Domestic Violence and Health Care Integration: A toolkit for creating sustainable partnerships

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LA BioMed, Women's Health Care Clinic Outreach & Education Program
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Contributors:
Jennifer Haddad, MTP, Director of Programs
Kim Burtle, CNM, Project Advisor
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INTRODUCTION

About the Organizations

Since 1952, the Los Angeles Biomedical Research Institute (LA BioMed)—a private, nonprofit biomedical research agency governed by a 27-member board of directors—has built a reputation as one of the nation's leading independent biomedical research organizations. Academically affiliated with the UCLA School of Medicine, LA BioMed is located on the campus of Harbor-ULCA Medical Center in Torrance, CA. LA BioMed collaborates on several innovative community health programs working closely with indigent, low-income, uninsured families and individuals to improve their health and their access to care. The Women's Health Care Clinic is one of these programs.

The Women's Health Care Clinic (WHCC) has been a leading provider of reproductive and preventative healthcare to the most underserved communities in the South and Harbor areas of Los Angeles County for over 50 years, ensuring access to quality, unbiased care. Its mission is to provide uninsured individuals, regardless of income, with the necessary information and services to plan their families and take care of their reproductive health needs. The WHCC operates inside WIC (Women, Infants and Children program) in Compton, and within the Catalina Island Medical Center in Avalon. Under the medical direction of nationally and internationally known, Anita L. Nelson, MD, care is delivered by a team of skilled, experienced Nurse Practitioners, a Medical Assistant and Clinic Health Worker. Leadership and oversight is provided by the Director of Programs, Project Advisor and Medical Director, a team with decades of experience in the field that has worked together at WHCC for over 10 years.

The WHCC has been at the forefront of health care and medical advancements since its inception. In 1966, WHCC started as the first training site for Pap testing for registered nurses. It was the first Women's Health Nurse Practitioner Training Program (WHCNPP) in the country. Historically, best practices in clinical services, as well as patient counseling and education, have been piloted and tested at the WHCC. Some of the advancements coming out of pilot projects at WHCC include: clinical trials on contraceptives and gynecological treatments; clinic-based screening approaches for domestic violence; and counseling and education for preconception care. Having transitioned out the WHCNPP after graduating over 120 classes, today, the WHCC is now a nationally trusted continuing education provider through the California Board of Registered Nursing.

WHCC principle activities include providing unbiased health services and education, regardless of income, to the most vulnerable populations in Los Angeles, as well skills-based training and continuing education hours for providers. Central activities also include development and implementation of special projects to improve access to care for underserved populations, and community-based health education and outreach. The WHCC has a history of long-standing partnerships and support from a diverse landscape of medical affiliations and community organizations with the common goal to serve the most underserved populations in Los Angeles.

Founded in 1979, Interval House is a Presidential Award-winning, comprehensive domestic violence program nationally recognized for pioneering culturally specific services for underserved domestic violence survivors and families in the Counties of Los Angeles and Orange. Interval House offers a complete continuum of housing and comprehensive support services. Services are provided by a team of staff and advocates most unique in the nation—over 98% are culturally diverse, multilingual, and have, themselves, overcome violence, homelessness and other cultural barriers to become dynamic leaders, advocates and role models. This unique peer-to-peer model has been acclaimed as the hallmark of Interval House's programming for over three decades.

Today, Interval House is the only program in the country to offer all programs and services in over 70 languages, 24 hours a day, 7 days a week. Interval House programs and leadership have been recognized with over 500 awards, including four Presidential Awards, four Governor's awards, and a U.S. Dept. of Justice Award, citing Interval House as a "model" domestic violence program to the nation.

Purpose of the Partnership

The Domestic Violence and Health Care Partnership (DVHCP) is an integrative vision put into action. It is a statewide initiative to move forward full integration of domestic violence (DV) and health care services. Through a wide spectrum of strategic approaches, the DVHCP aims to improve overall access to care, prevention, assessment and intervention throughout the safety net for domestic violence victims. Leadership, project oversight, training, technical assistance and evaluation is provided by Futures Without Violence, a national nonprofit organization leading groundbreaking educational programs, policies, and campaigns that empower those working to end violence against women and children around the world. This innovative project involved four cohorts of 19 partnerships across the state of California, for a funding cycle of either two or three years. Each team developed a thoughtful, strategic plan to create and sustain an effective partnership. Teams developed, implemented and executed a combination of unique shelter/advocate and clinic/provider-based approaches. Each partnership endured unique challenges and successes. Some achieved meaningful steps towards a progressive and sustainable integration of services, while others encountered more "fabulous flops" and barriers to move forward components of their strategic partnership plan.

The DVHCP promotes the idea of a wellness-driven safety net addressing both DV and health (reproductive, general, behavioral/mental, emotional) through integrated models of service and system-level improvements within DV and health organizations. This model project has been valuable in developing a roadmap for how healthcare providers and DV advocates can collaborate to ultimately offer health services in DV programs and DV support in various health care settings.

Our Partnership: WHCC + Interval House

WHCC and Interval House serve as critical access points for the most vulnerable communities in Los Angeles facing multiple cultural, linguistic and economic barriers to access. It is critical to formalize systems of care across the safety net in order to identify victims and at-risk victims, and facilitate their access to appropriate and needed services, while creating a safe and nurturing environment to access care.

WHCC has created and adapted policies and established systems for clinic-based DV assessment long before this initiative. Yet through this project, an even greater opportunity emerged—an opportunity to improve policies, expand capacity and strengthen collaboration and connection with a committed DV partner.

The DVHCP between WHCC and Interval House set out to accomplish the following:

- Formalize a sustainable partnership, identify key leadership and clarify roles and responsibilities within the partnership;
- Improve and update clinic policies for DV screening, reporting and intervention;
- Create a sustainable reciprocal referral system to streamline access to health services for DV clients and DV support services for disclosing patients;
- Create a nurturing and safe environment through the use of posters and culturally-responsive print materials in key areas/rooms at the clinics and shelter locations;
- Provide effective cross-training for providers, advocates and support staff on service integration, universal prevention education, evidence-based assessment tools, and response;
- Provide strategic approaches to shelter-based health education;
- Promote healthy relationships and DV prevention through dynamic community-based education;
- Create, at the completion of the project, a complete toolkit that blueprints best practices and strategies for duplicating an effective domestic violence and health care partnership.

This toolkit is ultimately a culmination of the lessons learned and best practices that have emerged from this project. The tested strategies and innovations outlined throughout the toolkit are made easily accessible for other or-

ganizations to adopt, duplicate, and adapt. The project demonstrated core system-level changes at both the DV and health sites, resulting in noteworthy mutually beneficial outcomes.

Health site benefits include:

- An improved understanding of the complex and broad effects of domestic violence on health, wellbeing, core family dynamics, and community;
- Greater knowledge of the scope of services and support of a DV program;
- A clear understanding of the underlying factors involved in creating a safe space within the clinic's physical environment needed for patients to talk openly, and disclose when they are ready;
- Awareness of the many available culturally-responsive, trauma-informed materials on health and domestic violence;
- Improvement of internal policies and procedures for DV/IPV screening, reporting, intervention, and universal prevention education;
- Stronger efficacy in the use of clinic/exam forms and patient medical records to document DV assessments while guiding providers through the conversation about DV, and safe and healthy relationships;
- Establishing a personal connection and strong working relationship with a local DV program to provide warm, trusted referrals to patients and streamline a solid reciprocal referral network;
- Strengthened infrastructure and expanded capacity of expertise, creative thinking, communication, counseling, evaluation and leadership.

DV program benefits include:

- A clear understanding of the scope and limits of services at the health site;
- Deepened knowledge of the effects of DV on health, reproductive coercion, contraception and basic women's health issues;
- Expanded scope of services and resources offered within the shelter;
- Institutionalizing the integration of ongoing health education into DV programming and groups;
- Utilization of a train-the-trainer model to prepare advocates to sustain shelter-based health education with the use of an evidence-based curriculum and health educator kits;
- Developing baseline policies for shelter-based health screenings, and eventually on-site access to health supplies like condoms, pregnancy tests, thermometers, feminine hygiene products and face masks;
- Establishing a personal connection and strong working relationship with a local clinic to provide warm, trusted referrals to clients and streamline a solid reciprocal referral network;
- Strengthened infrastructure and expanded capacity of expertise, creative thinking, communication, counseling, evaluation and leadership.

Additionally, the DVHCP brought the benefit of ongoing technical assistance and support from Futures Without Violence (FWV). The assistance and training provided by FWV was invaluable to ushering the success and progress of this partnership. FWV provided real-time support through challenges, ongoing accountability, and extensive learning exchange and network with all grantees across the state. Their sizable catalogue of free, culturally responsive, evidence-informed resources (safety cards, posters, toolkits, policy memos, training materials) was a cornerstone to guiding and informing the progression of our work.

Toolkit Objectives

Our goal is to share the core strategies and best practices of our project and provide a clear, simplified model for duplicating your own unique DV and health partnership. It is meant to share the experiences and lessons learned specific to our partnership, thus providing a framework for you to adopt and adapt the pieces that are relevant and fitting to your organization. Our hope is that you can take the best of our partnership's achievements, and then improve upon and expand these components within your organization to better serve your patients, clients and community.

This toolkit is designed to help you:

1. **Develop** and formalize a partnership that will move forward an integrated response to domestic violence and health care in your organization and community.
2. **Implement** proven strategic systems, protocols and best practices to effectively integrate DV and health care services.
3. **Evaluate** successes and challenges of your unique partnership, measuring outcomes and recreating strategies as needed.
4. **Sustain** the successful aspects of your unique partnership, independent of funding.
5. **Expand** the integration of services beyond your partnership to forward an effective integrated response to DV and health care and improve access within the safety net systems of care.

