



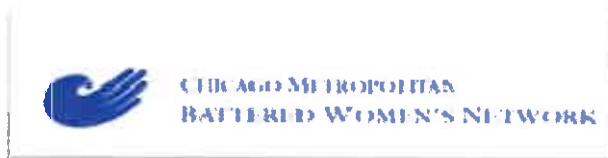
CHICAGO METROPOLITAN  
BATTERED WOMEN'S NETWORK

## **THE MEDICAL RESPONSE COLLABORATIVE MODEL (MRC)**

**Presented by:**

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## ORGANIZATIONAL HISTORY & BACKGROUND

In 1980, domestic violence service providers created The Chicago Metropolitan Battered Women's Network in order to exchange information about local resources for domestic violence survivors and to share best practices in responding to their needs. The Network still maintains the grassroots focus of its early years, but it is now a coalition of 100 organizations, allied professionals, and government workers serving domestic violence victims in Cook County. Our mission is to serve as a collaborative membership organization dedicated to improving the lives of those impacted by domestic violence through education, public policy and advocacy, and the connection of community members to direct service providers. Network members set the organization's annual goals and policy agenda and they are supported by a professional staff and a volunteer Board of Directors.

The Network performs its work in four focus areas:

1. **First response:** The Network runs Illinois' Official *Statewide 24-hour Domestic Violence Hotline* and serves as first responder for tens of thousands of Illinois residents each year. In FY 14, the hotline answered 23,233 calls for help.
2. **Advocacy & Public Policy:** The Network's *Strategic Response for Ending Domestic Violence* pursues an advocacy/policy agenda on behalf of victims and service providers. This Program works to change laws and regulations and presses for systems dealing with domestic violence to do so in ways that maximize the prevention of, and ultimately an end to, abuse.
3. **Professional Training:** The Network's *Centralized Training Institute (CTI)* presents expert training for human service and healthcare providers and criminal justice personnel. In FY2014, the CTI educated 1,012 professionals in 36 trainings.
4. **Member Services:** The Network provides its members with a venue to work together on common policy initiatives, joint fundraising opportunities (such as our collaborative Run Domestic Violence Out of Town, which uses the Chicago Marathon to raise funds for service providers) and capacity building. Since 2008, the Network has convened its members to collaborate on new ways of scaling impact and providing better services to domestic violence survivors as well as initiatives to adopt 21<sup>st</sup> Century nonprofit business models. Projects include the Outcomes Measures Project, which enables members to track the impact of their services on clients' ability to move beyond domestic violence, and the Medical Response Collaborative, focused on improving the healthcare system's response to domestic violence.



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### **THE MEDICAL RESPONSE COLLABORATIVE (MRC)**

The Centers for Disease Control finds that over 28% of domestic violence victims pursued medical care for their most recent assault, and 78% of these victims sought care in a hospital setting.<sup>1</sup> For over 19 years, domestic violence service providers (DVSPs) in Chicago have partnered with John H. Stroger Jr. Hospital of Cook County to deliver on-site professional intervention to domestic violence victims, but until very recently this has been the only hospital in Chicago with these much needed services. In the suburbs, only the Ingalls system, Alexian Brothers, Christ Hospital and several smaller community hospitals have on-site DVSPs.

DVSPs have long hoped to expand on-site services to more major hospitals in Chicago and suburban Cook County and to partner with healthcare providers to offer best practices training in handling domestic violence in the medical setting.

Passage of the Affordable Care Act (ACA) presents a unique opportunity to meet the Network's goal of innovating service delivery by intervening where most victims are instead of expecting victims to seek out service providers. The ACA requires health professionals to screen all teenage girls and women, ages 14-46, annually for intimate partner violence and provide or refer those who screen positive to intervention services. This requirement opens the door for more strategic partnerships between domestic violence service providers and healthcare providers.

