AT THE FOREFRONT UChicago Medicine

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Senator Klobuchar,

Thank you for the opportunity to answer additional questions for the record of the hearing entitled "The Gun Violence Epidemic: A Public Health Crisis." We sincerely appreciate your dedication and support to over 4.5 million American women impacted by intimate partner violence, including supporting a critical program like "Next Step" in Minnesota. Coordination and collaboration with wrap-around services that address social determinants of health, like housing, mental health, workforce development, and educational training, are among the highest priorities to prevent re-injury and promote recovery.

Our response aims to address your questions by describing the Violence Recovery Program model, the volume of patients engaged, the steps involved in promoting comprehensive recovery, and collaborative strategies with community partners to prevent re-injury. This response will continue by describing how our program supports victims of intimate partner violence (IPV) and the strategies we use to connect IPV survivors to resources. Our response will conclude with ideas on how Congress can help strengthen support for IPV survivors through Hospital-Based Violence Interventions (HVIP).

- **How has your program at the University of Chicago Medicine been successful in ensuring that patients go on to live safe and healthy lives?**

Launched on May 1st, 2018, the Violence Recovery Program (VRP) model operated through the Urban Health Initiative (UHI) at the University of Chicago Medicine (UCM) is a hospital-based violence intervention program that has engaged a total of 9,085 patients. The program's growth is evident, with 451 patients in the initial months (May 2018 to December 2018) escalating to 1,157 in 2019, 1,664 in 2020, a record high of 2,140 in 2021, 1,774 in 2022, and 1,744 as of December 12, 2023. Among those engaged, 80.6% were male, and 19.4% were female. A significant proportion of individuals engaged in the program fell within the age bracket of 22-30 years (25.6%), followed by 31-40 years (12.6%), 41-50 years (10.7%), and those over 50 years (10.1%). Notably, 96.1% of our patients identify as Black or African American.

Of the 1,744 individuals actively engaged in the VRP in 2023, 78% were male, while 22% were female. Delving into the age demographics, participants aged 22-30 comprised the largest segment, constituting approximately 30% of the total. The 31-40 age group closely followed with around 27%, and individuals aged 41-50 represented approximately 13% of the VRP participants.

Our data is thoughtfully categorized into violence type and injury type to offer a nuanced understanding of the challenges our patients face. In terms of violence type, the majority experienced Community Violence (86.3%), followed by Domestic Violence (13.5%), and a smaller fraction affected by Sexual Assault (0.2%). Regarding injury type, 68.2% suffered from gunshot wounds, 16.7% from assault, and 15.1% from stab wounds.

Operating 24 hours per day, seven days per week, and 365 days a year, the VRP responds to all Level I trauma activations for patients presenting to the ED with intentional and community violence-related injuries, in addition to pages, consults, and requests from trauma teams for Level II and non-trauma activations, for cases such as graze wounds and assault disclosures.

The violence recovery program model includes violence recovery specialists (VRSs) with the support of spiritual care, social workers, and child life specialists who provide crisis intervention and victim services through compassionate guidance for family and friend groups of violently injured patients immediately upon arrival at the UCM Trauma Center. Once the patient is medically stable, the VRS continues advocacy services for survivors and their families by administering psychological first aid, facilitating medical updates for families, advocating for and assisting with patient–family visitation, providing psychoeducation to patients and families, supporting hospital wayfinding and referring patients and families to immediate mental health services.

Following crisis intervention, a VRS assesses for imminent risk of re-injury and other socioecological needs, including the need for direct interventions and service referrals regarding mental and behavioral health as well as social determinants of health resources (housing, food, transportation, employment, and access to other public benefits ((e.g., SSI/SSA, TANF/AABD, SNAP, SSI, and CVC). The VRS works with the survivors to create an empowerment plan that includes referrals for the patient's highest-priority needs.

Following crisis intervention, a VRS assesses for imminent risk of re-injury and works with the survivors to create a "person-centered" empowerment plan that promotes the patients' self-awareness and freedom of choice to co-create a recovery strategy that uplifts the patients' autonomy. Through this approach, patient-centered needs typically are structural, including legal advocacy, housing stability, food security, employment and education status, transportation reliability, substance use support, crime victim compensation(CVC), and connecting patients to resources to address acute and ongoing mental health needs. VRSs work to mitigate barriers to care and provide a "warm hand-off" to other service providers by directly linking and personally connecting survivors with referral sources to ensure a successful transition of care. VRSs maintain meaningful, trusting, and open relationships with the survivors and, when necessary, make home visits for added follow-up support. Case management is tailored to the patient's individual needs and progress. This approach allows for intensive yet flexible support for clients with long-term or complex needs by helping them navigate and follow through with health and social service referrals.