Why this work is important

This is what we know:

- *Domestic violence is a public health issue*
- 17% of abused women reported that a partner prevented them from accessing healthcare
- Domestic violence significantly increases risk for unintended pregnancies
- 25% of abused adolescent females report that their male partner was trying to get them pregnant
- Those experiencing teen dating violence are more likely to:
    - Start having sex before age 15
    - Have multiple partners
    - Have a current STI or history of a STI
    - Not use condoms correctly or consistently
    - Choose partners who engage in high-risk sexual behaviors
    - Use drugs and/or alcohol before sex
- In family planning clinics nationwide, it is estimated that over half of women ages 16-29 have experienced domestic/sexual violence
- 1 in 4 women in the US has been raped at some point in their lives, and ½ of them report being raped by an intimate partner
- 1 in 3 women globally experience physical or sexual violence by an intimate partner
- Women who have experienced domestic/sexual violence are:
    - Twice as likely to experience depression
    - Twice as likely to abuse drugs (illegal and prescription) and alcohol
    - One and a half times more likely to contract HIV or a sexually transmitted infection

- Women in abusive relationships experience acute and chronic health issues, and have a complex medical history outside of injuries from violence
    - 42% of women who have experienced domestic/sexual violence have long-term disabilities related to the injuries from the violence
- Women who have experienced domestic/sexual violence are more likely than their counterparts to report complaints of symptomatic PTSD, asthma, diabetes, irritable bowl syndrome, chronic headaches, chronic pain, sleep disturbances, poor birth and pregnancy outcomes, and poor physical and mental health

There are clear linkages and undeniable connections between domestic/sexual violence, intimate partner abuse and health. More specifically, there are strong correlations between domestic/sexual violence and reproductive health and pregnancy. The evidence and troubling stories behind this work are strong motivators to further develop and expand DV and healthcare integration, be more cost-effective in care and DV support services, and improve quality and access to care for victims and survivors of abuse. We are reminded time and time again that DV is a prominent public health issue and significant social determinant of health. This is why we do this work.

Section I: DEVELOP

Developing the Partnership

This work begins, first, with building the foundation. Start with the basics of identifying, developing and nurturing a strong partnership using the following steps:

I. Choose your partner organization
II. Formalize the partnership
III. Identify goals and projected outcomes
IV. Identify and address barriers

I. Choosing your partner organization

Choosing the right partner is the first step to a successful partnership and service integration. When evaluating your options for a partnership, there are many factors to assess. Consider the following:

- Do you already have an established relationship with the organization?
- Do you have a strong history of a positive and effective working relationship?
- Are the organization's mission and core values aligned with those of your organization?
- How strong is the organization's infrastructure?
- Is the organization well-funded?
- Is the organization located in close proximity to your service area?
- What do you understand about the organization's ability to set and accomplish goals and follow through with projects?
- How strong is the organization's network within the community?
- Do you respect the organization and its leadership style and approach?
- Is your communication style compatible?
- Do you have experiences working through conflicts together?
- Can you envision a strong and effective partnership with the organization, with and without funding?

It may be best to chose a partner with whom you already have an established, healthy working relationship. The more you know about your partner organization—how they approach collaboration, their leadership style, communication tactics, ability to compromise and cooperate—the stronger the partnership will be and the less difficulties and conflicts you will encounter down the road.

It may also be valuable to consider the size and political climate of the organization. Sometimes, larger organizations or those that are a small part of a much larger system—i.e. a county health department, hospital or university—experience greater difficulty in implementing new projects, policies and strategies for improved services.

II. Formalizing the partnership

The culture and foundation of partnership set forth from the beginning is central to the long-term success and sustainability of the partnership. First, identify the leadership team and the key players. Clearly define the role of the partnership, as well as the role and responsibility of each member of the leadership and service team. Collectively come to an agreement on how the working relationship will be carried out. This includes:

- the greater role of the partnership within the context of the two organizations
- the role of each individual on the leadership team
- the role and duties of the frontline and administrative staff members
- the lead contact for each site
- the process for making decisions
- the preferred methods of communication
- the agreed upon communication schedule—frequency of phone and in-person meetings
- the process by which challenges and conflicts will be addressed and resolved, within and between the organizations
- the team members who will spearhead partnership evaluation, and the process and schedule by which evaluation will happen
- if applicable, the lead contact(s) for each site monitoring and tracking funds, deliverables and progress towards benchmarks
- if applicable, the member(s) responsible for completing and monitoring the contract agreement or Memorandum of Understanding (MOU).

The more clarity the teams have at the inception of the partnership, the more effective, efficient and successful the outcome. This is important regardless of whether it is a formal partnership as defined by a grant contract or funder, or an informal one. If the partnership is informal, in that it is not structured by a funder or contract, it is recommended to formalize the partnership by establishing a written and signed partnership agreement or MOU. Formalizing the partnership in writing helps to solidify and substantiate the working relationship, the roles of the members involved, the collective decision making process, and the mutually beneficial expected outcomes.

Although all of these elements is important, one of the central considerations to partnered success is the process by which challenges, disagreements, and conflicts will be addressed and resolved. Discussing this clearly at the beginning of the partnership will facilitate ease when differences arise.

III. Identifying goals and projected outcomes

Next, strategize, identify and formalize the core partnership goals and projected outcomes the leadership team hopes to accomplish. Goals should be mutually beneficial to the organizations and the individuals served. They should enhance capacity and improve systems of care within the targeted community or service area.

Remember, effective goals are SMART:

Specific and clear
Measurable and quantifiable
Attainable with the resources available
Realistic and relevant
Time bound

For example: *Implement shelter-based health education sessions, in English and Spanish, reaching a minimum of 180 DV clients by June 30, 2017.*

As a partnership, decide on the nature and content of the goals, the target population served, the number of goals, and the timeframe in which the goals will be achieved. Leadership can determine whether it is best to start slowly with one or two objectives within a three to six month timeframe, or dive into a full scope project with three to five

objectives over the course of a year, or longer. Teams may base this decision on the availability of resources, funding and staff time.

Keeping the goal in mind

It is important to keep the common goal in mind throughout this process, and particularly during the development phase and when challenges arise. Months down the road when facing turbulence, setbacks or disagreements, remember why you started this work: *to better serve your patients and clients*. Keep in mind the goal to see domestic violence and health services as one, interconnected service network, built on the foundation that good health is part of healing. Work from the viewpoint that more than likely, everyone involved is operating from good intentions.

DV and health sites have equal power and responsibility to empower and support good health, safety and wellness in their clients and patients, thus improving their overall quality of life. DV and health sites are equally important thresholds for care, and in order to provide the best possible care, there must be a complete service integration between advocates and providers. The underlying goal is for health care to be an entry point for DV prevention, screening, intervention and support (remembering that disclosure is not the goal), and for DV programs to be a pathway to overall healing and wellness addressing physical/mental health and reproductive life planning within the context of the safety plan. Recognize and remember throughout this process that there really is no separation between the two.

What can advocates do?

- Create and maintain a partnership with a preventative or reproductive health clinic and other health center
- Recognize that each organization plays a key role in this level of service integration to promote better health, safety and healthy relationships
- Adopt simple, integrated interventions and strategic innovations
- Reframe the shelter and DV program as a wellness center

What can health care providers do?

- Create and maintain a partnership with a DV program and/or DV task force
- Recognize that each organization plays a key role in this level of service integration to promote better health, safety and healthy relationships
- Adopt simple, doable, quick assessment and response strategies for the health care setting—providers have a unique opportunity for early detection and intervention of IPV and domestic/sexual violence
- Reframe the clinic as an integrated wellness center with expanded support systems for DV

Lastly, keep in mind that the bigger goal of this work is long-term sustainability. The DVHCP project was not meant to be a temporary trial or fading trend. Rather, it is a deep-rooted vision and investment that was designed to forever change the landscape of care for DV victims and survivors, informing policy improvements at the local, state and national level. As you move forward in your own unique partnership, keep **sustainability** at the forefront of your design as you shape and reshape the strategies for carrying out this work.

IV. Identifying and addressing barriers

Integrating and expanding new services often brings up challenges with staff. In the development phase, take time to explore barriers, biases and resistance that come up for staff. They are being asked to take on a whole new service model or modify an existing one—if even just by taking a few baby steps—and their enrollment in the process is vital to the success and sustainability of the work. Just as personal biases and beliefs must be explored and addressed in any type of counseling (pregnancy options counseling, DV counseling, STI/HIV counseling) the same must be done when integrating DV and health services.

Often times, advocates feel resistant to addressing health issues, especially reproductive health and reproductive coercion, in the shelter setting. They don't see the need, they don't understand the reasoning behind their new involvement with these issues, and they are uncomfortable talking about such intimate issues like sex, sexual practices, birth control, and emergency contraception, to name a few. At the same time, clinic staff often feels overwhelmed, uncomfortable and may even experience emotional triggers when asked to start talking to patients about healthy relationships, intimate partner abuse and domestic/sexual violence or adolescent relationship abuse. They often express uncertainty about how to handle the situation if a patient discloses information about abuse, and they express fear and/or anxiety at the thought of having to file a mandated report. They may feel unprepared in their understanding about what constitutes a mandatory report, and more importantly, what happens after a report is made. Lastly, there is the issue of time. It is common for team members to feel resistance or hesitance due to the simple fact of time, or lack thereof.

Whatever the barriers are for your staff, spend time talking about them, addressing them as best as possible, and reframing them with realistic opportunities before moving forward with implementation.

Common barriers for advocates:

- Not understanding the correlation between DV and health
- Not believing it is necessary or a priority to talk to victims/survivors about health
- Overall discomfort talking about sexual health and related topics
- Lack of adequate training and knowledge of reproductive health
- Not knowing what to do after a client discloses
- Overall lack of awareness of available resources
- Time factor

Common barriers for providers and clinic support staff:

- Not understanding the correlation between DV and health
- Not believing they have any power to help someone experiencing domestic/sexual violence
- Overall discomfort talking about domestic violence and related topics
- Lack of adequate training and knowledge of DV indicators, effective screening techniques, mandatory reporting and safety planning
- Not knowing what to do after a client discloses
- Overall lack of awareness of available resources
- Time factor

Section II: IMPLEMENT

Now that you have a clearly defined and structured partnership, it's time for implementation. Implementation is the 'what', 'how' and 'when' of your partnership objectives put into strategic action. This next section will outline the broad spectrum of integration strategies and best practices both at the DV and health sites. Several of these strategies were successfully implemented by the WHCC and Interval House and integrated in our regular programming. Others are strategies and actions taken by other grantees in our learning network across the state of California. All are effective in achieving some level of service integration between DV programs and health sites.

Be mindful of what is realistic for your partnership at this time. Remember that full integration is an extensive, multi-year process, and that will more than likely require funding. Decide how your partnership will work toward service integration; start small and build upon each preceding strategy. Some strategies are simple and can be implemented rather quickly. Others may require approval for internal policy change; participation from various department heads; hiring additional, qualified staff; or restructuring to create more time availably of specific staff positions.

The Importance of Staff Training

All of the following integrated services require staff training. Staff training, and better yet, cross-training with your partner organization, is central to the implementation process. Each new strategy or action plan must be reviewed, discussed and/or taught to *all* staff. This includes the leadership team, management, administrators, providers, clinic support staff, counselors, advocates, outreach workers, back office, and front desk staff. Depending on the organizational structure of the partner sites, this may also include the grants/contract officer, development officer, finance/accounting department, and others that may be indirectly connected to the project.

