to follow-up with (e.g. probation, school district, etc.), any gang affiliation, etc.

a. Identify potential resources and what services clients need, and if they have a case manager from any other organization.

**Inform case managers** of any pertinent information about their assigned clients. City hall representative will write out relevant information in the Point of Entry form, this form will then be given to the client’s assigned case manager.

**Follow up with stakeholders** regarding the client. Make sure to copy assigned case manager and other case managers as necessary.

## Monthly NNHVIP call representative

One case manager participates in the NNHVIP monthly Frontline Working group phone call. The call is on the **second Thursday of the month at 9am** and lasts up to one hour.

**Review the agenda for the call and the minutes from the last meeting** and be up-to-date on any pertinent issues or topics (funding issues, trends, etc.).

**Have a back-up case manager** notified at least one day prior in case of a conflict (e.g. court date).

**Participate in the call for 3 months at a time**

**Report out pertinent information and a summary** of the call at the weekly staff meeting.

## WIMP Facilitator

One case manager facilitates the WIMP program on the **third Thursday of the month from 4-6pm**. The WIMP supervisor is the contact person for WIMP referrals, however, other case managers may participate.

**Confirm Wraparound client and ICU nurse speakers** at least one day prior to the program. Note that all potential speakers must be vetted by the WIMP supervisor.

**Retrieve referral forms** from WIMP supervisor the morning of the program (see appendix).

**Prepare WIMP program packets** for each participant (referral form, paper for brief essay, 10-question survey, and program completion certificate).

**Meet participants** **and guest speakers in** Building 1 on the ground floor and escort them to the third floor of Building 1.

**Facilitate the program**. Begin by discussing relevant facts about violence in San Francisco and the impact it has on individuals and communities.

1. There is an existing PowerPoint presentation which facilitators are welcome to use.
2. The facilitator may choose to tell a personal story, or remain objective. It is not necessary to disclose anything that the facilitator does not wish to share.

**Introduce the Wraparound Client.** Participants will hear the stories of one or more former Wraparound clients who have successfully completed the program and are emotionally ready to share their story.

**Escort the group to the Intensive Care Unit.** Participants may speak with nurses or other healthcare providers about the sequence of recovery after a traumatic injury.

**Provide an essay prompt** for participants to write about the experience.

1. Participants should reflect on the experience, what they heard and saw, and what impact it made on how they feel about weapons and/or violence (for example, has their attitude changed? Did they learn something new?).
2. This is required for all court ordered youth, and will be sent to their probation officer.
3. There is also a brief 10-question survey. This is required, and may be provided to participants at any point in the program if the facilitator thinks that it will help foster discussion or insight.

## Director/Principal Investigator

**Provide daily oversight of WA**: Assessing program needs, staffing, staff-client alignment and ratios, and quality improvement activities.

**Oversee reporting mechanisms** of the program, developing long- and short term goals with the prevention coordinator, and identifying how to measure processes and outcomes.

**Providing supervision and direction** for the expansion and growth of the program, including communication with potential funders and stakeholders.

**Overseeing program evaluation and research activities** The Director will supervise all evaluation projects in the center, including overseeing evaluation design and implementation. The Director will also serve as Principal Investigator for all research projects in the center, ensuring that research is done in line with the IRB’s ethical directives and that scientifically sound manuscripts are published.

**Coordinating performance evaluations** The Director will oversee yearly 360° evaluations during which each staff member will be evaluated by all other members of the center.

**Finalize and review** all reports, publications, and other promotional materials.

**Meet with Supervising Case Manager** monthly to troubleshoot center activities.

**Develop collaborative relationships** by assisting in the development of critical partnerships in the City, regional and state-wide with violence prevention and risk reductions agencies at meetings and conferences, and networking with key personnel.

**Engage in advocacy efforts** **and long-term policy opportunities** for the development of sustainable violence prevention programs in trauma centers.

