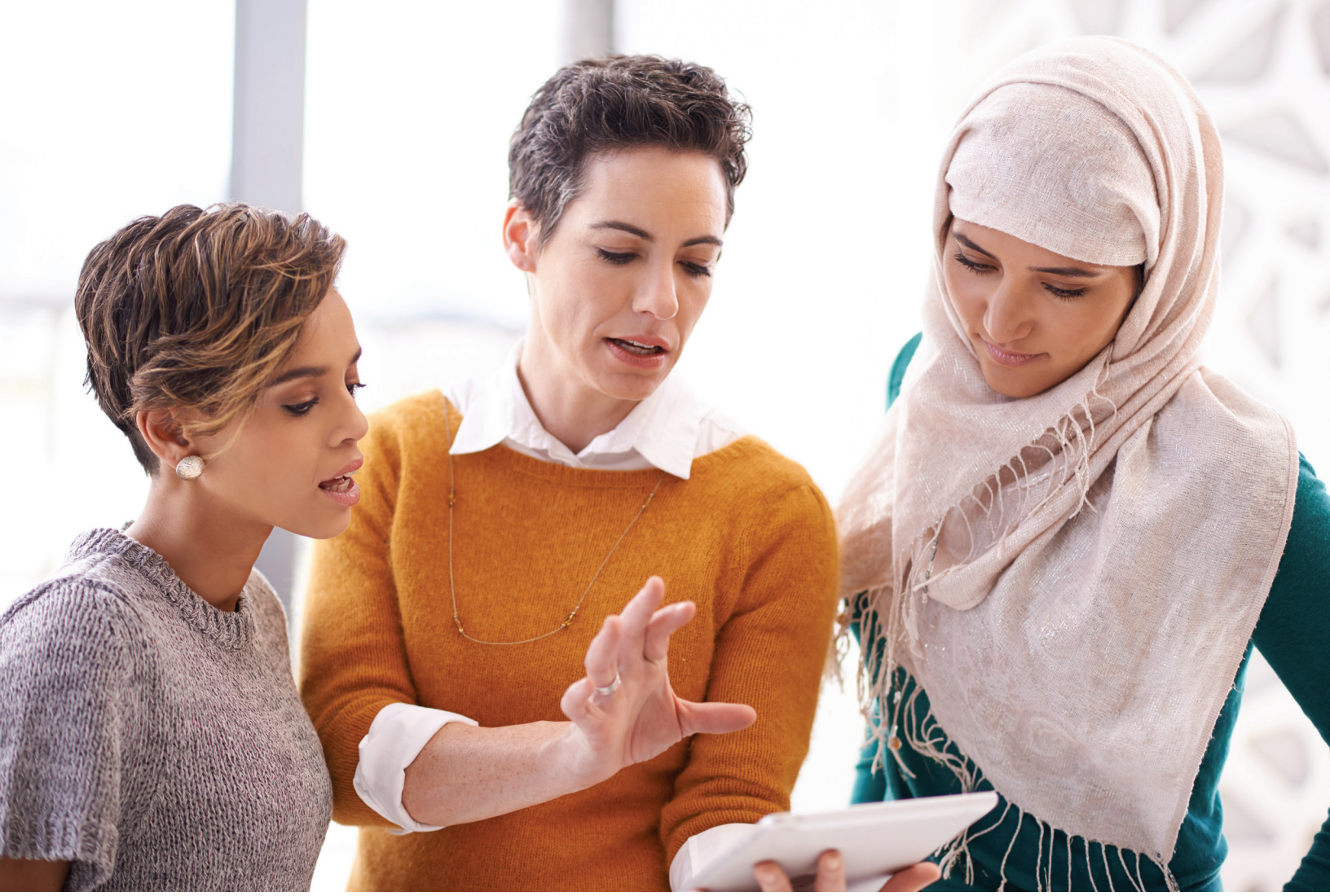

SUSTAINING PARTNERSHIPS: A STRATEGIC PLAN

A PRESCRIPTIVE GUIDE FOR SUSTAINING DOMESTIC VIOLENCE AND HEALTH CARE PARTNERSHIPS

CONTRIBUTORS:

Jennifer Haddad, MTP;
Lisa James, MA;
and Anisa Ali, MA

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INTRODUCTION

Health care professionals and health settings provide an early entry point to support domestic/sexual violence (DSV) survivors. They provide an opportunity for prevention, early identification, intervention, and anticipatory guidance on safe and healthy relationships. They have ongoing relationships with their patients and access survivors that DSV programs may not reach. Research tells us that health care providers are seen as trusted sources of information and that women who talk to their providers about DSV are more likely to seek out needed support.

For over two decades, health care providers, advocates, and national organizations, such as **Futures Without Violence**, have promoted routine assessment for violence and abuse, and effective response to survivors in health care settings. Most professional medical organizations recommend assessing for violence and abuse, such as the American Medical Association, the American Congress of Obstetricians and Gynecologists, the American Nurses Association, the American Academy of Pediatrics, and the American College of Emergency Physicians. Providers need training on the health impacts of DSV, trauma-informed care strategies, referrals and support, as well as resource materials, ongoing training, and model policies that provide a framework for moving toward a comprehensive health care response to violence and abuse.

DSV programs provide a wide range of services that promote safety and autonomy for survivors and can offer strategic and valuable solutions for health care providers. DSV programs also have an opportunity to improve health outcomes of survivors after abuse through evidence-based interventions and close collaboration with health care organizations. Expert opinions suggest that such interventions and collaborations may lead to reduced morbidity and mortality.

Domestic and sexual violence is a critical health care problem and one of the most significant social determinants of health. The prevalence of this issue is enormous. The Centers for Disease Control (CDC) estimates that more than 1 in 3 women and more than 1 in 4 men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime. The CDC also conservatively estimates that intimate partner violence (IPV) costs the health care system $8.3 billion annually from direct injuries and services.

Now more than ever, the time is right for domestic violence (DV) and health care partnerships. Two important policy changes have opened the door to innovative delivery of DSV services. The U.S. Preventive Health Services Task Force recommendations for IPV, combined with the guidelines in the Affordable Care Act, ensure that select U.S. health plans cover screening and brief counseling for domestic and other interpersonal violence, provide the opportunity to reach thousands more women and children with preventative messages, and improve the health and safety of current victims of abuse.

This is an opportunity for health and DSV programs to work together to not only develop partnerships, but also strengthen and sustain existing partnerships. Additionally, maintaining partnerships may yield new prospective sources of sustainable funding. This work creates an opportunity for key public and private health sector leaders and DSV service providers to build and strengthen a sustained effort to collaboratively and compassionately respond to violence and abuse. It also creates opportunities for promoting education and prevention, and improving timely access to care for DSV survivors, as well as for those not yet identified within the safety net.