A common mistake that organizations make is training only the providers or only the advocates. This limits the greater vision and sustainability of the DVHCP service integration, and it is a disservice to the patients and clients served by the organization. Creating new policies, activities, services and forms in an effective and sustainable manner, requires the enrollment and engagement of everyone at the organization. All staff members, although they may not be directly involved in providing the care or services, should have a strong knowledge and understanding of the organization's mission, scope of services, practices, policies, target populations served, community partners and current projects. A team-based approach will always optimize the work of the partnership.

For example, at the WHCC, front desk staff receives the same training as the medical assistants (MA) and providers. This is valuable because front desk staff truly is the face of the clinic. They are constantly representing the clinic at all times through the call center and as they greet patients at the front desk. They are the very first point of contact for patients. They are responsible for answering all questions, within reason, about services, eligibility, what to expect at a visit, referrals for outside care, etc. It is advantageous for them to be well trained and knowledgeable about the full spectrum of care provided. They oversee the patient waiting room at all times. They observe patient behaviors in ways the MAs or providers may not see. It would be a complete disservice if they were not trained to notice an abusive relationship walking through the door, a hostile partner, or bruises on a patient. Moreover, all staff participates in the process of screening for DV within the clinic walls. Although the providers are responsible for the heart of the assessment, it is most effective through a collective team effort in which each staff member understands their role. This is the beauty and power of including all staff in trainings and in-services.

Cross Training

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

Cross-trainings are collaborative staff trainings or in-services with your partner organization. The health team facilitates training for members of the DV program team, and the DV program team provides training for members of the health care team. This model creates an effective platform and inner-organization learning exchange where the training is provided by the experts. It is not only a way to integrate no-cost staff development, but also 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 our partnership, as well as the majority of the other grantee teams across the state.* 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.

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

- Most optimal: Host your partner organization at your site for a morning or afternoon training session (3-4 hours), and include breakfast, lunch or simple refreshments, if the budget permits.
- Less optimal: Host specific members of your partner organization to train at your next staff meeting
- Least optimal: Host a team conference call or webinar with your partner organization

The more face time allotted to spend with your partner site, the more valuable the training will be and the deeper the live connection will be. Do what is most feasible for your site at this time. Any cross training is better than no

cross training. Also, remember that this is an evolving process, and what is possible or realistic right now may change over time.

Trainings should be provided by the team members most comfortable with the content and delivery of the training, and should include members of the leadership team. The most effective trainings are 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 senses as possible to maintain stimulated learning, and include movement around the room. Trainings should also utilize diverse teaching methods such as:

- visual aids—posters, Power Points, charts, graphs, handouts, flip charts
- multi-media and video clips
- small or large group discussions
- activities and games
- self-tests
- teaching demos or models

Training topics may include:

- introduction/review of partnership and goals of the partnership
- partner organization's services, programs, history and eligibility
- content training for health sites
    - fundamentals of domestic/intimate partner violence, including the Power and Control Wheel *(see appendix C)*
    - healthy relationships
    - clinic-based DV screening, reporting and intervention
    - confidentiality and mandatory reporting
    - safety planning
    - what to expect after a report is made
    - connecting with law enforcement
    - tools to facilitate DV screening, reporting and intervention
- content training for DV sites
    - effects of DV on health
    - fundamentals of reproductive coercion
    - basic training on family planning, contraception and emergency contraception
    - basic training on women's health issues
    - shelter-based health assessments
    - tools to facilitate health assessments and shelter-based health education
- introduction/review of newly integrated strategies, policies, services and forms
- introduction of reciprocal referral system

(For a review of our partnerships cross training curricula, see appendix D)

Lastly, pre and post training evaluations *(see appendix E)* are a critical component of staff training to measure impact and learning. *Please refer to Section III: EVALUATE*.

Strategies and Best Practices for Integrating DV + Health Services

There is a spectrum of implementation strategies for integrating DV and health services. The following section outlines several strategies and best practices for integrating services at both the health and DV sites. The majority of these strategies have been tested, and proven successful, within our own partnership over the course of two years.

It is important to remember that integrating services, successfully and with long-term sustainability in mind, is in fact a gradual process. The ideas are outlined in a practical order, making progressive duplication easy and accessi-

ble. Begin by evaluating your bandwidth for implementation with your partner—assess available staff, funding, resources and time. This will prepare your partnership to move forward strategically, pragmatically, and feasibly.

Although the optimal goal is full integration—which may involve a clinic-based advocate or shelter-based clinic—remember that a strategic and sustainable first step may be to start with the basics. Master the basics. Make the basics standard operating procedure. Then, move forward with more sophisticated strategies, building upon the preceding tactics. Also note, implementing just one aspect of the full design is a step in the right direction, no matter the complexity.

Implementation may require an exercise of trial and error. It is not uncommon to create a plan, try it out, and then six months later after review and evaluation, decide to reshape, make adjustments, or even terminate a specific activity/policy/strategy. If the underlying cause for adaptation is feasibility and sustainability, and a more suitable alternative can be implemented, then go for it. It is perfectly ok to make changes throughout the partnership. Just be sure to invite an open forum with your partner organization to discuss the challenges, successes, concerns, and alternative ideas. Then, come to a collaborative and mutual agreement before making any changes. Failure to engage in a collaborative, cooperative decision-making process will inevitably lead to problems in the partnership later.

Enjoy the learning process with your partner, and remain flexible. There are no failures, only lessons learned.

Integrating DV Services in Health Programs

Normalize the conversation of DV and healthy relationships in the physical environment of the health site

**A WHCC + Interval House best practice*

- Engage the patient in an indirect conversation about healthy relationships right when they walks through the doors
- Provide information on healthy relationships in new patient packets
- Maintain this conversation throughout the physical space of the clinic by displaying culturally-responsive materials, wallet cards, waiting room videos, and posters in patient areas
    - Think of patient areas when they will engage with staff and be alone
    - Patient waiting rooms, counseling rooms/cubicles, hallways, exam rooms and patient restrooms
- This creates an awareness for patients that they are in a safe space to talk about their relationships, and if necessary, this it is a safe place to disclose
- This nurtures a safe environment that established patients will see every time they return to the clinic which creates a repeated opportunity for them to talk openly and disclose when ready

Normalize the conversation of DV and healthy relationships throughout the visit

**A WHCC + Interval House best practice*

- Integrate language and questions that speak to healthy relationships throughout all parts of the visit—at intake, vitals, counseling, the exam, the exit
- Implement universal prevention education and use of the Safety Card Intervention *(see page 23)*
- Provide staff trainings on DV/IPV, reproductive coercion, adolescent relationship abuse, and sexual assault, at least once a year, to facilitate comfort in talking about these issues routinely *(see appendix D)*
- Remind staff they don't have to be a DV expert. They simply need to be comfortable recognizing and talking about DV, navigating mandatory reporting laws, and utilizing the partnership referral system

Implement routine DV assessment and response in clinic visits

**A WHCC + Interval House best practice*

- Utilize elements of universal prevention education to go beyond a checklist-based approach
- Explain to patients, using patient-centered techniques, why you are asking about intimate relationship details

        - *"We've started giving information to all our patients about safe & healthy relationships and intimate partner violence—in case it's ever an issue for you and also so you can help a friend or family member if its an issue for them"*
    - Revise forms or electronic health records (EHR) to include inquiry about IPV
        - Medical history form, exam form *(see appendix A)*
    - Example assessment questions may include:
        - *Do you feel safe in your relationship?*
        - *Do you feel you have control to make your own decisions about pregnancy and birth control?*
        - *Has anything frightening happened to you in the last 6 months?*
    - Supplement assessment with the Safety Card Intervention
    - Always review the limits of confidentiality first
    - Always screen the patient alone first
    - Ask all patients and ask often
        - All initial and annual visits, all return visits that yield information about the relationship
        - Pregnant test visits, STI counseling/testing visits, IUD removal visits, emergency contraception visits, when patient's disclose they have a new partner
    - Establish or adopt (and maintain) a complete protocol for DV screening, reporting and intervention *(see appendix C)*. Ensure all staff is trained on the protocol, and that they understand the steps necessary if a patient discloses

Establish a referral list for domestic/sexual violence and adolescent relationship abuse *(see appendix C)*

**A WHCC + Interval House best practice*

- Include your partner organization, as well as at least 2 others in close proximity to your site
- Update the list on an annual basis, calling each of the sites and verifying current contact information, services, eligibility, locations, and any other important information for making referrals
- If possible, optimize the referral process by visiting/touring each of the sites making it a warm referral list
- Keep copies of the list available at the clinic
- Review the list with staff annually or whenever it is updated

Establish a policy for rooming alone *(see appendix C)*

**A WHCC + Interval House best practice*

- Always interview the patient alone first
- If the patient has a guest with them, inform the patient and guest of the policy to always interview patients alone, and they welcome to re-enter the room afterwards
- Provide staff training on how to talk to patients and guests about this policy, and how to handle hostile guests

Create a reciprocal referral system with your DV partner

**A WHCC + Interval House best practice*

- Work with your DV partner to establish a process for referring patients for DV support services, whether or not a report was made
- Have a clear understanding how the process will change or be expedited when a report is made, or if the patient's immediate safety is at risk
- Have a clear understanding of the scope of services offered by your DV partner so only appropriate referrals are made, and staff offers accurate and current information to patients
- Define the process for which referrals are made to the DV program in a way that allows for provider and advocate follow up
    - Create or adopt an internal referral form that is scanned/emailed or faxed *(see appendix B)*
    - Establish a protocol for phone referrals

- Maintain a DV referral log in the clinic so providers can follow up with patients and with the DV site about a patient's progress
- Have access to speak with a designated advocate during clinic hours, one in which a personal, face-to-face connection was made at the cross-trainings
- Have access to a 'backdoor' number or on-call advocate for emergency referrals or after-hour referrals.
- All referrals must be documented appropriately in the patient record, and also this could include the DV referral form

Build in blocked appointment times for DV clients

**A WHCC + Interval House best practice*

- Decide with your DV partner the best way to implement and manage a blocked appointment system to streamline appointment scheduling *(see appendix B)*
  - Designate specific clinic staff to manage the blocked appointment schedule
  - Have clinic staff send blocked appointments to DV staff on a weekly/bi-weekly basis by fax or email
  - Coordinate appointments by phone or encrypted email on a weekly/bi-weekly basis
  - Give designated advocates limited access to the blocked appointment schedule and teach them how to coordinate appointments for clients
  - Give DV partner access to a 'backdoor' number for emergency or time-sensitive referrals—pregnancy tests, emergency contraception visits, etc.
  - Blocked appointments don't need to limit access to appointments for other patients. Keep it simple and realistic to clinic flow and volume. Perhaps it's one standing appointment per day, or a few per week mirroring something like standing 'refill hours'