**Participate in critical meetings and presentations** with our internal and external partners and hospital personnel.

**Oversee grant opportunities** to maintain financial resources for the program. In conjunction with research staff, seek and review government and private funding opportunities.

**Provide liaison services to the Hospital administration** and other key internal physicians and personnel.

**Staff development**

**Oversee human resource issues** The Director is responsible for hiring and firing staff in the center and oversees other human resource issues such as approving vacation days.

## Injury Prevention Coordinator

*Required Training:*

*Basic to Intermediate Data Analysis*

*CITI training*

## Research Staff

*Required Training:*

Basic to Intermediate Data Analysis

CITI training

*Primary Responsibilities:*

**Maintain and report on database**: Verify and clean database on a quarterly basis. Generate individual and system-wide reports. Maintain confidentiality of the database. Attend courses on database functions. Assist with data needs for grant activities.

**Coordinates the research components of the program:** Responsible for all IRB related duties, new submissions, renewals, modifications, and additional documents. Ensure that staff are appropriately conducting the research components of the program (informed consent, HIPAA, and confidentiality). Conduct audits. Prepare materials for conferences and manuscripts.

**Coordinate evaluation and cost-analysis:** Continually refine evaluative component of the program. Develop evaluative and auditing tools. Attuned with associated costs of the program: staffing, services, and ROI. Ability to analyze, report on, and refine costs component.

**Funding and grant opportunities:** Routinely seek additional funding opportunities to maintain financial resources for programs, staffing, and clients. Assists with the application process. Work with contracts management staff to maintain accurate budgets. Maintain grant paperwork according to UCSF and federal standards during application and disbursement.

**Program Management:**  Coordinate of in-house programs. Schedule meetings with partners and internal staff. Create and update comprehensive list of community resources. Facilitate weekly staff meetings, and keeps and distributes minutes. Develop and update program manual and policies. Train and supervise volunteer staff and interns.

## Hospital Leadership

Wraparound engages with hospital leadership to ensure support from SFGH administration, and to collaborate with SFGH staff who are healthcare providers for Wraparound clients.

1. Ensure hospital staff maintain current knowledge of the Program.
2. Ensure hospital staff are Able to discuss Program structure and mission to internal and external stakeholders, including City, regional and state-wide organizations.
3. Ensure Wraparound staff are aware of hospital policies and programs. Attend relevant meetings in the following departments: ED, Trauma, Social Work, and Pediatrics.
4. Ensure hospital staff know Wraparound inclusion/exclusion criteria and services.
5. Conflict resolution and interfering with other CBOs

Hospital staff may include:

CEO and Hospital based Dean

Trauma Program: Physician and Nursing Leadership

Emergency Department: Physician and Nursing Leadership

Social Worker Department: Leadership

# Weekly Schedule

**Monday**

1:00pm Community Partner’s Meeting with Bethany from CRT and James from SVIP. Review relevant clients, delegate responsibilities for patients who are not eligible for Wraparound

**Tuesday**

2:00pm Case Managers meet to discuss case loads, new clients, and client assignment

**Wednesday**

9:00am City Hall/Violence Intervention Task Force meeting.