THE INITIATIVE

The Domestic Violence and Health Care Partnership (DVHCP) project—a multi-year, statewide initiative funded by the Blue Shield of California Foundation—is an effort to move forward systematic response to DV and health care service integration in four cohorts of 19 partnerships across the state of California. Each of the 19 teams has developed a thoughtful, strategic plan to create and sustain an effective partnership.

Through collaborative efforts, teams have implemented innovative health and DV based strategies and interventions that are improving systems of care and overall response to DV throughout California. In partnership with Futures Without Violence, the teams were provided with core support, training, technical assistance, and materials, as well as a unique learning community to foster peer exchange throughout the funding cycle. This document was specifically developed from the DVHCP initiative, but the strategies translate well across the diverse landscape of DV and health intersections.

Collectively, the partnerships have endured unique challenges and successes, and broke through barriers to achieve systems-level change. They have creatively developed, tested, and evaluated an array of promising practices and system-level changes, ultimately improving and expanding early identification and response to DV in the health care setting, and establishing baseline policies for improving timely access to care for survivors in the DV setting.

Over the past 3 years, DVHCPs have forged best practices and policies to address the unique health needs of survivors of violence and promote prevention. From training and technical assistance to improved organization and provider response to DSV, the DVHCPs have successfully integrated innovative service delivery models that make health care more accessible to survivors when they need it most.

This guide seeks to provide a prescriptive plan to support the sustainability of existing, healthy partnerships between health and DSV organizations. It will outline a checklist of action steps and considerations—in a FAQs format—that will help sustain and strengthen (beyond any particular grant cycle) ongoing operations, systems, and integrated service delivery models between established DV and health collaborations. Building on knowledge, skills, and lessons learned over the course of the initiation and development of diverse partnerships, this guide offers a prescriptive formula to keep working, effective partnerships alive and thriving.

Although the strategies and lessons shared throughout this guide came specifically out of the Domestic Violence and Health Care Partnership initiative, this guide can be a useful and adaptable tool for all types of partnerships impacting DSV and health.

SERVICE DELIVERY

What is the common goal?

Although the fundamental goals of individual partnerships may vary, the ultimate goal is to create access, better serve survivors of domestic and sexual violence (DSV), and promote prevention. The common partnership goal is to better serve the unique needs of survivors by promoting a holistic approach and integrated system of care. This may include developing policy, improving advocate and clinical response to DSV, and implementing prevention and intervention strategies that promote early identification of DSV and connect survivors to health care services.

While goals may vary between the DSV and health care fields, shared goals in partnership generally include:

- **Prevention:** domestic and sexual violence prevention and preventative health services
- **Early detection:** optimizing health care and DSV support service encounters to identify early abuse and violence and improve linkages to support, while understanding the impacts of abuse and violence on health and creating linkages to health care services for DSV survivors
- **Access:** ensuring and facilitating timely access to care and support services for patients and clients, while helping to eliminate or reduce barriers to access
- **Care:** practicing evidence-informed, culturally-humble response within health and DSV organizations, and providing trauma-informed care at both health and DSV sites
- **Cross-sector collaboration:** engaging partnership approaches to achieve the common goal by identifying champions, enrolling buy-in from organization executives, and leaning on your partner(s) to fill in the gaps, leverage services, strengthen the network, and eliminate duplication
- **Policy and systems-level change:** core practice change that is fundamental to improving and maintaining response and intervention to DSV, both within the health and DSV organization, and across sectors
- **Spread:** recognizing DSV as a social determinant of health, educating sectors and improving the collective response—local, state, and national—appropriately

ACTION STEP: Identify the common goals in your organization and in your partnership, and determine where there is alignment and where there are differences between the two (or more) partners

What needs to be sustained?

If you are coming to the end of a grant cycle, you might be thinking about sustainability. Together, determine the core components of your collaboration. Consider what worked well, what made the most impact, and what was successfully integrated into organizational practice and programming. Once a list has been created, partners can then strategically determine action steps for how sustainability will be achieved for each of these core components.

Informed by peer leaders, the essential building blocks of a partnership that need to be sustained beyond a grant cycle include:

- **Universal prevention education,** as well as assessment and response related to DSV and health in the clinical and advocate setting
- **Streamlined cross-referral systems,** as well as services in the clinical and advocate setting
- **Access:** Access to culturally responsive, trauma-informed services, care, resources, and educational materials for patients/clients, in addition to tools and resources for providers and advocates. Keep in mind that through partnerships, there is an increase in demand at both health and DSV programs. It is important to maintain an infrastructure that can meet the continued and increasing demands for patients and clients over time.
- **Integrated service models:** Consider what makes your partnership tick. Examine the core elements and the proven integrated service models that make your partnership a working, collaborative relationship beyond a name on a list of referrals. Perhaps it is an effective behavioral health model, or the placement of an advocate in the health setting. Evaluate what this is for your partnership, and determine what is critical to sustaining your partnership and its unique response to DSV.
- **Key staff,** including the core leadership team, project champions, co-located or offsite advocates and care coordinators, with clearly identified roles and responsibilities
- **Ongoing staff training and cross-training between partners:** Staff training is essential to a successful partnership and integrated service delivery. Integrate and maintain a team-based approach to ongoing, routine staff training for both providers and advocates, as well as a cross-training between partners.
- **Policy and written protocols, for both the health and DSV site:** **Developing and implementing new written policies and protocols**—critical to clinical and advocate-based response—is a big undertaking requiring a significant amount of staff time and resources. It is likely that after a partnership has been established, policies (new or improved) and written protocols have been developed and established. Once institutionalized, sustainability efforts shift toward maintaining and updating the policies and protocols annually or every two years.

- **Quality improvement (QI) checks:** Optimize and measure the partnership and practice changes made over time with regular, ongoing QI checks. Through the use of a quality assurance/quality improvement (QAQI) tool for **DSV programs** and for **health care settings**, partners can continue to identify and measure improvements made over time at both the health and DSV site. Introducing an effective tool organization-wide, as well as other standardized QI procedures, will ensure sustainability when core staff leaves. Use this tool as is, or make organization-specific adaptations for better use in demonstrating systems change and impact.

- **Data:** Ultimately, data is a process of demonstrating impact. It can permeate on a variety of levels including: program and direct service deliverables; programmatic outcomes; short and long term health and safety outcomes; cost savings and return on investment analysis; impact on systems change, both within the organization and across sectors; and broader systems change in understanding DSV as a social determinant of health. Understand that data, the capacity to demonstrate impact, and the ability tell the story of your partnership is at the heart of sustaining any program collaborations. It is important for getting buy-in from executive leadership, frontline staff, board of directors, and other key stakeholders; it is instrumental in making the case for project investments to funders, donors, and health plans; and it is essential to contributing to the greater sustainability of your project through dissemination, spread and policy change strategies, both at the state and federal level.

