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## A qualitative evaluation of the 2005–2011 National Academic Centers of Excellence in Youth Violence Prevention Program<sup>☆</sup>



Kristin M. Holland<sup>\*</sup>, Alana M. Vivolo-Kantor, Jason Dela Cruz, Greta M. Massetti, Reshma Mahendra

Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA, United States

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### ABSTRACT

The Centers for Disease Control and Prevention's Division of Violence Prevention (DVP) funded eight National Academic Centers of Excellence (ACEs) in Youth Violence Prevention from 2005 to 2010 and two Urban Partnership Academic Centers of Excellence (UPACEs) in Youth Violence Prevention from 2006 to 2011. The ACEs and UPACEs constitute DVP's 2005–2011 ACE Program. ACE Program goals include partnering with communities to promote youth violence (YV) prevention and fostering connections between research and community practice. This article describes a qualitative evaluation of the 2005–2011 ACE Program using an innovative approach for collecting and analyzing data from multiple large research centers via a web-based Information System (ACE-IS). The ACE-IS was established as an efficient mechanism to collect and document ACE research and programmatic activities. Performance indicators for the ACE Program were established in an ACE Program logic model. Data on performance indicators were collected through the ACE-IS biannually. Data assessed Centers' ability to develop, implement, and evaluate YV prevention activities. Performance indicator data demonstrate substantial progress on Centers' research in YV risk and protective factors, community partnerships, and other accomplishments. Findings provide important lessons learned, illustrate progress made by the Centers, and point to new directions for YV prevention research and programmatic efforts.

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### 1. Introduction

Youth violence is a major public health problem that results in significant negative impact on victims and communities. In 2011,

more than 4700 youth between the ages of 10 and 24 died by homicide, making homicide the third leading cause of death for this age group (Centers for Disease Control and Prevention [CDC], 2011). The negative consequences of youth violence are experienced most directly by individuals and families who may experience fear, injuries, and death caused by violence (CDC, 2011; Mercy, Butchart, Farrington, & Cerda, 2002). Yet, communities and society also experience the negative effects of violence, such as increased cost of health care, reduced productivity, diminished property values, and negative impacts on social cohesion and collective efficacy (Mercy et al., 2002; Sampson, Raudenbush, & Earls, 1997). Research in the field of youth violence has advanced our understanding of the context in which it occurs, its risk and protective factors, and its consequences. Additionally, empirical research has guided communities toward implementing promising and effective strategies to prevent violence before it starts (David-Ferdon and Simon, 2014). Partnerships between researchers and communities are essential to ensuring that the best available science informs violence prevention efforts in communities. Community–research partnerships can provide reciprocally beneficial relationships and inform researchers of

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<sup>\*</sup> Corresponding author at: Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway NE, MS F-63, Atlanta, GA 30341, United States.

E-mail address: [KHolland@cdc.gov](mailto:KHolland@cdc.gov) (K.M. Holland).

community needs while simultaneously educating community members about the value of implementing evidence-based approaches to violence prevention (Massetti and Vivolo, 2010).

CDC's Division of Violence Prevention (DVP) has funded the National Academic Centers of Excellence in Youth Violence Prevention (ACEs) Program since 2000 (now referred to as the National Centers for the Prevention of Youth Violence, YVPCs). The ACEs use a unique, multidisciplinary approach to research youth violence prevention strategies, collect and analyze surveillance data, and foster relationships with community partners to develop, implement, and evaluate prevention programs. Collaborations between universities, health departments, communities, and community-based organizations are developed to empower communities to address the problem of youth violence by building the necessary infrastructure to implement local programming.

Since the inception of the ACE Program, 16 research universities received ACE funding over three rounds of funding. In the first round (2000–2005), CDC funded ten ACEs. CDC funded eight ACEs from 2005 to 2010 and two Urban Partnership Academic Centers of Excellence in Youth Violence Prevention (UPACEs) from 2006 to 2011 in the second round. The ACEs and UPACEs together constituted DVP's 2005–2011 ACE Program. Currently, six academic institutions are receiving funding from 2010/2011 to 2015/2016 as the CDC's National Centers for the Prevention of Youth Violence. The objectives of the ACE Program have progressed with each new funding cycle, with the first and second funding cycles (2000–2005 and 2005–2011, respectively) focusing on building the infrastructure required to implement and evaluate youth violence prevention strategies, and the most recent funding cycle (2010–2016) aiming to evaluate the effectiveness of such strategies at reducing rates of youth violence in high-risk communities. Some of the goals of the ACE Program have remained constant, including the goals to serve as models for youth violence prevention; support the translation and application of research findings into communities; and enhance academic and community capacity and partnerships to prevent violence. In each round of funding, the Centers in the ACE Program have been expected to work with key stakeholders, youth, and community organizations, among others, to identify areas of need in their defined communities and projects and programs to implement to address those needs.