2:00pm Wraparound weekly staff meeting

**Thursday**

4:00pm every third Thursday: WIMP program

# Identifying and Enrolling Clients

### Identify Clients through Hospital Records

1. Identify potential clients through the Emergency Department log book
   1. Weekly lead case manager will review the entries in the ED log book from the previous day and write down ALL individuals who presented due to a GSW, SW, Laceration, or Assault (blunt trauma)
      1. Include patients of all ages at this point
      2. Include Full Name, MRN, date of injury, mechanism, gender, and age
2. Look up ED patients in LCR
   1. Log into LCR and enter the patients MRN to find their electronic medical records
      1. If the MRN does not work, use their name, age, and gender
      2. Confirm eligibility: GSW/SW/Assault, not self-inflicted, not sexual assault, domestic violence or child abuse, not currently incarcerated/in custody, not unintentional (e.g. dropped knife on foot), age 10-30, lives or injured in San Francisco/San Mateo counties.
3. Enter ALL patients from the ED log book into QuesGen under “Screen”
   * 1. Mark those who do not meet eligibility as “Ineligible”
4. Cross-referencing ED log book with Trauma Registry daily report
   1. Each morning, all staff receive a Daily Trauma Log from the trauma registry in their e-mail.
      1. Weekly lead case manager reviews the trauma log and cross-reference with names from the ED logbook to verify no patients were missed.
      2. Look up any additional patients in LCR and add them to QuesGen in the Screen section.

### Identifying Clients During ED Walk-throughs

* + - 1. Case managers are to perform daily walk-throughs of the Emergency Department to identify patients who may have walked up to the ED but were perhaps not entered into the log book or LCR.

### Identifying Clients through Referrals

* + - 1. Referrals are accepted for eligible individuals who can access services in San Francisco and have a violence-related injury but were treated at a different hospital or were recently released from police custody.
      2. Enter client data into a screen form in the same manner as client identified through the ED log or trauma registry reports.
      3. Enter contact information for referring organization and the hospital at which they were treated.
      4. Look up the client by name and date of birth in LCR to obtain any relevant patient care history (e.g. prior violence-related injuries).

### Initial client contact

1. The weekly lead case manager will make initial contact unless specifically delegated to another case manager.

1. Lead case manager will assign clients to the appropriate case manager.
   * 1. This is to prevent overlap, and to make sure every potential client is met by a case manager.
   1. Verify that client is in appropriate physical/mental condition to meet.
      1. If client is not able to meet, meet with the client’s family, if they are available and such contact is appropriate.
   2. Initial contact should inform potential client/their family about WA services.
      1. Provide WA brochure or other descriptive handout.
      2. Provide contact information.
      3. If client is ready, provide the Patients Rights, HIPAA, and consent form.
2. If client is discharged from the hospital prior to initial contact, case managers are to make 3 attempts by phone to establish contact.

### Client assignment to case manager

* + - 1. The weekly lead case manager notifies the supervising case manager of all new patients on a daily basis and gives an account of the initial assessments. Based on this, the supervising case manager will assign a point person to provide services pending either referral to an appropriate CBO or assignment of a case manager at the case conferencing meeting.
      2. Case managers decide collectively on Monday which of the potential clients will be WA clients.

1. Non-eligible client will be identified and referred to another organization (e.g. TRC, CRT, Youth Alive), if appropriate.
   1. Discuss ineligible clients at the Monday meeting with CRT and SVIP.
2. Considerations for case manager assignment include: Language, gender, cultural fit, caseload.
   * + 1. Wraparound caseload and capacity.
3. Case managers should have no more than 15-18 clients, depending on intensity.

### Enrolling clients

* + - 1. Before enrollment clients MUST receive/sign the following documents:

1. HIPAA explanation
2. Patient’s Rights
3. Consent form—this MUST be signed prior to enrollment if client data is to be used for WA-related research.
4. If client does not wish to participate in research, this MUST be documented on QuesGen.
5. If eligible, meet with case managers to delegate

Eligibility criteria: Aged 10-35, not self-inflicted, can access services in SF, not domestic violence related, not in psychotic state, screened high risk for re-injury.

1. If ineligible, address as following:

If older than 35: refer to case manager for individuals over 35 years old.

If self-inflicted: refer to appropriate community based organization

If not an SF resident: refer to appropriate resource in patient’s location

If domestic violence related: refer to appropriate resource

If in psychotic state: refer to appropriate resource

If screened low risk: assist with VOC and refer to DPH/CRT as appropriate.

* + - 1. After securing the above documents, find the clients name in the “Screen” section, assign a case manager, and mark as “Accepted.”