  Identify what data means to your organization and partnership, and identify the value it brings to the table. Identify where you are within the process of demonstrating impact through data, and determine where you need to be to support your ongoing sustainability efforts. Consider the following:

  - What data systems are currently in place?
  - What are you currently collecting and what additional data measures can you incorporate to advance your data efforts—integrating both practice change evaluation and impact on health and safety outcomes?
  - How are you correlating data to already established performance measures and continuous quality improvement?
  - What are you learning from the data you are collecting? What improvements are you making as a result of these learnings? For example, an increase in disclosures and referrals may be an indicator that you have implemented an effective assessment tool, or an inconsistency in screening may be an indicator of inadequate staff training or kinks in the screening workflow.
  - How are you currently using your data and how would you like to elevate this?
  - Who do you need to engage to collect, maintain, and monitor a higher level of data?
  - What staff training is needed around data collection, reporting, and analysis?
  - What staff time, support, technical assistance, technology, and equipment is required?
  - How will you embed a working, streamlined system for data collection, analysis, and reporting into your regular programming?
  - What funding must you secure in order to execute the data process?
  - Who are you sharing the data with and how are you ensuring the data is shared responsibly and ethically?

- **Formality of the partnership:** Having a contract or **memorandum of understanding (MOU)** in place will help to sustain formality of the partnership by outlining roles, responsibilities, expectations, shared goals, accountability, and other agreements. This might also be required in order to retain specific members of the partnership, such as placement of a co-located advocate within a clinic or hospital setting. Consider building into the MOU factors like consent, confidentiality and privacy of protected health information (PHI) for data sharing between partners, as well as outside the partnership. *(See appendix for sample MOU)*

ACTION STEP: List the core components and services specific to your partnership that need to be sustained, and then gauge what your partnership can realistically sustain with and without funding

ACTION STEP: Develop a revised MOU for the partnership that takes into account amendments and changes with the closing of the grant cycle. Together, assess emerging needs, as well as modified roles, responsibilities, goals, expectations, and any related financial agreements.

What can be sustained without funding?

Once you've identified the core components of your partnership that need to be sustained, determine which components require funding and which do not. In general, the components requiring funding tend to reside at the level of service delivery and tend to be more advanced intervention strategies, such as a co-located advocate, or providing shelter-based health services. Fortunately, peer partners agree that after making the initial timely and costly investments in the development of domestic violence and health care partnerships, many of the core components listed below can easily be sustained with minimal funding, once they have become established practice within the partner sites:

Informed by peer leaders, the essential building blocks of a partnership that need to be sustained beyond a grant cycle include:

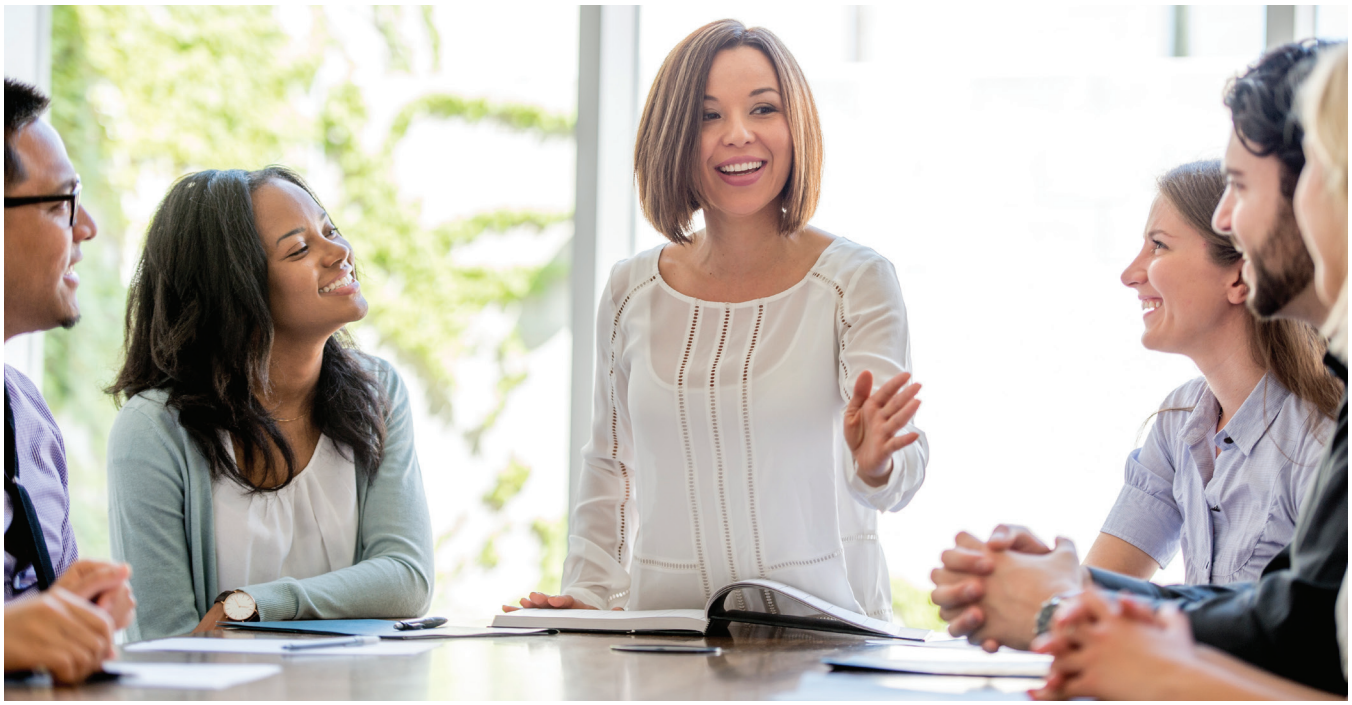
- **Universal prevention education on safe and healthy relationships, assessment and response in the clinical setting:** Once integrated into organizational programming, practice, and protocols, clinical DSV assessment is easily sustainable with minimal costs. A foreseen challenge in maintaining a team-based approach to clinical assessment and response is staff turnover.
- **Universal prevention education on safe and healthy relationships, assessment and response in the advocate setting:** Once integrated into organizational programming and practice, shelter-based health assessment is easily sustainable with minimal costs. A foreseen challenge in maintaining a team-based approach to health assessment and response is staff turnover.
- **Cross-referral system:** Once a cross-referral system is integrated into organizational practice, a basic cross-referral system is easily sustainable with minimal cost, depending on volume.
- **Policy and written protocols for both the clinical and DSV setting:** In order to sustain lasting systems within the partnership, its practices must be embedded into policy and written protocol and must occur within a construct that integrates ongoing training, supporting implementation, monitoring adherence, and evaluation that informs quality improvements made over time.
- **Access to culturally-responsive, trauma-informed educational materials for patients and clients, as well as tools and resources for providers and advocates:** Continued access to free tools and materials for patients, clients, and providers is available at **www.futureswithoutviolence.org** at no cost to organizations (organizations pay only a nominal fee for shipping costs).