With that in mind, The Network created the Medical Response Collaborative (MRC) in 2013. The MRC brings our member service providers together to collaboratively provide a coordinated response to domestic violence diagnosed in the healthcare system. It is comprised of (3) tracks which overlap to maximize impact:

1. **Policy & Advocacy** - The Network and its members developed recommendations for implementation of the ACA mandate for IPV screening and counseling. The group is advocating for these recommendations at the local, State and Federal levels in order to ensure that installation of this mandate is thoughtful and victim-centered. The Network has also worked to have domestic violence categorized as a "social determinant of health" during Illinois' recent work on Medicaid reform and health system transformation.

2. **Training** - In order for IPV screening to be effective, medical professionals must create a safe and confidential environment to gather information on a patient's experience, and must know how to comfortably respond to a positive screen. The Network's Centralized Training Institute is currently creating a new medical training track, where specialized training will be offered on screening, successful referrals and follow-up and the health implications of domestic violence.

3. *Service Delivery Model* – In an effort to address limited patient time allotted in most medical settings and the impact on positive screens for IPV, The Network worked with member DVSPs and local hospital leaders to develop a coordination of care service delivery model. This model connects IPV survivors with DVSPs while they are receiving medical attention. The model is now being piloted at 2 large hospitals, and a 3<sup>rd</sup> is about to come online. Once we test its effectiveness and work out any issues, we plan to market the model across the Chicago area.

All of this work is pointed towards our twin goals of preventing domestic violence in the long-term while helping current survivors to find help in the short-term. We believe that if we increase the number of women screened for domestic violence during Emergency Department or OBGYN visits, more cases will be caught earlier in the cycle of violence. This should provide more victims with increased access to both healthcare and domestic violence services, thereby reducing both the rate of domestic violence in the population and the lethality of cases. Much as early detection via mammograms reduces breast cancer mortality, we are hopeful that earlier detection of domestic violence will reduce mortality and morbidity.

The Network sees the MRC as a way to shift the medical system's view of domestic violence. Right now that system views domestic violence as a social problem. Studies suggest that as many domestic violence victims present at area ERs as those seeking care for chest pain and stomach distress. Yet, healthcare providers often fail to diagnose domestic violence, missing a key opportunity to connect victims to help. Using the new screening requirements in the ACA, we will advocate for doctors and nurses to treat domestic violence as a public health issue where they can play a central role in reducing violence and help those in crisis by properly screening and referring victims. We also hope the larger community will eventually echo this shift in medical institutions and help all Chicago area domestic violence survivors realize a safer and violence-free future.

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<sup>1</sup> [http://www.cdc.gov/ncipc/pub-res/ipv\\_cost/IPVBook-Final-Feb18.pdf](http://www.cdc.gov/ncipc/pub-res/ipv_cost/IPVBook-Final-Feb18.pdf)

## MEDICAL RESPONSE COLLABORATIVE

### *Model for Medical Response*



**\*See Attached Medical Response Model for details**

**Chicago Metropolitan Battered Women's Network  
Medical Response Model**

<b>MODULE</b>	<b>SERVICES INCLUDED</b>	
	<i>Basic</i>	<i>Enhanced</i>
<b>NEEDS ASSESSMENT</b>	<p>Assessment to determine Hospital medical response needs.</p> <ul style="list-style-type: none"> <li>• 24 hour access to crisis intervention via Helpline/hotline.</li> <li>• Safety Planning</li> <li>• Onsite Intake</li> <li>• Referrals &amp; Follow-up services</li> <li>• Services for special needs populations</li> </ul>	<p>Assessment to determine Hospital medical response needs.</p> <p><b>Basic Services Plus:</b></p> <ul style="list-style-type: none"> <li>• ED covered by in-person advocates during peak usage hours.</li> <li>• In-person advocates at outpatient ambulatory clinics.</li> </ul>
<b>CRISIS INTERVENTION</b>	<ul style="list-style-type: none"> <li>• Provision of aggregate metrics on service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Assistance in prepping for IPV best practice compliance prior to JCAHO accreditation review</li> <li>• Co-convening of Hospital-wide DV Committee</li> </ul>
<b>POLICY &amp; PROCEDURE CONSULTATION</b>	<ul style="list-style-type: none"> <li>• Consultation on best screening practices</li> </ul>	<ul style="list-style-type: none"> <li>• Screening performed by DV service providers</li> </ul>
<b>SCREENING</b>	<ul style="list-style-type: none"> <li>• Brief Trainings at Grand Rounds</li> <li>• Training via Video</li> <li>• One in-person training by department per year</li> <li>• Annual "booster" trainings</li> <li>• Quarterly regional training-DV healthcare best practices</li> <li>• DV Service Locator</li> <li>• DV Healthcare Toolkit</li> </ul>	<p><b>Basic Services Plus:</b></p> <ul style="list-style-type: none"> <li>• 40 hour domestic violence certified training on site at your institution or slots reserved for your staff at the agency's 40 hour training</li> </ul>
<b>TRAINING</b>		