1. DO NOT manually create a new patient entry in the “Intake” section—this will result in duplication.

# Client Follow-Up/Intensive Case Management

Case managers are given autonomy in their case management style, however certain procedures are required.

1. First 30 days-Getting to know the client and building trust
   1. Complete intake form within one week of client enrolling in Wraparound.
      1. Client **must have** received and signed the HIPAA, Patient’s Rights, and Consent forms.
      2. Complete Intake includes ALL contact information, demographic information, socio-economic status information, and any other relevant information (mental health diagnosis, substance abuse, etc.) at the time of injury.
   2. Complete an initial needs assessment within one month and enter identified needs on QuesGen.
      1. Needs entered into QuesGen should have clear outcomes, though they may contain intermediate goals. For example, if “Education Need” is selected, this may specifically mean obtaining a GED. The clear outcome should be written in the notes section of the needs form. An intermediate goal is to enroll in a GED class, meet with a school counselor, etc. Ideally the need should only be marked as “Met” when the need has been met (e.g when the client has obtained a GED), but if the need can only be achieved after a long process, it can be marked as “Met” when the client has successfully participated in the necessary process for 30 days (e.g after 30 days of classes).
      2. The needs assessment should be updated throughout the period of case management as needed. Be sure to mark the date that the need was identified on the needs form.
   3. Develop an action plan
      1. Use the assessment table to document activities (check-ins, services, etc.).
      2. Refer to community partners for services needed but not provided in-house.
   4. Level of contact with a client may vary depending on the intensity of the case. However, all clients must be contacted at least once a month.
      1. Focus on building trust with the client before diving into services.
   5. All notes regarding client meetings or services must be entered within one week of contact.
2. 60 days
   1. Re-evaluate client needs and document any changes or newly identified needs.
   2. Follow up on resources provided and evaluate client progress.
3. 90 days and beyond
   1. Continue to be in touch with clients as needed (but at least once a month).
   2. Follow-up on client’s enrollment in any programs, progress in school, etc.
   3. Check in with community partners about client’s activity in the community.
   4. Make contact with probation officer, school system, employer, etc.
      1. Provide letters of support for the client and act as a advocate for their needs as they begin to transition back into their life.

# Meetings

* + - 1. Community Team Building: Case review with SVIP and CRT

1. Collectively gather information from our community partners (including, CRT, SVIP and Charlie Morimoto report) at our regular Monday meeting
2. Review information and strategize potential services for client(s)
3. Make referrals to CRT or SVIP as needed. Ensure these referrals are documented in Quesgen
   * + 1. Case Management Meeting
4. Each case manager prepares 1-2 of their highest risk clients to discuss at the meeting. Case manager to inform the team of: name, age, gender, needs/challenges, work done so far, timeline for action plan
5. The supervising case manager distributes new clients.
6. Collectively review all clients discussed: trauma situation, family dynamics and relevant community resources
7. Discuss closing out clients
8. Announcements, resources and community concerns
   * + 1. Staff Meeting
9. Discuss new announcements concerning the program
10. Give updates on mentor programs
11. Give updates on partner programs
12. Discuss research projects
13. Give a weekly census of traumas that came through the hospital, a report of the case management and city hall meeting.

# Crisis Response Plan/Protocol: multiple casualties or high risk case

**Crisis response is not the duty of the Wraparound Project. Wraparound case managers will only participate in crisis response during work hours and as their primary duties permit.**

1. Gathering information.
2. The first case manager on site will obtain information on the situation from ED social workers, trauma team and other relevant groups. Assess if situation is critical, if so involve CRT, SVIP and hospital security.
3. Meet with other available WA team members and share this information.
4. Discuss managing family/crowds at hospital
   * + - 1. Case manager on site will delegate what tasks will be managed by Wraparound staff, and what other CBOs will address. For example, know who is working with the client directly, their family, other community members, etc.
5. Discuss coordination with hospital staff, including nurses and social workers.
   * + - 1. Make sure hospital staff knows what to expect from WA case managers and delegate tasks to avoid overlap or miscommunication.
         2. Let hospital staff know who to allow, or not allow, to speak with patients or family members.
6. Collectively find resources, key person(s) to help with dialog with client(s), family and community.
7. Debrief

When the incident has been resolved or is otherwise stable, discuss the events with other staff members. Seek self-care from TRC or other entity as needed.