- **Data:** Depending on the level of the data systems implemented, data efforts may or may not require funding in order to sustain. For folks who have data procedures built into already established electronic health records (EHR) or electronic systems like Efforts to Outcomes (ETO) or Apricot, costs may be minimal, and may only require staff time to monitor, analyze, and report. For folks who manually track data via paper documentation, or require a designated team to lead these efforts, more funding may be required to sustain.

ACTION STEP: Determine the core components and services specific to your partnership that can realistically be sustained without funding.

ACTION STEP: Develop a plan of action for sustaining the components that require funding, such as leveraging grant funds, implementing structures for billing reimbursement, or applying for new grant funds.

ACTION STEP: Consider ways to reduce costs associated with data to ensure its sustainability. This may mean identifying alternatives or implementing adjustments in your current model for data collection. Identify what is possible to sustain with your current resources.



What are the hard costs?

Identify within your organization and partnership the hard costs of sustainability.

Hard costs may include:

- **Staff time:** This is the most significant cost of a partnership. This may include the leadership team, project champions, and other key staff responsible for overseeing the success and operations of the partnership. This may also include new positions created specifically for the partnership, such as a co-located advocate or health coach, or hiring a new advocate to meet the increased demand for services. Identify the core members, and the total cost for salary and wages, including fringe benefits and other related overhead expenses.
- **Travel:** Travel costs may vary across partnerships depending on location, specific services and models of care. Many partnerships incur travel costs for activities such as in-person leadership team meetings, staff training, community-based outreach and prevention activities, and travel across the site network or county for co-located services.
- **Training**: Ongoing staff training is critical to sustainability. Costs may include staff time, speaker costs or training fees, materials, and wages lost due to earmarking provider or advocate time for training. Other related expenses might include the cost of food or refreshments for staff during trainings.
- **Supplies:** Supplies may vary depending on the model of care and intervention strategies, but may include health supplies offered at the shelter; AV equipment needed for training, patient/client education, or group work; medical supplies; office supplies; and multimedia equipment for technology-based approaches, such as computers, cell phones, tablets, etc.
- **Transportation:** Many partnerships offer transportation assistance to facilitate access to health care and DSV support services, such as bus tokens or taxi vouchers.
- **Policy and protocols:** Related policy and protocol costs may include consultant fees, and web-designer or software fees for updates in EHR and data systems.
- **Technology:** Costs may include updates/improvements to EHR software and hardware; software development/maintenance for electronic referral systems and electronic consents; implementation, updates, and improvements to data systems; electronic tickler or listserv system to maintain ongoing communication with community members, partners, supporters, donors, funders, and other key stakeholders; and costs associated with managing social media campaigns for awareness and prevention.

It can be difficult to create a strategic plan for sustainable funding without a clear sense of the actual cost of the partnership. Once the whole cost is identified, prioritize and then work with your partner to creatively address all costs. Consider resourceful ways to reduce some of these costs, if possible. Also consider compartmentalizing specific components of the partnership and then addressing funding needs for individual parts, rather than for the partnership at large.

For example:

- **Leverage staff time with your partner organization** or through the use of trained, supervised peer educators, interns, or volunteers. Consider partnering with a high school, college, or university to implement an intern-training program that maintains continuous access to additional staff support.
- **Lean on your partner, Futures Without Violence, project-based learning networks, and other community partners** to prevent duplication of services, materials and resources, and to reduce costs associated with materials that are available for free. Consider implementing trades with other organizations for consultation, support, and booster trainings to help reduce speaker costs for ongoing staff development.
- **Master the telling of your story** and share with your board of directors, donors, supporters, and community partners making an invitation for support through donations (both cash and in-kind).
- **Chunk down elements of your model when making proposals to private funders.** Consider creative ways to leverage funding opportunities to support a specific component of your partnership, making funding more attainable. For instance, seek funding to support transportation costs associated with the partnership, or submit for several smaller grants to cover individual pieces of the program, rather than one large grant to cover all components.

ACTION STEP: Map out all the hard costs involved in your partnership, including subcontractor fees to your partner organization, if applicable. Consider ways to offset costs by leveraging funds, implementing cost-sharing strategies with your partner, in-kind support, and leaning on your partner to fill gaps in services. Discuss creative, thoughtful, realistic ways these hard costs can be minimized. Once you know the cost required to sustain your specific partnership model, you can strategically develop a plan of action for generating (and leveraging) sustainable sources of funding.

BUILDING AND STRENGTHENING PARTNERSHIPS

Where can the project live so it survives beyond grant funding?

Ensuring domestic violence and health care partnerships live, thrive, and spread beyond the grant cycle can happen in a variety of ways. It requires equitable collaboration and clear commitment from all parties involved. Partners must be aligned in their vision and have shared goals, and the partnership must bring mutually beneficial value, as well. Engaging a team-based and collaborative approach to embedding the inner and outer workings of the partnership into organizational programming and practice is imperative to both sustaining the life of the partnership and strengthening it overtime. Ultimately, partners must embody the idea that the partnership and DV health care integration is not merely a special and temporary project, but rather an integrated part of the whole—it is part of what the organization does, part of the mission, and part of the service model within the community.

> *"It's not a program we run, it's part of what we do."*
>
> **– John Bridges,** Family Health Centers of San Diego

- **Leadership:** Sustaining partnerships can be supported beyond the grant cycle by organizing collaborative meetings between the key players of each organization and identifying mutually beneficial goals, roles, responsibilities, and expectations, without the context of a third party contract.
    - Determine who the champions will be and propose continued joint initiatives that include a comprehensive action plan to maintain and strengthen the partnership efforts made this far.
    - Once established, the key to success is maintaining leadership roles and nurturing the relationships built between health care professionals and DV advocates—each bring strengths and expertise to the table. It is important to take the time, at least annually, to continue to learn about and understand each other's work. The vision is to maintain successfully integrated practices and response into existing programs and services. This type of an integrated approach, overtime, will maximize the existing resources and improve the quality of services for patients/clients who have experienced DSV.
    - Peer partners agree that sustainability must be driven by the top, reinforced at the level of direct service, and informed by social determinants of health. All staff, not just

staff involved in executing program and partnership activities, must be engaged and informed, and buy-in from all staff must be achieved. All staff must feel motivated to not only continue this work, but also strengthen and expand the work, intrinsically, without the context of a grant-funded obligation. Promote the idea that your partnership is not a compartmentalized, specific project but a part of what the organization does, and a part of the greater mission. Engage administrative and executive leaders in the process, as well as board members.