Implement weekly or monthly clinic tours for DV clients

- Coordinate an ongoing tour schedule (weekly, bi-weekly or monthly) with your DV partner
- Coordinate group transportation to and from the clinic with your DV partner
- This strategy helps build relationships between DV clients and the health care professional with whom they would be receiving care
- This strategy may assist with dispelling myths and easing fears that DV victims and survivors have about providers, and reframe their overall relationship with the health care system

Promote prevention + safe and healthy relationships in the community

**A WHCC + Interval House best practice*

- Provide outreach in your community to expand awareness of available services and mainstream access to care, especially to underserved, at-risk populations
- Provide community-based workshops and classes on healthy relationships, DV/IPV, adolescent relationship abuse, sexual assault and reproductive coercion *(see appendix D)*
- Distribute brochures, patient education and clinic brochures at all events, as well as safety cards personalized with partner contact information

- Consider the following community organizations: schools (junior high, high school, junior college, universities, continuation schools), parent groups, teen parenting programs, drug/alcohol recovery programs, residential sober living homes, women's shelters, transitional housing, social service programs, WIC centers, mentoring groups

Host or hire a part-time co-located or full-time DV advocate

- This is the epitome of full integration of DV services at a health program
- This clearly requires physical space in the clinic for the advocate, as well as funds to support the cost or shared cost of the advocate
- Onsite advocate serves as the point of contact when DV is disclosed, allowing the expert DV professional to step in and fill the gaps of what is beyond the scope, capacity and time limitations of the provider
- This strategy allows for clinic-based DV counseling and support services to be weaved into the healthcare system
- This strategy is most practical and useful for larger, high-volume health systems
- Onsite advocates can also assist with the process of making a report, and working with law enforcement

Integrating Health Services at DV Programs

Normalize the conversation of health in the physical environment of the DV site

**A WHCC + Interval House best practice*

- Engage the patient in an indirect conversation about health (women's health, reproductive & preventative health) right when they walk through the doors
- Provide information on health on new client intake forms and welcome packets
- Maintain this conversation throughout the physical space of the shelter by displaying culturally-responsive materials, safety cards, waiting room videos, and posters in client areas
    - Think of client areas when they will engage with staff and be alone
    - Lobby, counseling rooms/cubicles, hallways, group meeting rooms and restrooms
- This creates an awareness for clients to know they are in a safe space to talk about their health, as well as their family planning and reproductive health needs, and it is a safe place to access information or maybe even care
- This creates a safe environment that short-term and long-term clients will see every time they are at the shelter or outreach office, creating a repeated opportunity for them to open up and ask for help when they are ready

Normalize the conversation of health within the shelter setting

**A WHCC + Interval House best practice*

- Create a culture of talking about health, and make it a regular part of advocate and client conversation
- Empower normalcy in talking about health, wellness and living a healthy, active lifestyle within the shelter-setting
- Implement universal prevention education and use of the Safety Card Intervention
- Provide staff trainings on health, the effects of DV on health, reproductive coercion and basic family planning and reproductive healthcare, at least once a year, to facilitate ease in talking about these issues *(see appendix D)*
- Remind staff they don't have to be a health expert. They simply need to be comfortable recognizing and talking about health, navigating common health needs of DV victims and survivors, and utilizing the partnership referral system

Implement routine health assessments at shelter intake

**A WHCC + Interval House best practice*

- Integrate questions and universal prevention education on intake, counseling and exit visits that speak to health, the effects of DV on health, and reproductive coercion
- Explain to clients, using trauma-informed techniques, why you are asking about intimate health details
    - *"Violence and abuse has many effects on our health and wellbeing. Because of this, we've started giving information to all our clients about health and how to know if your relationship is affecting your health."*

- Revise intake and/or exit forms to include inquiry about health and immediate or time-sensitive reproductive health needs *(see appendix A)*
- Example assessment questions include:
    - *Are you currently taking any medications?*
    - *Are you currently using any contraception? Y N What method?*
    - *When was the first date of last menstrual period?*
    - *Do you want to be pregnant?*
    - *Have you been seen by a health care provider in the last 12 months for anything other than physical injuries? If so, for what?*
- Supplement assessment with the Safety Card Intervention
- Be patient with new clients when going through the health assessment, as they are oftentimes overwhelmed with the situation, reliving the trauma in the interview, and health at that time is not usually their main priority. Because of this, some shelters opt to postpone the health intake until 48-72 hours after intake; however research shows that assessing health needs at intake, and a few days after, is most effective.

Establish a referral list for local clinics and health centers

**A WHCC + Interval House best practice*

- Include your partner organization, as well as at least 2 others in close proximity to your site
- Update the list on an annual basis, calling each of the sites and verifying current contact information, services, eligibility, locations, and any other information necessary when a referral is made
- If possible, optimize the referral process by visiting/touring each of the sites making it a warm referral list
- There is no need to re-invent the wheel. Most health sites have already established referral lists for outside health services. Adopt one already created from your health partner.
- Keep copies of the list available at the office and shelter locations
- Review the list with staff annually or whenever it is updated
- This strategy helps to improve access to health care for underserved victims and survivors of DV

Create a reciprocal referral system with your health partner

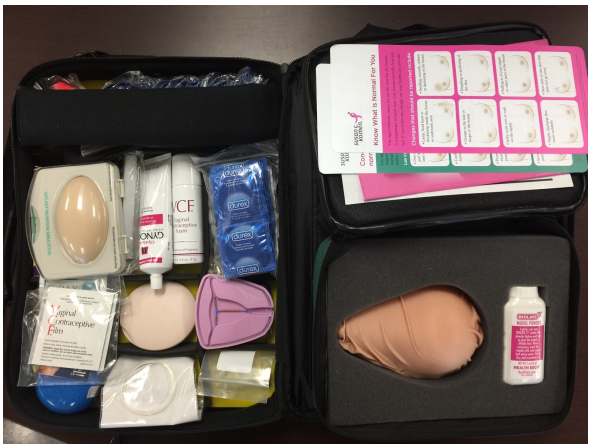
**A WHCC + Interval House best practice*

- Work with your health partner to establish a process for referring patients to healthcare services
- Have a clear understanding how the process will change or be expedited when a client has urgent or time-sensitive healthcare needs
- Have a clear understanding of the scope of services offered by your health site so only appropriate referrals are made, and staff offers accurate and current information to clients
- Define the process for which referrals are made in a way that allows for advocate follow-up
    - Create or adopt an internal referral form that is scanned/emailed or faxed *(see appendix B)*
    - Establish a protocol for phone referrals
    - Create a system for blocked appointments *(see appendix B)*
    - Maintain a health referral log in the shelter to allow for advocates to follow up with clients and help navigate healthcare needs moving forward
    - Have access to speak with a designated provider/medical assistant during clinic hours, one in which a personal, face-to-face connection was made at the cross-trainings
    - Have access to a 'backdoor' number or on-call provider or health staff person for emergency referrals or after-hour referrals.
- All referrals must be documented appropriately in the client record

Create a shelter-based health educator kit

**A WHCC + Interval House best practice*

- Work with your partner to create educator kits or a health box to keep at the office and/or at shelter locations
    - Health sites typically have access to these types of items through their retailers, and they typically can request samples/demos/models from pharmaceutical manufacturers
- Advocates can use the kits to facilitate hands-on learning in client conversations, counseling, or support groups
- The contents of the kit may vary depending on the health care services provided at your partner site, and the level of training provided to advocates
- Health Educator Kits can include a variety of teaching tools such as:
    - a pelvic and/or penis model
    - a breast model for teaching breast self-examination
    - samples/models of contraceptive methods (pills, vaginal ring, patch, IUDs, implant, sterilization coil, diaphragm, spermicides, etc.)
    - a demo sample of emergency contraception
    - condoms and lubricant
    - charts, graphs, brochures
    - flip charts and images illustrating elements of reproductive health
    - flash drives or CDs with short educational video clips



Provide outreach and health education at DV programs/groups

**A WHCC + Interval House best practice*

- Invite partner site to provide outreach on available health services to clients at the DV program
    - Create a regular outreach schedule to create consistency and repeated opportunities for clients to get information, retain information, and seek assistance when ready
    - Can be bi-weekly, weekly, or monthly based on the size of the shelter and the client turnover rate, taking into consideration the length of average stay of clients
    - Offer health education in multiple languages that fit the needs of the clients
    - The goal is to outreach to every new client at least once during their stay at the shelter, so every client walking through the doors is informed about the health impacts of DV and aware of how to access health services
- Implement health education at the DV program
    - Can be facilitated by health staff and/or DV staff
        - Start with staff from the health site providing the education, then gradually train and prepare advocates to take over for long-term sustainability
        - In preparing advocates to provide health education, start by inviting advocates to sit in/observe health education workshops facilitated by health staff
        - Schedule a cross-training using a train-the-trainer format, to teach advocates how to facilitate a simple health education workshop
        - Health education topics may include the effects of DV on health, basic family planning and contraceptive options, basic reproductive health information, and basic women's health information
    - Create a regular schedule for health education, and integrate into the regular DV programming
        - Can be bi-monthly or monthly

        - Schedule time for a 60 to 90 minute session
    - Offer health education in multiple languages that fit the needs of the clients
    - Can be launched as a separate health event, or integrate into already-established DV programs, like an ongoing support group or 10-week DV group
    - Implement Monthly Health Celebrations *(see page 20)*

Integrate a segment on health and domestic violence into the 40-hour curriculum

**A WHCC + Interval House best practice*

- Work with your partner to integrate into the 40 hour curriculum for DV volunteers a regular segment on DV and health
- This is a very effective way to initiate and sustain the conversation about DV and health with advocates, and it creates a natural threshold for more formal training in the future, while addressing barriers to this work at the start of an advocate's career
- Can be offered in a one or two hour time block
- Session can include information on:
    - the interconnection between DV and health
    - why victims and survivors delay health care and the consequences of delaying health care
    - common health complaints of victims and survivors
    - the mind-body connection
    - recommendations for improving health and wellness
    - information on the link between DV and women's health
    - reproductive coercion
    - the most optimal contraceptive options for victims and survivors

Provide onsite access to health supplies

**A WHCC + Interval House best practice*

- Work with your partner to create onsite access to basic health supplies at the office and shelter locations
- Reproductive health supplies may include: condoms, emergency contraception, urine pregnancy tests, feminine hygiene products
- General health supplies may include: thermometers, face masks, blood pressure machines
- This may require outside funding or it may require to be factored into the annual budget
- This strategy is most optimal after advocates have a full understanding of the DVHCP, why talking about health is important, and the underlying connection between DV and reproductive health