# Client Referrals to External Resources/Services

The following section outlines the protocol for referring clients to programs, resources and services offered through Community-based Organizations, government agencies, or local businesses.

1. For patient who are INELIGIBLE for Wraparound:
   1. Identify the reason for ineligibility (age, self-inflicted, domestic violence or child abuse, living outside of SF or San Mateo counties.)
   2. Contact the appropriate organization for referral services:
      1. TRC for domestic violence or child abuse
      2. Psychiatry department for self-inflicted injury
      3. CRT for over 35 years old with severe psychiatric or substance use disorder
      4. Other VIP in place of residence if unable to access services in SF.
2. For clients who ONLY need a victim of crime referral:
   1. Enter client in the Screen section of Quesgen. Do not accept as a client.
   2. Contact VOC to provide referral.
   3. If client eventually needs more services, return to the screen form and enroll as a client.
3. For ENROLLED CLIENTS who need services from outside organizations:
   1. Maintain regular contact with the client about their progress at any external programs (e.g. FUF, Project Rebound, 5 Keys Charter School)
   2. Maintain regular contact with a point-person at the organization to verify client’s participation, and to address any issues as they arise
      1. Case Managers should be proactive and reach out to the organizations, solicit feedback, and address any concerns.
   3. Note the referral in QuesGen under the Assessment table, and in the Needs table (if the referral pertains directly to a client need)
      1. For example, if the need is employment and the organization is Goodwill Industries, select Goodwill from the drop-down menu in the “referral” column of the Needs table.

# Development, Implementation, and Referrals to In-House Programs

The following section discusses and outlines expectations and protocols for developing and implementing in-house programs for WA clients.

1. Discuss the program with the entire case management team, finance manager and Program Director.
   1. Discuss the target population and expected enrollment.
   2. Identify what need the program meets.
   3. Determine the cost of the program and assess feasibility.
   4. Discuss the estimated costs of the program with finance manager to determine that it can be covered in the budget.
   5. If the program is approved, build consensus and buy-in from the Wraparound team to ensure all case managers will support the program (e.g. staying late on site, enrolling clients, etc.).
2. Draft an MOU or contract for the program
   1. Specify the timeline, expectations of the provider, expectations of Wraparound staff, and expectations for Wraparound clients.
   2. Specify costs and how the payment will be disbursed.
   3. Specify expected enrollment.
   4. Submit a curriculum and program description.
   5. Provide the finance manager with an estimate of the cost of the program and a description of how stipends and other fees will be disbursed. After discussion with the finance manager, the amount discussed is set aside in the main budget.
3. Identify clients for the program
   1. Select clients who are reliable, interested, and committed to the program.
   2. Follow-up with clients to ensure participation and consistent attendance.
4. Determine incentives for clients
   1. Stipend amounts for in-house programs must be discussed and agreed on by all case managers and approved by the supervising case manager.
   2. Note that not every program requires incentives.
   3. If incentives are used, make sure they are not overcompensating, and include any incentive costs in the budget.
   4. Money or gift cards should be given to the client at the conclusion of the program, except when it is necessary to otherwise split the stipends.
   5. Prior to disbursement, final stipend amounts must be agreed upon by case managers
5. Provide regular updates.
   1. After the first session, the facilitator should debrief with all the other case managers about the session.
   2. Identify any issues as they arise, and work collectively to address them.
   3. Work with the facilitator to adjust the curriculum, costs, or other expectations so that the program runs smoothly.
   4. Follow-up again at a mid-point, and at the conclusion of the program.
6. Debrief clients about their experiences in the program.
   1. Check-in with clients to gauge their interest, if their expectations are met, and if there are any changes that would improve their experience.
   2. At the conclusion of the program, ask clients to evaluate their experience. This will help to inform future programs.