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## OVERVIEW OF THE MEDICAL RESPONSE COLLABORATIVE MACNEAL HOSPITAL

### Prevalence of Problem:

National studies predict that 1 in 4 American females will experience domestic violence in their lifetimes. The CDC finds that over 28% of domestic violence victims sought medical care for their most recent assault. 78% of these victims pursued care at a hospital.<sup>1</sup> Some medical studies find that as many domestic violence victims present at ERs as those seeking care for chest pain and stomach distress.

**MacNeal Catchment area:** Chicago Metropolitan Battered Women's Network (The Network) member programs report the following number of cases over the past year in the region served by MacNeal Hospital:

- Mujeres Latinas en Accion – 313 adult domestic violence survivors (North Riverside office)
- Constance Morris House/Pillars -- 306 domestic violence survivors and 163 sexual assault clients
- Sarah's Inn – 334 domestic violence clients
- Arab American Family Services – 45

**TOTAL MACNEAL AREA CASES ANNUALLY = 998**

### Benefits of Partnering with The Network's Medical Response Collaborative (MRC)

1. **The MRC can help MacNeal Hospital comply with current law, accreditation standards and best practices:**
  - *The Affordable Care Act requires that healthcare providers screen all females 14 to 46 annually for intimate partner violence and refer those who screen positive to counseling services.*
  - *The Joint Commission Standard PC.01.02.09 requires that a hospital "assesses the patient who may be a victim of possible abuse and neglect." This includes having written criteria to identify victims of abuse, maintaining lists of community agencies for referral, training staff in the recognition of victims of abuse and on their role in follow-up, and using criteria to regularly screen for abuse upon patient entry into hospital and on an ongoing basis.*
  - *In 2013, the US Preventive Services Task Force (USPSTF) recommended "that doctors and other health care providers screen women of childbearing age for intimate partner violence and refer those who report such violence to services for abused women. These services include support groups, counseling, information cards and community services."<sup>2</sup>*

[over]

<sup>1</sup> [http://www.cdc.gov/ncipc/pub-res/ipv\\_cost/IPVBook-Final-Feb18.pdf](http://www.cdc.gov/ncipc/pub-res/ipv_cost/IPVBook-Final-Feb18.pdf)

<sup>2</sup> <http://annals.org/article.aspx?articleid=1558516>

## 2. The MRC can help MacNeal Hospital meet the Triple Aim.

**A. Improving Patient Satisfaction:** In an ongoing survey of Network Members' clients (6 months after completion of services), 83% report being very satisfied with the therapy they received and 82% were very satisfied with the safety planning services they used. A partnership between MacNeal and the MRC would connect your patients to these services, some of which could be offered on-site and some in community based agencies, depending on the hospital's needs. Once MacNeal implements MRC services, The Network will work with MacNeal to analyze HCAHP data and other sources to determine how patients rate MRC services.

### **B. Increasing Quality:**

- 1) The MRC can help MacNeal to implement a regular screening protocol and to continuously improve this practice. Regular screening for domestic violence should connect many patients to earlier intervention, thereby decreasing patient harm.
- 2) Research indicates that domestic violence victims have more hospitalizations (77% versus 50% controls) and more admissions (420 vs. 199 for the control group). The same research suggests that hospital partnership with a DV service provider agency will likely reduce misdiagnosis of victims and hospitalizations for high-cost specialty care.<sup>3</sup>

### **C. Lowering Costs:**

Studies of domestic violence survivors' health care utilization show that **total annual health care costs were --**

- ✓ 42% higher for women experiencing ongoing physical abuse
- ✓ 24% higher for women who experienced physical abuse within the past 5 years
- ✓ 19% higher for women who experienced physical abuse more than 5 years ago<sup>4</sup>

Women who reported injuries as a consequence of their most recent IPV victimization utilized the following services due to their injuries (mean number of visits):

- 2 ED visits
- 3.5 physician visits
- 5.2 dental visits
- 19.7 physical therapy visits<sup>5</sup>

With proper screening and assessment, more survivors will be identified and connected with services earlier. This should reduce ongoing healthcare costs.