Establish a shelter-based clinic

- This is the epitome of full integration of health services at a DV program, and establishing this level of integration is a complex process
- A shelter-based clinic is an extension or satellite site of the larger health facility. It allows for onsite access to either limited or full-service health care services for DV victims and survivors
- A shelter-based clinic requires a number of factors to be in place in order to be implemented effectively, efficiently and with compliance. Consider the following:
    - The shelter must have the appropriate physical space to house a compliant exam room and/or designated clinic area
    - Onsite health services are provided by a licensed clinician—like a Physician's Assistant or Nurse Practitioner—and may include vitals, a medical history, exam, labs, medications, outside prescriptions, counseling, and referrals
    - Depending on the volume of the clinic, and the skill of the clinician, there may also need to be a Medical Assistant onsite to assist with intake, vitals, counseling, education, and referrals

- Clinic management would need to handle the billing and reimbursement aspects of the clinic, which would vary depending on the payer (Family PACT, MediCal, Managed Care, private health insurance, etc.)
- Funding will be required to cover the cost or shared cost of the clinical staff, medical supplies, labs, and other operational expenses
- Clinic management would need to handle appropriate malpractice coverage, permits and licensure in order to provide health services at the satellite site
- Clinic management would need to establish policies and protocols for responding to 'code blue' medical emergencies at the DV site, whether minor or severe
- Services should be provided in the language(s) of the clients
- Efforts to promote the onsite clinic and funnel clients into the clinic—like outreach, shelter-based health assessments, and health education events—would be critical in order to make the clinic cost-effective

Monthly Health Celebrations

One of the most unprecedented strategies launched in our partnership was the 'Monthly Health Celebration". The Celebrations were devised as a unique platform for integrating shelter-based outreach and health education to improve access to current, accurate health information, and streamline direct access into health care for victims and survivors of DV. They were large-scale events, reaching over a hundred clients, on average, at each event. The Celebrations provided a fun, positive and empowering circle for women to gather, share and learn about health and wellness, in a safe and intimate setting. They provided a sisterhood environment for clients to connect not only with members of the health team, but also their counselors, advocates, and peers.

The Monthly Health Celebration was a very unique way to integrate health education in a structured format that was inviting, engaging and familial. In our partnership, we completed the Celebrations for eight consecutive months. It was at that point, that we had to step back and re-evaluate our work and feasibility. On one hand, the Celebrations were widely embraced, loved, very well attended and effective. On the other hand, at the scale with which they were produced, the Celebrations caused the use of more staff time and resources than what was feasible, creating serious concern for sustainability. It was at that time, after elaborate team meetings and strategic planning, that the Celebrations transitioned into a different model for shelter-based health education—regular health education sessions integrated into the established, ongoing 10-week DV group at Interval House. Each cycle of the 10-week curriculum, now includes a session dedicated solely to the effects of DV on health. Although this new model for shelter-based education is quite different from that of the Celebrations, it is effective, easily doable, sustainable and has become institutionalized within standard operating procedures at Interval House. This is ultimately the goal of the DVHCP.

Adopting the Celebration Model

Despite the fact that our partnership chose to transition out of the Celebrations, they can in fact be adopted by other organizations easily and effectively. This next section will outline the framework for structuring the Monthly Health Celebration approach within your organization. You are invited to adapt the core compo-

nents of the Celebration model to make it workable, cost-effective and sustainable for your partnership. We believe with some adjustments, it can be done, and can be done well.

I. The set up

For many victims and survivors of domestic violence, urgent pressures such as relocation, legal issues, and emotional/physical stress pose overwhelming barriers to health care. During the planning process for this initiative, WHCC and Interval House worked together to determine who the target audience would be (both shelter and outreach clients) and how the workshops could effectively engage and entice survivors on a voluntary basis, given their instability and the heavy demands on their lives. We designed the Celebration model with a very client-centered, trauma-informed focus, ensuring that in addition to offering client incentives (funded by Blue Shield of California Foundation), the workshops are intentionally framed and promoted as fun, empowering events. This was central to the success of the Celebrations.

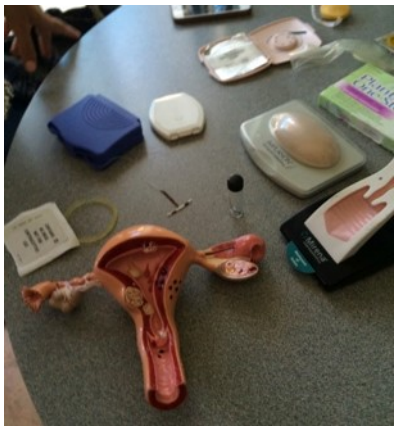
All the Interval House advocates, counselors and leaders were scheduled to be a part of the Celebrations, to greet, welcome, and encourage all clients. The ability to provide a structured opportunity, in a celebratory environment, for clients to socialize and connect with staff who have helped them through their times of crises created an energy of comfortability that resulted in a high level of interest and engagement with clients in talking about their health and well-being—and ultimately, accessing health services.

II. Incentives

To remove logistical barriers in accessing care at the clinic, Interval House and WHCC provided transportation vouchers to clients (funded by Blue Shield of California Foundation) and actively arranged carpools and taxi rides to ensure that all clients are supported and encouraged in their efforts to access care. Clients also received a gift card (funded by Blue Shield of California Foundation) upon attending their first Celebration. We worked together to create tracking systems to monitor appropriate distribution of gift cards. Although the gift cards were effective in helping to engage client participation, it is questionable as to whether or not they were sustainable. Furthermore, although incentives assist with launching new programs, the underlying goal is to inspire an intrinsic desire for participation that derives out of self-love, self-respect, and an inner willingness to take care of one's health, rather than through financial incentives. Adopt the pieces that fit for your partnership. For those interested in more cost-effective incentive ideas, consider relieving clients from certain house chores, extra privileges, or added shelter-based activities.

III. Health Education

WHCC staff provided a 90-minute health education workshop, simultaneously, in English and Spanish, at an Interval House shelter. Consider the space required in your setting to do this. If simultaneous groups are not feasible due to lack of space, consider scheduling different languages back to back.



Topics included women's health, family planning, sexually transmitted infections and HIV, breast cancer awareness, and nutrition. Topics can range based on whatever is most relevant within your partnership. Shelter clients were provided an opportunity to ask questions about their health in a safe, empowering space.

IV. Appointment Stations

The Celebration model created an opportunity for clients to be directly linked to the clinic through on-site appointment scheduling. Advocates set up onsite appointment stations outside the meeting rooms. After the workshop, where they received topic-specific education and information about clinic services, clients were invited to visit the appointment stations, to talk with their advocates and schedule an appointment at the WHCC. Advocates were trained on how to book appointments, how to talk with clients about clinic services, and how to briefly assess clients for eligibility of free care. All necessary intake/referral forms *(see appendix B)* were provided at the station as well, to prepare clients for what to expect at their visit. Additionally, at the stations, clients could access clinic brochures/flyers, and patient education materials. Clients were given reminder cards for their appointment, and if needed, they were offered assistance with round-trip transportation to the clinic.

The appointment stations were simply resource tables set up outside the meeting rooms. Advocates worked the station, clinic staff assisted when needed. Consider who in your organization can manage the station. Our Celebrations were attended by over 100 clients, which required 2-3 staff to be at the appointment station. Think about what's realistic, adequate and feasible for group; smaller shelters may only need one staff person at the station. Also, if advocates aren't available, health staff can easily take this on. Discuss in your partnership how and who can manage this aspect of the event.

IV. Special Events

To add an extra special touch to the Monthly Health Celebrations, our partnership coordinated special guests from time to time. This included a performance from a singer/songwriter who was a DV survivor, and a percussionist to lead a healing drum circle. The special performances were scheduled as an additional part of the Celebration, for those who wanted to stay. They were in no way linked to the health education, nor the topic covered, but simply a special gift to bring to the clients and staff. Consider your community partners, circle of influence, close network, family and friends. Who do you, and others in your partnership, know that would be willing to donate their time to come out and support your event…a musician, singer, percussionist, artist, yoga teacher, movement teacher, cook, etc. Think about special days (Health Cares about DV Day, Mother's Day), holidays or awareness months (April is Sexual Assault Awareness Month, May is Women's Health Awareness Month, October is DV Awareness Month), and consider making your Celebration extra special on those days to honor the clients participating.

V. The Celebratory Experience

As a result of the Monthly Health Celebrations, WHCC and Interval House have seen a remarkable increase in health care engagement and access, especially among victims who have reported never having had a well-woman exam, those who have had exams but had no knowledge of their medical results, and

those who had not previously disclosed. Our partnership created a bridge to health care that has been so important in helping victims prioritize their health, utilize services, and develop a medical home. It was not uncommon that in one month's time, after one Celebration, over 50 clients would schedule an appointment at the clinic. In addition, the Monthly Health Celebrations provide a valuable avenue for cross-training and sustainability among the Interval House staff, who have the opportunity to grow, evolve, and continue to share the knowledge they've learned with clients well into the future.

Reflect on all the information shared and consider the following:

- How do you envision the Celebration model fitting within your organization?
- What would you need to change or shift?
- What would it take in your partnership to adopt the Celebration model?
- What staff would be involved?
- How would you promote and optimize attendance?
- How much staff time would be required and allotted to promote and inform clients of the event?
- How often would be realistic for your partnership…monthly? quarterly? semi-annually?
- What meeting space is available for your use?
- How much funding would it take?
- What health topics would be covered?
- Would you offer some variation of incentives or transportation?
- Could you do Celebrations in multiple languages?
- What materials would you need to create or purchase?
- What staff training would need to be provided?
- Would advocates or clinic staff manage follow up for appointments, including coordinating ride-shares, transportation, or reminder calls?
- How would you evaluate client satisfaction, effectiveness and impact? *(see appendix F)*

Be creative, be flexible and have fun! Shape and reshape the Celebrations to fit your program and partnership, and benefit your clients, and lift up cultural humility in your geographical area.

Universal Prevention Education + The Safety Card Intervention

Universal prevention education and the safety card intervention *(see appendix H)* provide a simple, effective process for DV and/or health assessments, beyond questionnaires, checklists and direct inquiry. Through the use of these combined methods, both with in-person conversations and on-paper screening, a deeper conversation about DV and healthy/unhealthy relationships can be facilitated. Combining these strategies help shift the emphasis away from disclosure as the goal. Instead, this process helps to:

- plant seeds for patients/clients to open up and ask questions when they feel ready,
- better inform conversations around healthy and unhealthy relationships with all patients/clients while providing education on signs of abuse and health impacts of DV,
- move beyond direct inquiry only, and invite full integration of education, prevention, counseling and care,
- facilitate a more meaningful discussion—that also invites patients/clients to help others—reducing fear and isolation, and increases options for safety and nonjudgmental education.