# 

# Closing a Case

The following section discusses guidelines for closing a case.

1. The supervising case manager MUST sign off before a case is closed.
   1. Discuss the cases you plan to close at the weekly case conference meeting on Wednesdays.
2. Reasons to close a case:
   1. Majority of needs are met or client is only receiving “extended services”- returning Wraparound client receiving services such as employment or housing.
      1. Not all client needs will be met. If more that **50% of the needs are met** and the client’s **situation is stable**, the case may be closed.
   2. Case manager has lost contact with client or client is no longer responsive or interested in receiving services.
      1. Case managers should make a minimum of 3 attempts to contact a client before closing a case due to loss of contact.
      2. Wraparound is voluntary. While case managers should work to engage clients, they should not pressure them to participate.
   3. Client has moved to a new location, is incarcerated (long term), or has passed away.
      1. If a client has moved to a new location that has a VIP, contact the local VIP to notify them.
      2. If the client is incarcerated, case managers may continue to provide legal advocacy.
      3. If the client has passed away, case managers may continue to support their family, but the case should be closed.
3. Note the date and reason for closing a case in QuesGen.
   1. Provide any relevant notes (e.g. where a client moved to, how many contact attempts were made, etc.).
   2. When closing a case, make note of the following indicators:
      1. Housing status at closing
      2. Education level
      3. Employment status
      4. Incarceration/probation status

# 

# Trainings, seminars, and conferences

*Conducting Training*

1. When a VIP is interested in a training from Wraparound staff:

a. Consult with team members to find an appropriate time and date. At least 2 case managers should be available for the training.

b. Consult with the inquiring program about their needs and priorities, what topics they are specifically interested in learning about

c. Use the training manual provided by NNHVIP. All the materials are in a training binder in the Case Managers’ office, and saved on the S drive.

d. If there are topics the program would like to cover that are not in the manual, work collectively to create an effective tool to cover that topic (e.g. meeting with social work/nursing staff, case study examples and role playing, etc.)

e. Record date/time of training, and name of attendees.

f. Discuss any associated costs with the finance manager so that the finance manager can create an invoice for reimbursement.

*Seminars*

Case managers may be asked to present at seminars for doctors, students, and community groups.

1. Prepare materials in advance

a. There are existing PowerPoint presentations, fact sheets, and other materials already prepared and saved on the S drive.

b. If the existing presentations are not appropriate and you want to create a new one, discuss any information you need from the Research Coordinator at least one week in advance.

*Conference*

Wraparound staff attends the annual NNHVIP conference. Case managers may attend additional conferences if the topics are appropriate and funding is available.

1. If presenting at a conference, work collaboratively to develop the presentation.

a. Determine the topic and format of the presentation

b. Delegate roles in the presentation. Make sure each case manager has an opportunity to present, and that no single case manager takes on undue responsibilities.

c. If research data is needed, request this from the Research Coordinator at least 3 weeks prior to finalizing the presentation.

*Attending Trainings*

Wraparound case managers are encouraged to attend continuing education programs.

1. Let all case managers know about upcoming opportunities. Add trainings to the shared calendar.

2. Keep a log of all trainings attended on the S drive so that these can be added to the website or other Wraparound materials. All attendees are responsible for logging their trainings.

3. Check if there are additional requirements to receive a certificate.

4. If a training has a fee, speak with the Director and budget officer before enrolling. If the fee is approved, keep all receipts for reimbursement.