- **Policy and systems:**
  - Establish an integrated and institutionalized response to violence and abuse
  - Develop organization-wide culturally appropriate response, resources, and materials
- **Language and culture:**
  - Invest in the continued development of knowledge and skills of health and DSV service providers
  - Renovate old models of training by incorporating new principles in content—impact of DSV on health; reproductive coercion; universal prevention education principles; modernized, evidence-based assessment and intervention strategies—and redesign avenues for ongoing training and education to overcome staff turnover (such as e-learning opportunities, involvement from Human Resources, 40-hour training curricula, and continuing education programs for health care providers)
- **Impact data:**
  - Upon completion of the initial development (and cost) of streamlined manual and/or electronic data systems, consider integrating new portals into existing data systems that captures more meaningful data on health access, and health and safety outcomes. Expanding data collection in this way can be a gradual process, and may require minimal effort and cost over time. Building upon data that is collected will help create a place where the partnership can live beyond any particular grant cycle while continuing to demonstrate impact overtime. Using data strategically to make the case for your partnership and tell the story of impact leverages your work and supports sustainability and quality improvements.
- **Telling the story:**
  - Safeguard the life of the partnership through the process of telling the story.

Identify innovative and feasible ways to tell the unique story of your partnership that captures both qualitative and quantitative aspects across service delivery, outcomes, and systems-level change. The format and pathway for how you tell the story varies across partnerships, but might include a logic model, infographic, digital story, web-based portal, data reports, or disseminating information to audiences at local, state, and national convenings, conferences and meetings. It might also guide the development of proposals and conversations with private and public funders, donors, health plans, and other key stakeholders. The following are examples that have come out of the Domestic Violence and Health Care Partnership initiative:

- The partnership between WEAVE and Sacramento Native American Health Center (SNAHC) created a digital story documenting the meaningful principles of their collaboration; their unique service delivery model; the impact on individuals, the organization, and the community; and their goals for expansion and spread. Their digital story can be viewed here: **https://youtu.be/WVkODr1dviY**
- The Family Assistance Program and San Bernardino County Department of Public Health crafted and leveraged their story verbally to secure more funding for core project staff positions, engaged new partners in their model, and received high recognitions including the "Promising Practice" award from the National Association of County City Health Officials (NACCHO), and the 2016 Achievement Award from the National Association of Counties (NACo).
- The YWCA of San Gabriel Valley and ChapCare leveraged their story through the development of logic models and data, which landed them an invite to share their story, model, successes, and lessons learned with the California Improvement Network (CIN), lead by the California Health Care Foundation, a large network of safety net and commercial sector health care delivery organizations, community clinic consortia, and related quality and performance improvement organizations. *(See appendix for sample logic model)*
- John Snow, Inc. (JSI) created a compelling infographic that illustrates the impact of domestic violence on health, the health care system, quality of life, and self-sufficiency. *(See appendix for infographic)*

ACTION STEP: Identify how you have developed a home for the partnership thus far, at both the health and DV site, and discuss how this can expand.

ACTION STEP: Identify where your organization can improve upon embedding the partnership into its mission, programming, long-term goals, funding priorities, and strategic plan. Evaluate where work can be done with staff to better institutionalize your partnership model and support long-term sustainability efforts.

ACTION STEP: Consider ways in which you can tell and leverage the unique story of your partnership and integrated model of care.

Who are the core members? What is the plan if they leave?

Determine a clear plan for staff turnover, especially if key members and champions leave. Key staff includes those who maintain and support core operations of the partnership, drive core elements of the integrated model of care, and on-the-ground champions who execute direct service delivery and key interventions. This includes:

- Executive staff, program and clinic directors, and medical directors
- Project directors and coordinators
- Project champions at both partner sites
- Key clinicians, providers, and ancillary staff
- Key advocates, counselors, therapists, and social workers
- Co-located advocates, promotoras, and health coaches
- Care coordinators and case managers
- Key community liaisons, educators, and outreach workers

Staff turnover is a universal and inevitable challenge for all organizations and partnerships. Peer leaders suggest a variety of strategies to work through the foreseen challenges of staff turnover:

- Engage multiple staff in partnership processes, and cross-train staff across departments to ensure back up in someone's absence
- Implement a buddy system or process for shadowing key players involved in the partnership
- Integrate core elements of the partnership, as well as information about the connection between health and DSV, within Human Resources to ensure all new hires are oriented appropriately
- Use electronic or web-based training modules that are accessible to all staff at any time
- Integrate the connection between DSV and health, and reproductive coercion into 40-hour training curricula for advocates
- Integrate key project roles and responsibilities into organization charts and staff job descriptions
- Schedule regular staff meetings designated to reviewing policies and written protocols

ACTION STEP: Develop a clear plan for how the partnership, key roles, and services will be sustained when core members leave the organization, both temporarily and permanently. Remember, the more the partnership is embedded into organizational infrastructure and perceived as 'a part of what we do', the more resilient the partnership will be as staff turns over.

How often will leadership and key staff meet and communicate? What will be the process and format for communication and partner exchange—in-person, by phone, by email?

Regular, ongoing communication is critical to sustaining and strengthening partnerships and integrated service delivery models. Again, what makes the partnership tick? Your partnership works because of the relationships and trust built over time. Your partnership includes live, dedicated, passionate human beings with shared goals to better serve survivors of DSV. Your partner is not just a name on a list of referrals; this is one of the most valuable distinctions of partnership. Communication, in a variety of ways, is essential to maintaining and strengthening the collaborative nature of your partnership.

Identify with your partner your communication needs:

- How will communication happen? Which modes of communication work best for key members—text, email, phone, in person?
- How often do you need to communicate by text, phone, and email?
- How often do you need to meet in person, and what is feasible given your available time and resources, to sustain the established core elements of your partnership?
- Who specifically on staff is responsible for leading partnership meetings
- What is the proposed agenda for ongoing meetings?
    - Provide updates?
    - Review data reports and deliverables?
    - Quality improvement checks?
    - Review procedures, kinks and challenges, and troubleshoot?
    - Discuss patient/client cases?
    - Discuss staff performance?
    - Review financials and fundraising efforts?
    - Share successes, lessons learned, and impactful stories?
    - Engage in social bonding and team building?