The safety card intervention is a simple, evidence-informed tool that integrates universal prevention education on safe and healthy with all patients/clients within the context of what you are already doing. For providers, it is an en-

gaging, effective, brochure-based intervention in the format of a 'self-test' that guides the process of DV assessment, prevention and intervention, and includes adolescent counseling, and visit-specific harm reduction strategies. It is easy to use, easy to adopt and easy to integrate into the health or intake visit. It serves as effective for prevention, and both primary and secondary intervention for those exposed to violence.

For advocates, it is an effective awareness tool illustrating how DV affects health. It guides the process of talking about health—especially more intimate areas of health like sexual health, contraception and sexually transmitted infections—within the context of relationship abuse. It helps advocates educate on the health impacts of IPV, create linkages for clients into the healthcare support system, and imprint the importance of advocating for one's health for future reference.

In our partnership, universal prevention education and the use of safety cards was central to integrating services, implementing reciprocal referrals and improving DV and health assessment and response. DV and health staff felt it was in fact easy to integrate and it simplified the process for both advocates and providers. The WHCC and Interval House have both institutionalized this strategy because it is effective, attainable and sustainable (with or without funding). Essentially, there are no hard costs required to implement, other than staff time, since a wide array of safety cards, in different languages, are available at no cost through Futures Without Violence. The total time to implement this strategy can be as little as one minute and typically no longer than two or three minutes, unless a positive disclosure happens.

Implementation was simple. After one round of cross-trainings, DV and health staff was ready to start using this strategy. Training curriculum on this intervention came from Futures with Violence and was adapted by the leadership team to fit our specific program. Consider implementing this process in your own setting.

The 4 C-Step Guide to universal prevention education + the safety card intervention
The following is a simple outline for use of this strategy. For full guidelines and for more information on how to handle positive disclosures in the clinic setting, please refer to the WHCC DV-IPV Protocol for Screening, Reporting and Intervention *(see appendix C)*.

1. Confidentiality
    - Be clear on mandatory reporting laws and discuss limits of confidentiality with ALL patients/clients before using this intervention
    - Always implement in a private setting

2. Conversation
    - Normalize the conversation through universal prevention education
    - *"We've started giving information to all our patients about healthy and unhealthy relationships and IPV, so they know how to get help for themselves or so they can help others."*

3. Card
    - Go through the card
    - *"See, it's kind of like a magazine quiz. It talks about healthy and safe relationships, ones that aren't and how they can affect your health. On the back are confidential hotline numbers you can call 24/7."*
    - Make the connection: *"Is this happening in your relationship?"*
        - Helps your patient make the connection between her relationship, IPV and her health
        - Offers options for support and visit-specific harm reduction strategies
        - Helps to guide the conversation and identify signs of IPV and abuse
        - Plants seeds and teaches patients/clients how to use and understand the card for future use

4. Connection

- Connect the patient/client to the appropriate resources or additional information
- Make a warm referral with your partner site
- Follow up at next visit or counseling session

Positive Disclosure

- Thank the patient for sharing
- Convey empathy for the patient who has experienced fear, anxiety and shame
- Tell the patient they are no alone, its not their fault and you are there to help
- Validate that IPV is common, and is a health issue and offer the appropriate harm reduction strategies
- Let her know you will support her unconditionally without judgment
- Ask if she has immediate safety concerns and discuss options
- Refer to a domestic/sexual violence advocate for safety planning and additional support
- Follow up at next visit

Section III: EVALUATE

Evaluation is central to building effective, long-term and sustainable partnerships. It is the cornerstone to capturing the impact and value of the work of the partnership, and it is the pathway to improving upon this work. In the context of a grant-funded partnership, evaluation is essential for capturing impact and value of your funder's investment. Evaluate the partnership and all implementation strategies at the beginning, middle and end, even if it is an informal partnership without the formality of a grant. Share the results of the evaluation efforts with the appropriate team members. In some cases, results may only need to be shared with the leadership team; in other cases, results may need to be shared with all team members.

Evaluation is important not only for informing your work, but for informing this work moving forward as the DVHCP expands. The results of your evaluation efforts can be used to facilitate obtaining additional sustainable funding sources. Evaluation can yield the capturing of impact data and measures that can essentially aid in sustainable funding sources and reimbursement strategies as well. Without evaluation, opportunities for feedback, growth and improvement is lost, and valuable data on DVHCP outcomes is lost. Results can be shared with current stakeholders and funders, community partners, donors, and other key supporters of your program. They can be shared with correlating coalitions, boards, and task forces to inform the priorities of policy makers and other key champions in domestic/sexual violence and health.

Many resist evaluation as they don't see the importance and equate it with difficulty and meaningless, mundane extra busy-work. This couldn't be farther from the truth, unless folks are dishonest in their reflection and evaluation. Place value on evaluation and create value for your team. Often times, this comes from clear conversations around evaluation—why we're doing it, what we want to learn from it, and how it will be used.

There are several ways to evaluate the partnership. One of the simplest techniques is through honest, transparent communication. As effective as this can be, it is imperative that individual team members feel safe in order to express openly about their experiences in the partnership. A more effective way might be through private, on-paper evaluations and surveys. FWV has a portfolio of effective evaluations available for use. They can be used as is, or can be adapted and revised to better fit your individual project and partnership *(see appendix E)*.

Evaluating the Partnership

Evaluation is critical to a lasting, healthy relationship, and must occur on all levels of the partnership, including collaboration and leadership, direct service, programmatic implementation, quality improvements, and systems change.

- Designate time to evaluate the culture, health, depth and strength of the partnership, as well as the attitudes of leadership and key staff involved, and the collaborative trends. The goal is to measure and capture the level of respect, commitment and attitudes key members hold for the team collective, and the shifts that happen over time. This level of evaluation can occur through a meeting format, or through the use of a tool or standardized survey, such as the Collaborative Behavior Survey *(see appendix G)* created by Futures Without Violence. Consider doing this at least once annually.

- Evaluate the impact of the bi-directional staff training. Ask staff to rate their perceived level of learning and understand of all new content, universal education techniques, assessment and invention tools, new or improved referral systems, and other implemented strategies for integrated services. Measuring impact of newly introduced tools, strategies and system-level processes may best be done immediately after the training (pre and post tests), as well as 30-days, 90-days or 180-days post training. This will allow you to capture the sustainable impact on service integration that resulted in the trainings and staff development, while yielding information on areas needing to be strengthened. Partners can adopt pre and post tests, as well as 6-month post evaluations for providers and advocates, from Futures Without Violence *(see appendix E)*.

- Evaluate service delivery models. Collect feedback, suggestions and satisfaction from both patients and clients. Implement simple, easy to read and understand, short feedback surveys from patients and clients throughout the course of the partnership. Strategically, this may be 30, 90 or 180 days post training, to capture patient/client experience after new strategies are introduced and implemented. Offer surveys in all languages in which services are offered at your organization, and keep them short—no more than 5-8 questions. Launch an interval of time and guidelines for the frequency in which they will be distributed and collected. Be sure to include all staff in the evaluation process, to stimulate buy in from all program areas. Create a blind system to distribute surveys to facilitate an accurate sample of the patient/client population, and evaluate with an unbiased approach, with the use of equity principles. For example, surveys are administered to all initial patients/clients over the course of a set calendar month, or surveys are distributed to every third client served over the course of a 6-week timeframe *(see appendix F)*.

- Evaluate and monitor progress and results. Put in place systems for documentation to collect quantitative data throughout the course of the partnership. Maintain records of the number of individuals who:
    - were assessed for DV,
    - were given safety cards, or other educational tools on safe and healthy relationships,
    - where screened positive for DV,
    - were referred to each partner site,
    - were assessed for urgent or time-sensitive health needs,
    - were referred to the co-located advocate,
    - attended outreach and education events,
    - who needed/received transportation assistance to the shelter or health site.

- Develop a process for ongoing quality improvement (QI) checks to measure and evaluate organization-wide movement towards comprehensive and systematic response to health and DV. Consider implementing policies for engaging leadership and key staff to convene routinely to discuss necessary QI, as well as roles, responsibilities and steps to put in place new policies and procedures. Partners can adapt already established QI tools within the organization, or chose to adopt the QA/QI tool for health settings and DV programs developed by Futures Without Violence *(see appendix G)*. Identify an ideal schedule for QI checks; this could be quarterly or bi-annually.

Maintain anonymity on all evaluation pieces to protect privacy of team members, invite more honest responses and remove biases for the one collecting and analyzing the data. Always give context to the reasoning behind why the evaluations are important, to help folks understand the value and to create a buy in for the process, which is often resisted.

Evaluating the Project

As your project progresses, benchmarks are met, and partnerships grow stronger, it can be easy to get swept away in the excitement of this work, and lose sight of the impact and sustainability factors, particularly if the project is funded. Be mindful and remain reflective on implementation strategies on a regular basis. This could be quarterly, or semi-annually. Develop a process by which evaluation can happen, and can happen safely and effectively. It is not uncommon for partners to feel differently about certain implementation strategies, communication techniques, or resources. Engage in a collective, collaborative and constructive evaluation process to continue honing your work together, and minimize challenges, conflicts and inefficient activities.

If something is not feasible or inefficient, re-evaluate, reshape, and adapt. Make your work not only possible, but sustainable with the resources that are available to you. For example, if the Monthly Health Celebration strategy resonates with you, but just isn't doable at the same scale described to you, adapt it! Adopt the parts that fit and reshape the pieces that don't. Make the necessary changes to make it sustainable and feasible. The only way to identify these types of project shifts, is through a process of evaluation.

As an individual organization, and as a team, review, inquire, and investigate how things are working, and how well they are working. If shifts are made, or the team decides that a particular activity needs to stop, this doesn't mean it is a failure. It is simply a lesson learned…a 'fabulous flop'. These flops are at the core of truly integrating this work, having realistic expectations of sustainability, and creating a strategic structure and action plan for long-term maintenance and expansion.