Although the VRP model has advanced dramatically over the past five years, the evaluation efforts have made modest advancements in understanding the program's impact. The program measures success and impact using mixed methods incorporating frontline staff and patient voices through stories and experiences alongside quantitative measurements on the frequency and types of patient engagement over time. Our program's success and impact indicators are currently focused on process measures, including the number of engagements, interventions, and referrals during hospital stay and post-discharge. Our evaluation focuses on investigating:

(1) What are the patient and family's immediate and long-term needs?
(2) How were the patient and family's self-identified needs met (# of encounters, interventions, and referrals needed to meet said needs)?
(3) What are individual-, hospital-, and community-level barriers and facilitators to meeting said needs?

To better understand children and family engaged by the VRP, a recent analysis of 1,982 VRP patients served between 10/1/2021 and 10/1/2022 was conducted. Findings show that 21.6 percent were children at or under 21 years old, for a total of 428 children and an average of 36 children served per month. This is comparable to the 417 children served by the VRP the previous year. Of the patients engaged during the study period, 45.6 percent had their families engaged during crisis intervention as well, for 904 families served. Of these 904 families engaged, 246 said they had a child or children that could benefit from Child Life or other child-related services. The number of total children across all of these families was 478. The 478 child family members engaged during crisis intervention are distinct from the 428 patients under 21 years old that the VRP served during this period. The VRP has engaged 6,211 patients since the program expanded significantly, thanks to funding from the Block Hassenfeld Casdin Collaborative, which was established in May 2019. Of these, 3,504 patients were 21 or younger and had their families engaged with interventions and referrals. Interventions are defined as social and mental health services provided to patients and families by violence recovery specialists. Some of these interventions include social services and mental health referrals.

- 3,181 patients and families (90.8 percent of the total seen) received one or more interventions during the crisis
- 270 families (7.7 percent) received one of more crisis interventions when a patient died after admission
- 3,244 patients (92.7 percent) received one or more social services interventions
- 336 received housing interventions ▪ Of those, 52 received housing referrals
- 377 received employment interventions ▪ Of those, 206 received employment referrals,
- 113 received food interventions ▪ Of those, 71 received food referrals,
- 154 received education interventions,
- 1,298 received victim's compensation support interventions,
- 1,017 received mental health interventions ▪ Of those, 302 received mental health referrals

- 123 received transportation assistance interventions.

Five years of VRP implementation suggest that improving social and structural determinants of health is a vital component of healing and comprehensive recovery. Our data show that access to public benefits (e.g., SSI/SSA, TANF/AABD, SNAP, SSI, and CVC) and access to mental health services, housing, food security, employment, and criminal record expungement are high on the list of the immediate and long-term needs of patients. VRP also recognizes the importance of connecting patients to legal services to help address economic instability, access to public benefits and employee benefits, housing, and State victim compensation programs. Understanding the administrative burden and time-consuming process for VRS to address health-harming legal needs, in 2022, a multi-disciplinary group that included a team of clinicians, Chicago Legal Aid lawyers, violence recovery specialists, and coordinators collaborated to improve strategies to address social-structural determinants of health through the implementation of a medical-legal partnership (MLP). The MLP aims to address the health-harming legal needs by improving access to benefit programs designed for survivors, but that is typically burdensome, especially for survivors of violence managing the trauma associated with victimization. Preliminary pilot phase data show that embedding an MLP within the VRP program is highly feasible and acceptable, with a high participation rate of 95% and 91.5%, respectively (Pillai et al., 2023).

Finally, coordination and collaboration with community stakeholders, especially community violence interventions, has been another approach that has helped contribute to ensuring patients go on to live safe and healthy lives. In 2021, VRP secured an MOU with Metropolitan Family Services (MFS) Metropolitan Peace Initiative (MPI) to collaborate with its Communities Partnership 4 Peace (CP4P) initiative. CP4P provides a community-driven multi-sector response to reduce gun violence within 27 Chicago communities with the highest rates of gun violence. CP4P elevates the role of 13 community-based violence intervention organizations within these communities. CP4P aims to engage residents, community stakeholders, survivors of violence, and bereaved families to participate in the solution to gun violence while forging closer partnerships with public agencies, hospitals, and the police department. This HVIP-CVI relationship has been critical to helping survivors of violence with a comprehensive recovery, as well as improving VRP's safe discharge strategies through CVI's increased knowledge of community-based conflicts and coordinating with street outreach partners to develop plans to prevent re-injury. As CP4P collaborators, VRP leadership participates in the Mayor's Office of Violence Reduction Community Safety Coordinator Center (CSCC) and attends weekly, biweekly, and monthly meetings such as:

- Weekly citywide victim services meetings
- Chicago Police Department Area 1 and Area 2 violence response coordination calls with CVI partners
- South Side of Chicago High-Risk Intervention meetings
- CSCC biweekly leadership meetings