- When and where will meetings happen?
- How often will internal communication happen?
- How can ongoing staff training, new hire onboarding or shadowing be integrated into continuous partnership communication and scheduled meetings to support sustainability through staff turnover? Consider what this looks like for you, taking into account available staff time, funding, and workload. Decide with your partner what the communication parameters will be, in a way that is mutually beneficial and realistic. Peer leaders suggest:
    - Ongoing daily to weekly internal communication with core staff and project champions (i.e. morning huddles, weekly check-ins, regular email correspondence)
    - Ongoing internal communication about project practices, policies, evaluation, and impact with all staff at regularly scheduled staff meetings
    - Ongoing, regularly scheduled in-person meetings with project leadership team and core members at least once quarterly, or as often as once per month
    - Ongoing text, email, and phone communication with core members on a weekly to monthly basis, or as needed
    - Ongoing text, email, and phone communication with frontline staff weekly or as often as needed in order to maintain streamlined referrals, address individual issues, and coordinate scheduled activities related to outreach, prevention, and education
    - Regularly scheduled meetings with executive staff once quarterly, and with board of directors annually or semi-annually

ACTION STEP: Develop a schedule for how often the leadership team and core staff will meet, dialogue and exchange, and outline the specific ways in which communication will happen—email, phone, in-person meetings. Consider an ongoing scheduled agenda and talking points to ensure all aspects of the partnership are routinely addressed.

What will be the process for data collection and assessing quality assurance and quality improvements?

Consider developing a streamlined process for data collection and reporting, as well as linked procedures for continuous quality improvement checks to monitor deliverables, outcomes, impact, and progress toward achieving goals set forth by the partnership. For instance, designate specific staff members who will meet regularly, perhaps on a quarterly basis, to review data reports and discuss the findings, and correlate quality improvement measures, challenges, successes, and impact. Determine an effective and relevant tool, such as a **QA/QI tool for health settings** or **QA/QI tool for domestic violence programs** to structure, guide, and measure the quality improvements made over time.

Valuable data measures might include:

- Number of patients assessed for DSV (and/or why assessment did not take place)
- Number of clients served in the DSV program that are assessed for health needs
- Number of patients/clients that were offered educational materials on health and DSV, as part of universal prevention education
- Number of positive disclosures
- Tracking who on staff completes the assessment and universal education
    - CHW, MA, RN, NP, MD, LCSW, advocate, coach
- Harm reduction strategies and supports provided to DSV survivors
- Number of bi-directional referrals made between health setting and DSV program
- Number of referrals made from outreach and social media efforts
- Implementation of ongoing staff training and/or cross-training between partners
    - When and where
    - Topic
    - Staff who attended
    - Evaluation and impact
- Progress toward establishing or maintaining new or improved policy and written protocols
- Staff meeting agendas integrating booster trainings and QI conversations on policies and procedures

- Evaluation of staff performance on project activities and systematic response
- Progress toward improvements made in the physical environment of the clinic or shelter (i.e. the display of culturally responsive posters and educational materials, use of videos)
- Progress of community-based outreach and prevention efforts
    - Date, location, population type
    - Number of people reached
    - Topic
    - Distance/travel documentation
- Short term and long term health and safety outcomes
- Review of related financial reports and project cost analysis
- Progress toward systems and policy change at the level of the organization, community, and county
- Progress towards expanded goals or long-term strategic plans

Your program can also measure systematic response including: specific assessment and intervention methods; networking and training opportunities; self-care and support for staff; education and prevention; and maintaining a safe environment for discussion of IPV. For example, Kaiser Permanente measures three elements that every facility must have to make this work move forward:

- a clinic or medical center clinician champion;
- a multi-disciplinary team (which should include community advocacy representatives); and
- a clearly delineated referral protocol.

Integrating elements of QAQI or specific metrics into EHR or existing data systems will help facilitate these efforts, and make capturing quantitative data and deliverables more accessible (while leveraging costs).

ACTION STEP: Develop a clear plan for data collection, evaluation, and QA/QI checks. Institutionalize regular, ongoing meetings for data and QI into organizational practice, and core partnership activities. Set a schedule for reviewing data reports, updating data systems, and monitoring quality assurance and quality improvements. Consider scheduling on a monthly, bi-monthly, or quarterly basis.

TRAINING

Given staff turnover, what is the optimal plan for continued, routine staff training?

Ongoing, quality staff training is vital to sustaining domestic violence and health care partnerships. Training is fundamental in implementing new tools and practices, initiating and standardizing policy change, and maintaining quality assurance in existing practices and response interventions. Design an optimal training regimen for your organization and your partnership that will commence following the close of the grant cycle. For some, this may mean continuing your staff training model from the grant cycle, and for others, this may mean redesigning a modified, more sustainable staff training regimen beyond the grant cycle, that is more feasible given available staff time and resources.

An optimal plan for staff training includes:

- orientation and onboarding for new hires;
- routine booster training with updates on field advancements, expanded content, and routine skills-based education;
- bi-directional training opportunities.

An optimal plan for staff training uses a team-based approach inclusive of all staff.

Staff turnover is an inevitable and perpetual challenge for all organizations and partnerships. Devising, and then embedding, a formalized structure for staff is crucial to an organization's resilience as members enter and exit. Through the continuation of training opportunities, and the longevity and overlap of new and tenured staff members, a cohesive adherence to partnership practices, policies, and procedures can materialize.

Aim to train smarter, not harder, and conserve your resources.

Rather than re-invent the wheel expending limited time and funds, optimize your relationships with fellow grantees, the learning network, community partners, and local/national supports. Identify the full scope of your support systems, and network for ideas, best practices, useful training tools, and modules that you can adopt and adapt. Futures Without Violence is always an available resource for ongoing access to training, technical assistance, webinars, materials, and toolkits.

What is the optimal plan for bi-directional training?

Cross-training involves a collaborative model for staff training with your partner organization. The health care team facilitates training for members of the DSV program, and the DSV team provides training for members of the health care program. This model creates an effective platform and inner-organization learning exchange where the experts provide the training. This is a way to integrate no-cost staff development, and it is a powerful way to facilitate and nurture personal connections with the individuals involved in the partnership. This has been one of the most significant gems to come out of the domestic violence and health care partnership project. Your partner is no longer just a name and phone number on a referral list, but a team of actual human beings, with whom you have spent time and connected. Cross-training facilitates a deeper understanding of your partner's mission, values, culture, services, locations, eligibility, history, accomplishments, practices, and procedures. It also provides an opportunity for the partnership to come together to think creatively, brainstorm new ideas, troubleshoot, acknowledge, and celebrate.

There are a variety of ways in which cross-trainings can be done:

- Host your partner organization at your site for a morning or afternoon training session (2-4 hours), and include breakfast, lunch, or simple refreshments, if the budget permits
- Host specific members of your partner organization to train at your next regularly scheduled staff meeting
- Host a team conference call or webinar with your partner organization

The more face time allotted to spend with your partner site staff, the more valuable the training will be, and the deeper the live connection will be.

Identify what is most feasible for your partnership at this time. Remember that any amount of cross training is better than no cross training. Also, keep in mind that this is an evolving process, and what is possible and realistic right now may change overtime.

Who should receive ongoing training?