To more thoroughly understand how the Centers meet the goals and objectives of the ACE Program, and disseminate lessons learned to the larger youth violence prevention community, CDC tracks the ACE Program's accomplishments over time using qualitative and quantitative evaluation methods. The current report presents findings from the evaluation of the 2005–2011 ACE Program. The emphasis of the ACE Program in this round of funding was to advance research in youth violence risk and protective factors and further community-research partnerships to build community capacity to prevent violence rather than to demonstrate reductions in youth violence in the target communities. The qualitative evaluation of work completed by the 2005–2011 ACE Program grantees was conducted at the end of their funding cycle and examined the extent to which they fulfilled major performance indicators outlined in the CDC's 2005 Request for Applications (RFA). The performance indicators were developed to ensure that the inputs and activities of the Centers that were necessary to achieve expected outputs and outcomes would be implemented. The fulfillment of these performance indicators would suggest the successful development of Center infrastructures that can enable communities' success in using evidence-based approaches and reducing rates of youth violence.

Using data regarding major performance indicators, the primary goal of this qualitative evaluation was to examine whether the 2005–2011 ACEs and UPACEs met objectives prescribed in the RFA. These objectives included tasks such as

tracking the distribution of youth violence in a defined community; building the scientific infrastructure necessary to support the development and widespread application of effective youth violence interventions; promoting interdisciplinary research strategies to address youth violence in a defined community; fostering collaboration between researchers and communities by bringing together individuals with diverse perspectives; and mobilizing and empowering communities to address youth violence.

A secondary goal of this evaluation process was to assess the novel data collection and review process used to conduct this qualitative evaluation. The ACE-Information System (ACE-IS; described below) was used to collect and aggregate a large amount of qualitative and quantitative data submitted by the Centers. This process and the utility of an online information system for data collection are described and critiqued below.

### 1.1. Conceptual framework of the ACE Program

The conceptual framework for the 2005–2011 ACE Program was developed to describe the orientation of the ACE Program, its activities, and the outcomes it was expected to achieve (Vivolo, Matjasko, & Massetti, 2011). The elements of the ACE logic model (see Fig. 1) and its linkages are consistent with the Congressional language authorizing the ACE Program and CDC's National Center for Injury Prevention and Control (NCIPC) research priorities. This model served as a planning mechanism and guided ACE Program activities during the 5-year grant period and identifies the inputs, activities, outputs, and outcomes common to Centers funded from 2005 to 2011. Finally, the model illustrates the expected relationships among these components.

The logic model (which was published in the ACE RFA) included a set of 14 performance indicators to track and measure the progress of the ACE Program and each Center in meeting its goals. The performance indicators provided a set of key determinants for the evaluation of the ACE Program's impact on improved practice and policy, as well as the Centers' impact on reduction of risk factors or promotion of protective factors over time. Together, the ACE Program logic model and performance indicators served as the basis for conducting the ACE Program evaluation.

The purpose of this manuscript is to describe aggregate data compiled across the eight ACEs and two UPACEs demonstrating their progress on ACE performance indicators perceived as critical for the development of a Center that could successfully accomplish the objectives prescribed in the RFA. Data related to the indicators highlight the successes, outcomes, and accomplishments for each Center since the beginning of the 2005 funding cycle and demonstrate progress in building community capacity to address the impact on youth violence rates, reduce risk factors, and promote protective factors relative to youth violence prevention efforts in communities.

## 2. Method

The ACE Program evaluation was conducted by CDC staff at the end of the 2005–2011 ACE Program funding cycle. Data were compiled on the extent to which the logic model inputs were used to shape the ACE Program, the activities that were undertaken by the Centers in the ACE Program, the quality of the activities, and the specific outcomes of the ACE Program.

The ACE-Information System (ACE-IS) is a CDC-hosted online tool for data collection and was used by the Centers in the ACE Program over the course of their funding for reporting purposes (see Fig. 2 for a screenshot of the ACE-IS report format; data entry pages appear similar but include check boxes, radio buttons, and dropdown menus for item selection). Using the key performance indicators as a guide, the Centers entered data about their projects

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