Through funding from a Senator Durbin federal earmark, Senator Durbin's funding through Southland RISE, and funding from the Illinois Department of Human Services Reimagine Public Safety and Violence Prevention initiative, VRP significantly expanded its program, creating an outpatient case management specialist embedded in the outpatient trauma clinic as part of the program's model. These funding sources have allowed VRP to strengthen communication with CVI partners following a violent incident. The VRS outpatient teams meet with CVI partners weekly to conduct reviews of the CSCC's Crime Prevention and Information Center (CPIC) alerts, which summarize violent incidents by police district and beat, including the type of injury, age, gender of the victim, and hospital destination. These weekly sessions allow our collaborative violence response teams to evaluate our respective workflows, understand the community-level and hospital-based responses to incidents, help evaluate the risk for re-injury through the perspectives of our CVI partners, learn about their community-level mediation strategies, and exchange essential resources to contribute towards the path of comprehensive recovery. The partnership between VRP and CVIs significantly contributed to the advancement of VRP's outreach efforts. Thanks to the framework created by our CVI leaders, VRP has successfully implemented text thread communications to provide real-time updates when someone is violently injured in these communities.

In 2022, the Violence Recovery Program engaged 38% of all pediatric and adult trauma patients. Of patients engaged in our program since 2018, 2.1% have been re-injured and re-engaged with our program. While this re-injury rate outcome speaks to the power of the program's coordination and collaboration within the hospital and community partners, this re-injury rate is only at the program level. However, thanks to Senator Durbin's Hospital Engagement Action and Leadership (HEAL) initiative, we are working to establish data-sharing agreements with the Chicago Department of Public Health along with nine other Chicago area Level One trauma centers and emergency rooms. In 2023, various HEAL working groups were established to discuss ways to help improve coordination with different departments within and across hospitals to build an infrastructure that would allow programs like ours to share data, standardize definitions for community violence, firearm injury, and HVIP eligibility criteria, to assess further our goals toward reducing re-injury and promoting recovery.

- **What resources and support do hospital-based violence intervention programs, such as yours, provide for victims of intimate partner abuse?**

Although Intimate Partner Violence (IPV) impacts all communities, it is often underreported. When disclosed, patients have unique needs related to imminent risk and social determinants of health, such as relocation assistance, safety, and emergency housing. Since the program's inception on May 1st, 2018 through December 12th 2023, 1,181 patients engaged (13.5%) were recorded as experiencing domestic violence. Given their highly attuned approach to trauma-informed, patient-centered care, the VRS has a uniquely personal and influential role in building rapport with survivors. For these reasons, survivors may feel more comfortable disclosing to a VRS that they have experienced domestic and sexual violence. The VRS engages IPV victims using a healing-centered approach that is guided by a person-centered approach that aims not

to prioritize disclosure of victimization. Instead, to best support our patients in the emergency room/inpatient, we recognize and understand the importance of trust.
VRS foregrounds providing the patients emotional support, timely response to immediate needs, providing the survivor with a safe and confidential space, mirroring their language, assessing for safe discharge, engaging with the medical team and hospital social worker on possible discharge dates and shelter referrals. Through this case management dynamic, the VRS is mindful of the tenuous nature of building trust and the factors that can erode building trust. These factors include a heightened awareness of the "Power and Control' wheel that often exists between survivors and abusers, including intimidation, coercion and threats, emotional and economic abuse, using isolation, minimizing, using male privilege, and manipulating children (need citation). Violence Recovery Specialists (VRS), whose expertise and training may foster a safe environment for DV disclosure. However, importantly, to provide trauma-informed care to DV survivors, disclosure cannot be the singular goal. Instead, our VRS objectives are to universally screen for DV and present resources to survivors so that they have options when they are ready to seek support. The VRS are often adept with building trust through their person-centered approach that avoids pressuring the survivor to disclose domestic violence or sexual assault, not using terms like domestic violence or sexual assault and instead mirroring language that the survivor uses as a strategy to generate trust, and not putting pressure on the survivor to speak with police or press charges. Our specialists find that using this support helps generate a long-term relationship with the survivor and, when the survivor is ready, allows us to assist patients by calling domestic violence hotlines or shelters individually and emotionally supporting the patient through the intake. Through a relationship strengthened by intensive case management, the VRS determines eligibility for rehabilitation centers, long-term space including own apartment and counseling support, and consistent contact with the patient to ensure a path towards comprehensive recovery.