Tools to assist you in evaluating the work include *(see appendix E and F)*:

- Pre + Post Training Evaluation
    - evaluates impact and value of provider and advocate trainings immediately
- 6-month Post Training Evaluation
    - evaluates impact and value of provider and advocate trainings 6 months after implementation of new strategies
- Patient Feedback Survey
    - evaluates impact and experience of DV services in the health program from patients
- Client Feedback Survey
    - evaluates impact and experience of health services in the DV program from clients

Section IV: SUSTAIN

Although sustainability is ultimately an evolving process, and a massive undertaking, consider that sustainability might occur in three key phases:

1. Preparing for sustainability and setting the stage
2. Demonstrating impact
3. Institutionalizing the DVHCP into organizational culture, practices and culture

Set the stage for sustainability:

- Approach the partnership from its inception with a clear intention and goal to build a lasting and long-term partnership. Sustainability is essentially the single most important factor of this work. After months, or years, of building an effective partnership, you will have caused systems change, policy and procedure im-

provements, innovative service delivery models, collaborative problem-solving tactics, and qualitative and quantitative impact. It would be devastating, and truly a loss, to have all the valuable work and results come to an abrupt end because core funding ended or sustainable sources of funding were limited. In order to prevent this, sustainability must be at the forefront of your thinking from day one. If partners initiate a project or partnership with the intention of ceasing when funding ends, this project is guaranteed to have different, and less optimal results. It could lead to a lack of investment from the team, which could negatively impact outcomes and impact, as well as the strength of the partnership.

- Always keep sustainability in mind in all phases of the project—planning and development, implementation, adaptation, and expansion. If something is not sustainable, adapt it, or adopt a new methodology. Throughout the process of building the partnership and it's core components, think about feasibility for long-term implementation. If challenges and cost outweigh resources, capacity and bandwidth, it will not be manageable for the long-term; it will instead drain your resources, time and movement toward capacity building.

- Consider creating a strategic plan for sustainability in the early stages of development. A strategic plan might include success steps and agreements made between partners; lessons learned; plans and strategies for leveraging services, as well as new and existing funding streams; clear protocols for working through staff turnover; and strategies for dissemination and contributing to larger policy change—county-wide, state-wide and nationally. Designate key staff to spearhead sustainability efforts over the life of the partnership.

- In the pursuit of sustainable funding streams, consider chunking elements of the partnership and approach funding in pieces, rather than as a whole. Be creative in efforts toward sustainable funding sources considering out-of-the-box strategies. This may include fee-for-service contracts between partners, leveraging existing grant funds to support components of the partnership, and generating new funding streams through reimbursement strategies and foundation grants.

- It's important to maintain a space of honesty and transparency with your partner site. All partners must be on board to sustain program components, bi-directional systems, policies and practices, essentially without funding, or with minimal funding. Avoid rigid thinking around practices that are taxing to a partner site, and investigate alternatives to ensure sustainability and streamline DVHCP strategies. This may bring up challenges and conflicts between partner sites, however, though honest communication, collaborative creative thinking, compromising on mutually beneficial and workable solutions, alternatives can, and will emerge. Most importantly, keep the *why* in mind. Why did you engage in this work? What was your underlying original and common goal to embarking on this journey together? Chances are it was to better serve DV survivors, improve access to care and empower safe and healthy relationships as well as improve health outcomes. Remember to keep the patients and clients in mind when experiencing challenges or conflicts.

- Identify a champion at each partner site, as well as other key players and organizations that need to be involved in order to support long-term sustainability. A champion will oversee the DVHCP, spearhead key aspects of the partnerships, and ensure sustainability efforts are implemented over the life of the partnership. A champion is also central to sustaining DVHCP practice and procedures given the inevitable challenge of staff turn over.

Demonstrate effectiveness:

- Data measures and impact data is fundamental to sustainable implementation, achieving prospective objectives and deliverables, and making the case for the partnership to leadership, funders, new partners, and policy makers. Without data, it is near impossible to demonstrate success, efficiency, and effectiveness, as well as cost value and return on investment.

- Measure and document quantitative impact over the course of the partnership. This includes outcomes and improvements in service delivery, programmatic implementation, and systems level change:
    - number of clinic-based DV assessments
    - number of shelter-based health assessments
    - number of positive disclosures
    - number of referrals made to partner site
    - number of staff trained
    - number of clinical and shelter-based outreach and education activities
    - number of community-based outreach and education activities
    - improved health and safety outcomes
    - quality improvements made over time

- Measure and collect qualitative data from patients, clients and staff to capture the impact of the DVHCP and tell the story of its value. This can be integrated into existing patient or client satisfaction surveys; new feedback surveys for patients, clients and staff; results of collaborative behavior measures; written and verbal testimonials from patients and clients; and interviews.

- Engage opportunities to tell the story of your DVHCP with a wider audience. Pursue sharing best practices, lessons learned and impact with your organization advisory council, stakeholders, local consortia, larger task-forces and national organizations, funders and at county, state and national conferences. Utilize diverse media platforms to tell the story on your website, local television and radio strategies, and through social media campaigns.

Institutionalize DVHCP practices into organizational culture and policy:

- Integrate key elements of your partnership into standardized policy and procedure and always supplement with written protocols. Coordinate staff trainings with policy and procedure updates. Ensure that all staff (new and existing) are informed of any and all policy and procedure changes, and that they are aware of where to locate written protocols, scripts and checklists/instruction sheets.

- Integrate regular and on-going staff in-services and cross training at both partner sites. Staff training is central to sustainable improvements and practices. Consider offering training at least once per year.

- Integrate training on DVHCP practice and systems (including assessment and response) for all newly hired in a standardized on-boarding training process. They can occur in orientation, through Human Resources, a buddy system for shadowing, or through e-learning training modules.

- Integrate elements of the DVHCP on your marketing materials, program brochure and website.

- Create and instill a culture of DVHCP, and safe and healthy relationships, into the organizations. This may include normalizing the conversation of DVHCPs and the impact of DV on health, utilizing (and regularly stocking) safety cards and other educational resources, displaying posters and showing waiting room videos, thinking and talking about DVCHP as an integrated service the organization provides rather than a temporary “special project”, examining ways to expand the DVCHP, and engaging in team building and celebratory activities with your partner on a regular basis. Consider your partner as an extension of your staff.

- Designate a champion for the partnership at both sites, and ensure this role is consistently fulfilled. Without a champion, the partnership is likely to lose momentum and die with staff turn over.

- Engage executive leadership and the Board of Directors. Without enrollment from the higher ups, the partnership is likely to die.

- Integrate core aspects of the partnership into routine, ongoing evaluation processes and quality improvement checks.

- Align the DVHCP with core funding streams and new and existing fundraising efforts.

Section V: EXPAND

Congratulations! You've successfully built and strengthened a domestic violence and health care partnership within your organization and community. It was an in-depth process that required an exceptional level of commitment, hard work, persistence, flexibility and consistency. Partnerships are a highly effective strategy for early identification of DV, education and prevention efforts, addressing the unique health needs of DV survivors, and improving comprehensive and systematic response to violence. Although initiating and building partnerships can be a massive undertaking that requires lots of dedication, staff time, funding and resources, ultimately, once established and depending on the specific practices and strategies implemented, the level of manpower and financial demands will diminish over time.

In thinking about the greater vision for sustaining domestic violence and health care partnerships, consider ways your partnership can contribute to expansion efforts. This may include:

- Expanding the partnership to additional sites (or satellite sites) within your organization
- Duplicating the partnership with additional sites in your community
- Offering training opportunities and individualized technical assistance to other organizations in your community who seek to develop DV health care partnerships
- Align your partnership to integrate with community-wide care networks
- Positioning partnership strategies, best practices, lessons learned and policies to inform county-level systems change
- Participate in your local health or DV task-force
- Align with local, state and national initiatives that engage multi-sector approaches to health and DV
- Contributing to policy making and fundraising efforts in your region or state on:
    - DV and health care partnerships
    - Best practices and strategies for collaboration between sectors
    - Awareness of health impacts of DV
    - Systematic response to DV in the clinical and advocate setting
    - Impact of DVHCPs
    - Standardized education, assessment, and intervention tools and strategies
    - DV as a social determinant of health

Expansion presents varying landscapes for each organization. Consider the specific goals of your organization, and of your partnership. Determine if, and how, they fit into a greater contribution to sustaining partnerships between the health and domestic violence fields, keeping your current resources and capacity in mind.

Ultimately, every collaborative effort to better integrate health and DV services and inform improved response and intervention contributes to the greater vision to better support DV survivors, prevent DV, create evolutionary evidence-based systems-level change, and positively impact health and safety outcomes for people nationwide.

REFERENCES

Futures Without Violence
www.futureswithoutviolence.org

Futures Without Violence online catalogue for educational materials, tools and resources
https://secure3.convio.net/fvpf/site/Ecommerce/15587835?FOLDER=0&store_id=1241

Health Cares About IPV
http://www.healthcaresaboutipv.org

A Guide to Sustaining Public Health Partnerships to Prevent and Address Violence Against Women
http://www.healthcaresaboutipv.org/wp-content/blogs.dir/3/files/2012/09/public_health_partnerships_with_advocates1.pdf

Creating Protocols on IPV
http://www.healthcaresaboutipv.org/getting-started/creating-protocols-on-ipv/

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

2010 CDC National Intimate Partner and Sexual Violence Survey
www.cdc.gov/violenceprevention/nisvs/index.html

Bedsider
www.bedsider.org

California's Domestic Violence & Mandatory Reporting Law: Requirements for Health Care Providers
http://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_calif.pdf

DV Advocates Guide to Partnering with Health Care: Models for Collaboration and Reimbursement
https://drive.google.com/file/d/0B0qQChbLkUz5QlVOaEZubDA0UzA/view?usp=sharing

DEFINITIONS

(from Futures Without Violence)

Reproductive Coercion

"…Involves behaviors that a partner uses to maintain power and control in a relationship that are related to reproductive health."