*Community Outreach*

If invited to a community event, case managers must be prepared to hand out informational literature (brochures etc)

* + - 1. All invitations must be agreed upon by the Wraparound team at the weekly staff meeting.
      2. If agreed upon, a lead case manager will be assigned for the project.
      3. A minimum of 2 Wraparound representatives must be present at the outreach.
      4. Note that we do not actively recruit clients at these events but provide awareness for our services as needed.

# Data Entry

\*\*Note that this section will be updated with screen shots after revisions are made to QuesGen\*\*

*Screen Form*

1. Enter ALL patients presenting for violence-related injuries into QuesGen (from ED log book, Trauma Registry report, or referrals)  
   🡪Go to Main Menu drop-down on the left side

🡪 Select “Screening”

🡪 Click on “New Screen” in the top right corner

🡪Enter as much patient information as possible from LCR, ED log book, or other sources (MRN, full name, mechanism, gender, age, DOB, date/time/day of injury)

🡪 Enter risk status

1. Select the appropriate screen status:
   1. Ineligible, missed, approached/declined, approached/accepted program, approached/accepted program and research
2. If patient is “missed”, all attempts to connect with the client are to be entered into the screen activity table
3. If patient in ineligible, mark “ineligible” and select the reason for ineligibility from the drop-down menu
4. If client is eligible, a New Client Intake form will be automatically created once “Accepted” is selected under “Screen Status”  
   -**DO NOT** create a new Intake form manually—it will not link with the screen form
5. In the “Comments” box enter contact information and any relevant information (e.g. patient is recovering from surgery and will be contacted next week)

*Intake Form*

1. Basic screen information will transfer automatically from the screen form.

2. Enter level of services needed (low or full)

a. Low: Client only needs assistance with paper work (e.g. VOC form), referrals to TRC, and only 1-6 hours per week  
b. Full: Client needs a range of services that require more than 6 hours per week

3. For Date enrolled: enter date that consent form was signed

4. Enter all other information not imported from the screen form

-Incarceration and probation status  
-Health insurance status  
-Prior injuries  
- documented status  
- marital, parity, education, employment status

🡪 for education status, only check the HIGHEST level of education attained.

*Need Form*

1. Only add each need once (e.g. education should not be listed twice as a need)

2. For Needs status:

a. Identified means you have determined that the client has this need, but you have not pursued services

b. In progress means that services are being pursued, but have not been completed

c. Met means that the services have been completed (e.g. finished a job readiness training, attended at least 3 sessions with a mental health provider, obtained a driver’s license)

3. “Notes” are where you can specify the goal of that need (e.g. education need, in the note you may write GED).

4.Date identified should be the date that you assessed the client. Do not put the enrollment date if this was not the date that an assessment was conducted.

5. “Referred to” provides a drop-down menu of CBOs that provide services for Wraparound clients. You may add to this list. If a service was provided through a CBO or government agency, please select them! (e.g. GED obtained through 5 Keys Charted School program)

6. Referral Note you may write the name of a contact person at the CBO, or any relevant comments (e.g. attended one class but did not complete GED).

7. Date Resolved should be the date (if applicable) that the need was met (e.g. obtained GED, received license). DO NOT put the date the case is closed.

*Bi-Weekly Assessment Form*

You may use the Assessment Form for you case notes. This form is also used for program evaluation. Please fill in an approximation of how many hours per week you spent with the client. If you fill in a note more than once per week, you only need to put the approximate hours for one of the notes, but make sure it includes the full estimate!

# Safety in the community

The physical safety of Wraparound staff is a top priority. Staff are advised to abide by the safety guidelines outlined in this manual.

Planning the home visit

* Know in advance where you are going including directions to the street, building or apartment.
* Call ahead so the family can anticipate your visit.
* Ensure visit location and anticipated duration are entered into the program calendar and fellow case managers and program manager are informed of the intent to visit.
* Learn about the family and neighborhood you plan to visit: determine safety concerns, cultural or language differences prior to visit.
* Learn about a “safe” place in case of an emergency.
* Plan visits during the day only.
* If relevant, identify appropriate community partners to accompany you on the visit.