- Health care providers (physicians, nurses, nurse practitioners, midwives, physician assistants)
- Clinic support staff (medical and nursing assistants, LVNs, clinic health workers)
- Public health professionals
- Health educators and community liaisons
- DSV service providers and advocates
- Co-located advocates, health coaches, and promotoras
- Case managers and care coordinators
- Project champions
- Social workers
- Mental health professionals (counselors, therapists, and psychologists)
- Interns, volunteers, and peer educators
- Clerical, front desk, and hotline staff
- Back office staff and billers
- Administrative staff
- Executive staff

Consider extending training opportunities to other support staff such as security guards, parking lot attendants, and janitorial staff who may observe abusive and/or threatening behaviors and have safety concerns for patients/clients.

What is the optimal training schedule and format?

Staff training is most effective when scheduled on an ongoing basis—at minimum, plan for once annually, ideally, once per quarter. When new services, policies, practices, and interventions are scheduled for implementation, additional trainings must be scheduled.

Trainings can be facilitated by guest speakers or by the staff members most comfortable with the content and delivery of the training. The most effective trainings tend to be facilitated by a dynamic duo or small team to create variety and bring in different areas of expertise. They should be interactive and spark as many of the senses as possible to maintain stimulated adult learning, and include movement around the room.

Trainings should also utilize diverse teaching methods such as:

- Visual aids—posters, PowerPoint, charts, graphs, handouts, flip charts
- Experiential activities, role playing, and individual and team exercises
- Small and large group discussions
- Multi-media and video clips
- Self-tests
- Teaching demos or models
- Depending on the phase of your partnership, ongoing training topics might include:
- Review of partnership—goals, key roles, practices, progress
- Review of each partner organization's services, values, programs, history, eligibility, and policies
- Trauma and the health impacts of violence and abuse
- Fundamentals of DSV, including the Power and Control Wheel
- Universal prevention education strategies on safe and healthy relationships
- Reproductive coercion and assessment strategies
- Family planning basics, including emergency contraception

- Women's health and sexual health
- Clinical training on DSV assessment, reporting, and intervention (and what to expect after a report is made)
- Shelter or DSV program-based health assessment and intervention
- Trauma-informed care
- Cultural humility
- Safety planning and integrating health into safety planning
- Mandatory reporting requirements, as applicable, and strategies for trauma informed reporting
- Alternatives to justice
- Introduction/review of newly integrated strategies, policies, procedures, protocols, services, and forms
- Review/update of streamlined reciprocal referral system

Lastly, always integrate pre and post training evaluations to measure impact and learning, inform future quality improvement, and continuous practice change.

Where can the staff-training requirement and regimen live to ensure sustainability?

Given that staff turnover is a universal and inevitable challenge for all organizations and partnerships, reflect on where the staff-training regimen can live. Peer leaders suggest a variety of strategies to embed training requirements into organizational and partnership programming to ensure sustainability and resiliency:

- Embedding the staff training/cross-training regimen into policy and written protocol
    - Create a system for internal cross-training across departments to ensure back up in someone's absence
    - Implement a buddy system or process for shadowing key players and project champions
    - Integrate partnership core elements, and information about health and DSV within Human Resources processes to ensure all new hires are oriented appropriately
    - Integrate key project roles and responsibilities into organization charts and staff job descriptions
    - Schedule regular and ongoing staff meetings designated to reviewing policies and written protocols
- Building core training requirements into electronic or web-based training modules that are accessible to all staff at any time
- Integrating the connection between DSV and health and reproductive coercion into 40-hour training curricula for advocates
- Engage executive staff and board of directors in staff training plans, and invite them to attend the in-services, as well
- Utilize a corporate compliance calendar that provides monthly drills on a variety of topics, and includes training on DSV and response
- Schedule and rotate staff to participate in ongoing webinars, conferences, and events on DSV, health, and other related topics

ACTION STEP: Identify the core values and common goals for staff training within each organization and the partnership.

ACTION STEP: Develop your optimal plan for staff training with your partner. Decide on an effective and viable schedule for internal staff training and bi-directional training, taking into consideration your goals and available resources. Determine the ideal format (objectives, agenda for topics/content, speakers, location, evaluation plan, etc.) that will strengthen the collaboration, lessen disruption of staff turnover, and ease the onboarding process and transition of new hires.

ACTION STEP: Establish a home for your staff-training regimen. Identify any systems or policy change that must occur in order to support this and help build in ongoing training into organization infrastructure.

Dissemination and spread: Who can promote training and systems change in your community? In your state?

In support of the greater sustainability of partnerships, greater systems and policy-change efforts, and broader understanding of DSV as a social determinant of health, ongoing staff training must expand beyond the four walls of your organization and partnership. All providers, health care professionals, advocates and DSV support staff must have access to quality, evidence-based, culturally responsive, trauma-informed training opportunities.

Given your lessons learned and experiential success in DSV health care integration, consider how your organization can contribute to expanded efforts towards improved response to DSV:

- Who within your partnership is poised to take on training facilitation for health and DSV service providers of other organizations?
- How can your training requirement support a train-the-trainer model?
- How can your organization leverage your staff-training model to create new funding streams through consultation and fee-for-service training structures for other organizations within your community? Within your county? Within your state?
- How can your partnership tell and leverage the story to create opportunities for dissemination and spread regionally, statewide, and nationally?

ACTION STEP: Gauge the interest and readiness of your partnership to engage in greater dissemination and spread of domestic violence and health care partnerships and systems change work.

ACTION STEP: Identify who on staff is most poised to take on this level of involvement, and clearly identify your available resources to support these efforts. Look to your network for already existing train-the-trainer curricula to prepare key members poised and prepared for this work.

ACTION STEP: Network within your community and county, and at local/state/national conferences and events to tell your story. Make yourself available to share your story, lessons learned, and promising practices with others and make invitations for training and consultation—consider developing a structure for fee-for-service training. For example, meet with county health departments, health plans or coalitions working on California Accountable Communities for Health Initiative, as well as other state and national initiatives .

ACTION STEP: Join local or statewide consortia addressing health, DSV, abuse, trauma, and social determinants of health to be at the table to share your experiential understanding, strategies, and best practices for improved response to DSV at the systems-level.