- Coercive, unprotected sex
- Attempts to control her fertility through verbal and/or physical threats
- Interfering with proper use of birth control methods
- Occurs in heterosexual and same-sex couples
- Critical connection point between women's health and DV

Birth Control Sabotage

Active interference with contraception use by a partner

- Hiding, withholding or destroying pills
- Putting holes in a condom or breaking a condom
- Refusing to pull-out when that is the agreed upon method
- Pulling out the ring
- Tearing off the patch or pulling out an IUD

Pregnancy Coercion or Pregnancy Pressure

- Attempts to cause a pregnancy against her wishes
- Controlling outcomes of a pregnancy
- Occurs in adult and adolescent relationships

DIGITAL APPENDIX

A. Assessment forms

i. **DV site (intake form):**
https://drive.google.com/file/d/0B0qQChbLkUz5QTRlUk80bmIyNjg/view?usp=sharing

ii. **Health site (medical history & female exam form):**
https://drive.google.com/file/d/0B0qQChbLkUz5SGZKekpOblBmS3M/view?usp=sharing

B. Streamlined Referral System

i. **DV to Clinic Referral Form:**
https://drive.google.com/file/d/0B0qQChbLkUz5WjM5TENVUDVlVzQ/view?usp=sharing

ii. **Clinic to DV Referral Form:**
https://drive.google.com/file/d/0B0qQChbLkUz5eWo3bGZYQ1p0T3c/view?usp=sharing

iii. **DV-based clinic appointment schedule:**
https://drive.google.com/file/d/0B0qQChbLkUz5UGxpb3RYWnlldE0/view?usp=sharing

iv. **Clinic-based blocked appointment schedule for DV clients:**
https://drive.google.com/file/d/0B0qQChbLkUz5bjNxQkhPdnRONmM/view?usp=sharing

C. DV Protocol + Resources

i. **WHCC DV-IPV Protocol for Screening, Reporting and Intervention:**
https://drive.google.com/file/d/0B0qQChbLkUz5QUpBMEpZUlBzQzg/view?usp=sharing

ii. **Clinic DV Resource List:**
https://drive.google.com/file/d/0B0qQChbLkUz5UEh2cmJ4RUwtVTg/view?usp=sharing

iii. **NCDSV Power + Control Wheel:**
https://drive.google.com/file/d/0B0qQChbLkUz5cFJGekEzVWlvQVk/view?usp=sharing

iv. **NCDSV Equity Wheel:**
https://drive.google.com/file/d/0B0qQChbLkUz5WlQxOWduNzdFYWM/view?usp=sharing

D. Cross Training Curricula + Monthly Health Celebrations

i. **Year 1: Interval House Training (9/22/14)**
https://drive.google.com/file/d/0B0qQChbLkUz5bDhWd0V6ekk2RUk/view?usp=sharing

ii. **Year 1: WHCC Training (10/24/14)**
Part I: https://drive.google.com/file/d/0B0qQChbLkUz5LUt0d05PVDVWQk0/view?usp=sharing
Part II: https://drive.google.com/file/d/0B0qQChbLkUz5SXhCazh3Vkt6dE0/view?usp=sharing

iii. **Year 2: Interval House Training (11/2/15)**
Part I: https://drive.google.com/file/d/0B0qQChbLkUz5ZXNad1ZGN01UczA/view?usp=sharing
Part II: https://drive.google.com/file/d/0B0qQChbLkUz5djdIWmU1Mm14dFE/view?usp=sharing

iv. **Effects of DV on Health curriculum:**
https://drive.google.com/file/d/0B0qQChbLkUz5djdIWmU1Mm14dFE/view?usp=sharing

v. **Monthly Health Celebration Flyer:**
https://drive.google.com/file/d/0B0qQChbLkUz5U2dWN3JUeklDMHc/view?usp=sharing

E. Training Evaluations (by Futures Without Violence)

i. **Pre training evaluation (advocates):**
https://drive.google.com/file/d/0B0qQChbLkUz5dzJwZnZQWHFkOU0/view?usp=sharing

ii. **Pre training evaluation (providers):**
https://drive.google.com/file/d/0B0qQChbLkUz5VnV5UXpnMlB2OGs/view?usp=sharing

iii. **Post training evaluation (advocates):**
https://drive.google.com/file/d/0B0qQChbLkUz5eXdsMlV0SlRJTVk/view?usp=sharing

iv. **Post training evaluation (providers):**
https://drive.google.com/file/d/0B0qQChbLkUz5RzJ4alg5LTFBbEE/view?usp=sharing

F. Patient + Client Satisfaction Survey (by Futures Without Violence)

i. **DV site:**
https://drive.google.com/file/d/0B0qQChbLkUz5a2d5SExOVldRODg/view?usp=sharing

ii. **Health site:**
https://drive.google.com/file/d/0B0qQChbLkUz5THZUcUx1LUtIQk0/view?usp=sharing

G. Quality Improvement Tools (by Futures Without Violence)

i. **QAQI Tool (advocates):**
https://drive.google.com/file/d/0B0qQChbLkUz5Tm1Ma1N1WmtqV3M/view?usp=sharing

ii. **QAQI Tool (providers):**
https://drive.google.com/file/d/0B0qQChbLkUz5QU5ZYVBqQnM0djQ/view?usp=sharing

iii. **Collaborative Behavior Survey:**
https://www.ctsiredcap.pitt.edu/redcap/surveys/?s=HPLT4LFEYD

H. Safety Cards

How is my health being affected?

Ask yourself:

- ✔ Are you over-eating and gaining weight?
- ✔ Do you often find yourself depressed or anxious?
- ✔ Do you have frequent headaches and/or chronic back or abdominal pain?
- ✔ Have you been diagnosed with hypertension or heart disease?

Any of these health problems may be the result of chronic stress from an abusive relationship. Making these connections can help you take steps towards better health.

How are your children doing?

Studies show that children who live in homes where their mother has been hurt are more likely to experience learning disabilities, behavior problems, drug and alcohol abuse, or even repeat abusive behavior as adults. But, children can also get through the hard times and here are some ways you can help:

1. Let them know it isn't their fault.
2. Keep an open door for when your child is ready to talk.
3. If your child is anxious or has behaviors that concern you, consult a pediatrician or counselor. Connect them to children's programs available in domestic violence programs.

FUTURES WITHOUT VIOLENCE™

Formerly Family Violence Prevention Fund

FuturesWithoutViolence.org

Funded in part by the U.S. Department of Health and Human Services' Office on Women's Health (Grant #1 ASTWH110023-01-00) and Administration on Children, Youth and Families (Grant #90EV0414).

If you are being hurt by your partner, it is NOT your fault. You deserve to be safe and healthy.

Call the National Domestic Violence Hotline for toll-free, 24/7 support with:

safety planning, housing options, and local referrals.

1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

Call 911 if you are in immediate danger.

Are you in a HEALTHY relationship?

Ask yourself:

- ✔ Is my partner willing to communicate openly when there are problems?
- ✔ Does my partner give me space to spend time with other people?
- ✔ Is my partner kind and supportive?

If you answered *YES* to these questions, it is likely that you are in a healthy relationship. Studies show that this kind of relationship leads to better physical and mental health, longer life and better outcomes for your children.

Are you in an UNHEALTHY relationship?

Ask yourself:

- ✔ Does my partner shame me or humiliate me in front of others or in private?
- ✔ Does my partner control where I go, who I talk to, and how I spend money?
- ✔ Has my partner hurt or threatened me, or forced me to have sex?

If you answered *YES* to any of these questions, your health and safety may be in danger.

Here are some proven steps you can take to help you cope and improve your health.

1. Talk with someone supportive that you trust about what's going on.
2. If it is safe, write about the pain you have experienced.
3. Reduce your stress through deep breathing and exercise.
4. Talk to your health care provider about things you may be doing to help you cope, such as: over-drinking, using drugs, or over-eating and support for next steps.

If your safety is at risk, here's how you can protect yourself:

1. Call 911 if you are in immediate danger.
2. Prepare an emergency kit for a situation where you have to leave suddenly (keys, money, legal and important documents, medicines, social security numbers, bank account information etc.) Call a domestic violence hotline for additional help planning.
3. Develop a safety plan with your children, including people they can call in an emergency including 911.
4. Talk to your health care provider, who can provide you with a private phone to call for help.

Who controls PREGNANCY decisions?

Ask yourself. Has my partner ever:

- ✔ Tried to pressure or make me get pregnant?
- ✔ Hurt or threatened me because I didn't agree to get pregnant?

If I've ever been pregnant:

- ✔ Has my partner told me he would hurt me if I didn't do what he wanted with the pregnancy (in either direction—continuing the pregnancy or abortion)?

If you answered *YES* to any of these questions, you are not alone and you deserve to make your own decisions without being afraid.

Getting Help

- ✔ If your partner checks your cell phone or texts, talk to your health care provider about using their phone to call domestic violence services—so your partner can't see it on your call log.
- ✔ If you have an STD and are afraid your partner will hurt you if you tell him, talk with your health care provider about how to be safer and how they might tell your partner about the infection without using your name.
- ✔ Studies show educating friends and family about abuse can help them take steps to be safer—giving them this card can make a difference in their lives.

Funded in part by the U.S. Department of Health and Human Services' Office on Women's Health (Grant #1 ASTWH110023-01-00) and Administration on Children, Youth and Families (Grant #90EV0414).

FUTURES WITHOUT VIOLENCE®

FuturesWithoutViolence.org

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

All these national hotlines can connect you to your local resources and provide support:

For help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233)
TTY 1-800-787-3224
www.thehotline.org

National Dating Abuse Helpline
1-866-331-9474
www.loveisrespect.org

National Sexual Assault Hotline
1-800-656-HOPE (1-800-656-4673)
www.rainn.org

Are you in a HEALTHY relationship?

Ask yourself:

- ✔ Is my partner kind to me and respectful of my choices?
- ✔ Does my partner support my using birth control?
- ✔ Does my partner support my decisions about if or when I want to have more children?

If you answered *YES* to these questions, it is likely that you are in a healthy relationship. *Studies show that this kind of relationship leads to better health, longer life, and helps your children.*

Are you in an UNHEALTHY relationship?

Ask yourself:

- ✔ Does my partner mess with my birth control or try to get me pregnant when I don't want to be?
- ✔ Does my partner refuse to use condoms when I ask?
- ✔ Does my partner make me have sex when I don't want to?
- ✔ Does my partner tell me who I can talk to or where I can go?

If you answered *YES* to any of these questions, your health and safety may be in danger.

Is your BODY being affected?

Ask yourself:

- ✔ Am I afraid to ask my partner to use condoms?
- ✔ Am I afraid my partner would hurt me if I told him I had an STD and he needed to be treated too?
- ✔ Have I hidden birth control from my partner so he wouldn't get me pregnant?
- ✔ Has my partner made me afraid or physically hurt me?

If you answered *YES* to any of these questions, you may be at risk for STD/HIV, unwanted pregnancies and serious injury.

Taking Control:

Your partner may see pregnancy as a way to keep you in his life and stay connected to you through a child—even if that isn't what you want.

If your partner makes you have sex, messes or tampers with your birth control or refuses to use condoms:

- ✔ Talk to your health care provider about birth control you can control (like IUD, implant, or shot/injection).
- ✔ The IUD is a safe device that is put into the uterus and prevents pregnancy up to 10 years. The strings can be cut off so your partner can't feel them. The IUD can be removed at anytime when you want to become pregnant.
- ✔ Emergency contraception (some call it the morning after pill) can be taken up to five days after unprotected sex to prevent pregnancy. It can be taken out of its packaging and slipped into an envelope or empty pill bottle so your partner won't know.