As you go on a home visit

* Ensure your cell phone is fully charged. Pre-program emergency contact numbers into your phone (psychiatric emergency services, local law enforcement, roadside assistance, etc)
* Trust your instincts: do not conduct a home visit when you feel uncomfortable or threatened.
* Be professional in dress and manner.
* Do not carry more money than is necessary.
* Do not carry or wear flashy or expensive accessories such as expensive purses or jewelry. Keep your phone out of sight.
* Wear Identification card, and know where it is at all times.
* Stay alert to your surroundings, look and listen for any unusual circumstances.
* Walk close to the curb, away from doorways, bushes and alleys where someone could hide. Walk confidently and at a steady pace.

Potentially unsafe situations

* Conduct home visits in response to a crisis or without the SVIP team at your own discretion. Do not take risks!
* Meet in a neutral/public location if necessary.
* Make sure parents are present for underage clients.
* If too many people are present in the home, reschedule visit for a better time.
* Visit during daylight hours only.

Transportation

* Have enough gas in your car.
* Carry emergency supplies: first aid kit, latex gloves, jumper cables, flashlights, face masks.
* Park your car in a well-lit, well-travelled area.
* Park in an area you can easily leave (e.g. do not park facing a dead-end street)
* Check your surroundings before leaving your car. If you feel uneasy, do not get out of your car.
* Always lock your car doors after entering or leaving your car.
* When returning to your car, have your keys in your hand so you do not linger outside the car.
* Check the backseat before entering your car.
* If you think you are being followed, drive to a public place or a police or sheriff’s station.
* If your car breaks down, make arrangements for roadside assistance or contact your supervisor or other case managers. If someone stops to help, do not get a ride from them, instead ask them to call the police or towing service if you are unable to do so yourself.
* Do not stop to help motorists parked on the side of the road. Use your cell phone to request assistance for them.

Going into the home

* Carefully observe the outside of the house for any signs of danger, and listen for unsafe circumstances (arguing, threats, loud animals)
* Note any unusual circumstances (house appears unoccupied, strangers hanging around)
* Knock before entering and wait to be asked outside.
* Be aware of all activities in home (look out for illegal activities). Use caution when drugs or alcohol are detected. If appropriate, re-schedule the visit for another time.
* Do not enter the home if the situation seems questionable. Case managers should have an alternative plan such as postponing the visit or meeting client in another designated place.

In the home

* Remain alert to your surroundings.
* Observe the emotional state of those in the home throughout your visit.
* Observe the presence of any weapons or other dangerous items or situations.
* Remain cautious when approaching pets within the home or community as pets may be protective of their owners. It may be necessary to ask for the pet to be removed or restrained during your visit.
* Prioritize personal safety when intervening with potentially volatile situations in the home.
* If you are at risk or the situation becomes unprofessional, assess the situation and request assistance from your supervising case manager or leave immediately.
* Call 911 if there is a medical emergency. Never try to take care of the situation on your own.

Personal safety tips

* Do not park or walk in dark or lonely areas, walk quickly to well-lit or well-travelled areas.
* Do not enter an elevator with another person that makes you uneasy. If you find yourself in such a situation, get off on the next floor.
* Immediately report all suspicious persons and activities to the authorities.
* If you think you are being followed, walk or drive quickly to a public area or police station.

After the visit

* Drive a few blocks, then text the supervising case manager that you have completed your visit. (Be careful not to text and drive)
* Share information as appropriate with other team members.
* Immediately report any unusual or unsafe situations to the supervising case manager. Discuss issues of confidentiality, family relationships, and legal responsibilities.
* Develop strategies to address safety issues in advance of future visits.
* When necessary, take any required actions for abuse/neglect reporting.