RESOURCES

Futures Without Violence Online Catalogue for Educational Materials, Tools, and Resources
https://secure3.convio.net/fvpf/site/Ecommerce/15587835?FOLDER=0&store_id=1241

IPV Health
http://www.ipvhealth.org

A Guide to Sustaining Public Health Partnerships to Prevent and Address Violence Against Women
http://www.futureswithoutviolence.org/userfiles/file/HealthCare/public_health_partnerships_with_advocates.pdf

Creating Protocols on IPV
http://ipvhealthpartners.org/wp-content/uploads/2017/02/Sample-Health-Center-Protocols.zip

Model Policies
https://www.futureswithoutviolence.org/domestic-violence-and-health-care-protocols/

APPENDIX

i. Sample MOU for domestic violence and health care partnerships

Memorandum of Understanding

This Memorandum of Understanding is entered into by *Jenesse Center, Inc.* ***and*** *Watts Healthcare Corporation****, and is effective May 1, 2016 thru April 30, 2019.*** *Jenesse Center, Inc.* ***and*** *Watts Healthcare Corporation* ***agree to work collaboratively to provide coordinated services for victims of domestic violence.***

Each agency agrees to participate by coordinating or providing the following services:

1. **Jenesse Center, Inc.** and **Watts Healthcare Corporation** agree to refer appropriate clients to one another and to coordinate services to mutual clientele.
2. **Jenesse Center, Inc.** will serve as a referral source for clients identified by **Watts Healthcare Corporation** and will provide domestic violence supportive services in the form of: case management, individual, group and family counseling, mental health assessments, legal assessments and services, emergency shelter, transitional shelters, drop-in services, children's enrichment program, transportation, outreach activities, 24-hour crisis hotline and vocational services.
3. **Watts Healthcare Corporation** will provide medical, mental health and case management services to clients referred by Jenesse Center, Inc.
4. **Jenesse Center, Inc.** staff will be available to provide domestic violence awareness, prevention and treatment education to **Watts Healthcare Corporation** staff.
5. **Watts Healthcare Corporation** staff will be available to provide training on health topics, disease prevention and healthy lifestyles to clients of **Jenesse Center, Inc.**
6. Representatives of **Jenesse Center, Inc.** and **Watts Healthcare Corporation** will meet on an as needed basis

This memorandum of understanding is effective May 1, 2016 and may be terminated by either party, in writing, at least thirty (30) days prior to the date of the termination.

We, the undersigned, do hereby approve this document.

Chief Executive Officer	Date	President & CEO	Date
Jenesse Center, Inc.		Watts Healthcare Corporation	

ii. DVHCP Logic Model

DVHCP Logic Model			
Program Inputs *(Existing Factors)*	***Program Outputs*** *(Deliverables)*	***Program Outcomes*** *(What we will measure)*	***Program Impact*** *(What could be expected over time if outcomes are reached)*
• Clinical and DV expertise and experience • Community Need • Facilities and infrastructure: Clinics and DV programs • Existing relationships and referral systems • Existing policies and protocols • Funder Commitment	• Trainings provided to clinic staff – number of providers trained • Trainings provided to DV provider staff – number of DV providers trained • Number of DV clients served • Number of clinic patients served • Number of referrals from clinic to DV provider • Number of referrals from DV provider to clinic • Number of team planning meetings • Implementation of new/improved organization policies, procedures, and protocols • Implementation of integrated prevention and intervention models (co-located advocate, promotora, home visitor, CHW, outreach, shelter-based education, clinic-based groups	• Increased health & DV providers awareness and knowledge about the health impacts of DV, response and interventions • Increased health care provider skills in early detection, universal education, DV assessment and intervention • Increased DV provider skills in universal education, health assessments, facilitating timely access to care, and establishing a medical home • Increased QAQI for health care response to DV • Increased QAQI for DV service provider response to health • Decreased violence / increased safety experienced by DV survivors - *Self-reported safety* - *Safety plan implementation* - *Self-efficacy in making positive change* - *Self-sufficiency* - *Parenting self-efficacy* • Improved health outcomes of DV survivors - *Depression* - *Anxiety* - *Unintended pregnancies/induced abortion* - *HIV and STIs* - *Low birth weight and premature births* - *ACES and childhood development measures* - *Child immunizations* - *Harmful alcohol/substance use* - *Non-Fatal Injuries*	• Improved health & safety outcomes • Safer families • Healthier families • Less DV in communities • Improved systems and multi-sector response to DV - *Organizationally* - *Locally* - *State-wide* - *Nationally* ***TELLING THE STORY*** *(Making the case for DVHCPs)* • Programmatic impact • Direct service impact • Cost-savings & return on investment • Impact on systems change - *Within organizations and across sectors* • DV as a social determinant of health

iii.

THE IMPACT OF DOMESTIC VIOLENCE ON HEALTH

DV LEADS TO ADVERSE HEALTH CONSEQUENCES

PHYSICAL AND CHRONIC

SHORT-TERM bruises, fractures & injuries

LONG-TERM chronic pain, headaches, fatigue, immune, endocrine & gastrointestinal disorders

2x the risk of asthma, irritable bowel syndrome & diabetes

MENTAL HEALTH

DV SURVIVORS ARE:

3x MORE LIKELY TO HAVE A MENTAL HEALTH CONDITION

DEPRESSION is as high as **70%**

PTSD is as high as **84%**

HEALTH RISK BEHAVIORS

DV SURVIVORS ARE:

6x more likely to become dependent on drugs or alcohol

2x more likely to smoke, become obese, and practice sexual risk behaviors, increasing risk for STDs and HIV

REPRODUCTIVE HEALTH

DV INCREASES RISK FOR:

Unintended pregnancies and poor pregnancy & birth outcomes

DV BURDENS THE HEALTH SYSTEM

The **MEDICAL COST BURDEN** from DV in the first year after victimization is as high as **$7 BILLION**

HEALTH CARE UTILIZATION & COSTS for abused women are up to **20% HIGHER** and stay higher for up to 5 years after victimization

CHILDREN WHO WITNESS ABUSE ARE

3x more likely to use mental health services, and are more likely to use all health care services

THE CYCLE OF VIOLENCE

THIS IS ONLY PART OF THE PICTURE.

DV OFTEN GOES UNDIAGNOSED & UNDISCLOSED.

DV IS HIGHLY PREVALENT

1 IN 3 WOMEN

WILL EXPERIENCE DV IN HER LIFETIME.

DV affects over **12 MILLION** Americans every year, **DISPROPORTIONATELY YOUNG, LOW-INCOME WOMEN OF COLOR.**

DV'S IMPACT EXTENDS BEYOND HEALTH

DV REDUCES QUALITY OF LIFE & LIFETIME POTENTIAL, AND LEADS TO:

- ↓ Loss of productivity and wages from missing work
- ↑ Need for housing services
- ↑ Risk for future victimization

WITNESSING ABUSE AS A CHILD RAISES RISK FOR ADULT VICTIMIZATION & PERPETRATION.

DV IS A CRITICAL HEALTH ISSUE. IT'S TIME TO LEVERAGE THE SHIFTING HEALTH POLICY LANDSCAPE AND FOCUS ATTENTION AND RESOURCES ON DV.

JSI

Made possible with the support of Blue Shield of California Foundation. Read the full report on jsi.com: http://bit.ly/2cfJhaD.