**3. The MRC can help MacNeal meet the needs of its own employees.** Domestic violence service providers located in other area hospitals report that after they have established a program, hospital employees begin to approach them to request help with their own experiences of domestic violence. The MRC will provide consultation and assistance to MacNeal's EAP program so that the hospital can best respond to employees experiencing domestic violence.

## 4. It's the right thing to do.

<sup>3</sup> Futures Without Violence, <http://www.futureswithoutviolence.org/the-business-case-for-domestic-violence-programs-in-health-care-settings/>

<sup>4</sup> Futures Without Violence, <http://www.futureswithoutviolence.org/making-the-connection-intimate-partner-violence-and-public-health/>

<sup>5</sup> Ibid.





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**MEDICAL RESPONSE COLLABORATIVE  
LEAD AGENCY JOB DESCRIPTION**

Recommended Responsibilities of Lead Agency for Medical Response Collaborative Pilot Projects:

1. Coordinate and communicate with all domestic violence provider members of the pilot group.
2. Maintain relationships with key advocates and other key leaders at the pilot hospital.
3. Provide Medical Response services and coordinate the provision of pilot agencies service provision.
4. Serve as point of contact for hospital.
5. Serve as point of contact with the Network regarding progress of the pilot.
6. Develop and coordinate a hospital-wide Domestic Violence Advisory Committee, provide representation at the meetings (and, if possible, Co-Chair the committee with hospital reps).
7. Coordinate collection of any data needed to report pilot program progress to hospital, pilot funders, the Network and other stakeholders.
8. Work with the Network and other pilot agencies to institutionalize services at hospital after pilot ends.
9. Work with Network and other pilot agencies to leverage ongoing funding for service delivery at hospital.
10. Continue to participate in pilot planning meetings via the Medical Response Collaborative.

Resources Needed to be Lead Agency:

1. Staff time to complete all above responsibilities.
2. Staff with knowledge and experience regarding Medical response (or willingness to train staff as needed).
3. Staff senior enough to manage relationships between domestic violence providers and to build confidence and trust of senior Medical staff.
4. A commitment to seeing pilot project as a collaborative effort and to working collaboratively (and not competitively) with other pilot agencies.
5. A willingness to have direct and transparent conversations with programs in the pilot as needed.



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**MEDICAL RESPONSE COLLABORATIVE  
PARTNER AGENCY JOB DESCRIPTION**

Recommended Responsibilities of Partner Agencies for Medical Response  
Collaborative Pilot Projects:

1. Consult on special populations or needs (language, culture, ability, gender, etc.) of those served by the hospital. (We discussed language, referral for services and the use of telehealth.)
2. Be a referral source for services.
3. Participate as a member of the hospital-wide domestic violence committee.
4. Work with all partners and the Lead agency to coordinate on-site staffing at the hospital assisting with domestic violence screening, crisis intervention/safety planning, referrals and consultation.
5. Coordinate with all partners and the Lead agency to provide ongoing training to healthcare personnel.
6. Develop and coordinate outreach to the community served by the hospital to join in the efforts to identify and respond to domestic violence.
7. Develop a common set of outcomes with all partners, the Lead agency and the hospital.
8. Continue to participate in pilot planning meetings via the Medical Response Collaborative.

Resources Needed:

1. Staff time to complete all above responsibilities.
2. Staff with knowledge and experience regarding Medical response (or willingness to train staff as needed).
3. A commitment to seeing pilot project as a collaborative effort and to working collaboratively (and not competitively) with other pilot agencies.
4. A willingness to have direct and transparent conversations with partner agencies in the pilot.