In 2022, the UHI evaluation and monitoring team and select VRS with extensive IPV training developed a research group to help identify the pathways by which the VRS could better support Domestic Violence (DV) and Sexual Assault (SA) survivors and develop more robust operational definitions for the violence types used in the program's data collection tools. The DV/SA research group reviewed patients engaged between May 2018 and June 2022, among 6,490 patients, the VRP engaged 821 due to domestic violence (12.7%). Looking at patients engaged in the program for DV, 46% were discharged from the Emergency Department (ED) within 24 hours. Most patients were male (58%), which is consistent with the overall VRP patient population. However, we did observe a higher share of female patients in this sub-group (42%). Noting that there is a dearth of resources for male survivors of DV in Illinois, with only six shelters accepting men over 18 years old. DV patients tend to present to ED for stab wounds (48%) and assault (38%), whereas the overall VRP patient population tends to present for injuries due to gun violence. Within this patient group, patients tend to fall within the 22-40 year age range (60%). Patients also tend to be Black or African American (96%) and non-Hispanic (81%).

Some additional preliminary and unpublished results include that a high share of incidents occurred within the home of the patient, their family, or their abuser. In addition, some cases occurring within the home were incorrectly categorized as community violence, especially when a male patient was injured. However, after further review, the DV/SA research team found that these cases were, in fact, domestic violence cases. The greatest need for DV/SA survivors was housing and relocation. DV patients often reported that they would be returning to locations where they would have a high chance of encountering their abuser. The safe discharge needs highlight the structural inequities, specifically housing and a dearth of resources for survivors in Chicago. Violent incidents worsened existing barriers and posed new challenges to securing the social determinants of health – and this lack of basic needs was associated with higher re-injury risk. The DV/SA research team also identified an opportunity to probe deeper into resilience and protective factors to aid a patient's recovery. Many patients expressed the importance of family and children and could engage in self-advocacy to voice their social service and mental health needs; however, this was not intentionally captured in our data collection tools.

In alignment with patient-centered care, we know survivors use their strategies to cope and keep themselves safe. Including this perspective in safety assessments and planning is a practice to build rapport and coordinate care for the survivor amongst teams in the hospital. Other themes to explore in the coming months include interview techniques, resources available out-of-state, parenting resources, and more precise definitions for terms like PTSD, acute stress, and substance use.

What can Congress do to strengthen support for victims of intimate partner abuse, particularly with respect to hospital-based violence intervention programs?

Funding multi-disciplinary partnerships with HVIPs and DV shelters

There is currently a shortage in DV funding, DV community-based service providers, and DV advocate legal staff. Investing in Multi-disciplinary partnerships between HVIPs, legal advocates, and domestic violence experts embedded within HVIPs to work directly in the hospital could help with securing the support domestic violence victims need. Furthermore, a partnership with a shelter that has accessibility for disabled survivors combined with a collaborative agreement with a substance use clinic could help with reducing re-injury. Survivors who abuse substances are often asked to leave DV shelters due to their substance use.

Emergency Assistance Support

Continued support, like the protections under the Violence Against Women Act to secure emergency relocation services, is vital to preventing re-injury. Expanding relocation assistance, including transportation assistance funding, rideshare, public transit, and out-of-state.

As previously shared, 46% of domestic violence patients engaged by our HVIP are discharged from the emergency room and thus never admitted to the inpatient floors of the hospital. Funding for hotel stays for survivors who wish to leave the violent relationship situation but need to be discharged from the hospital is essential to secure immediate safety.

Securing expedited services for reacquiring state identification is equally essential, as survivors often leave their personal belongings as a safety strategy.

Expand funding for male DV victims

In addition to preliminary findings from our VRS-led research group that highlighted that 58% of our DV patients engaged between May 2018 and June 2022 were male , a separate study by Zakrison et al., 2018, found that one out of every seven male patients presenting to the trauma center were affected by intimate partner violence. Male patients may encounter gendered barriers in health settings that impede their comfort and ability to disclose DV experiences, including concerns that they will not be believed by health providers or a lack of confidence in a provider's ability to facilitate DV support and resources (Taylor, 2022). Further, DV resources and shelters tend only to be made available to female patients, with an overall dearth of DV shelters accepting male survivors over the age of 18 (NPR, 2017). Men's shelters are few and always full, so it would be helpful to have funding for short-stay housing and hotels. The mental health services for men experiencing DV regard them as the aggressors no matter if they were the victim, so specialized mental health services for men experiencing DV from a trauma-informed, therapeutic lens that treats them like survivors.

Future Outlook:

The VRP's success is not solely reflected in the numbers but in the lives it has touched and the communities it has positively influenced. By addressing the root causes of violence, we are fostering a safer environment and aiding in the recovery of those affected.

Moving forward, we remain committed to expanding the program's reach, refining our strategies based on the insights gained, and collaborating with stakeholders to create lasting change. We believe that by sharing this information with you, we can collectively work towards policies that support the continuation and growth of initiatives like the VRP.

Thank you for your ongoing support of this public health initiative.

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