



THE STRENGTHENING COLLABORATIONS PROJECT

PROGRESS REPORT

DECEMBER 2013

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INTRODUCTION

Project Goal

The goal of The Strengthening Collaborations Project is to enhance partnerships between health care organizations and community-based organizations in Massachusetts that support best practices for responding to domestic and sexual violence.

Background

Domestic and sexual violence are public health issues that pose significant health risks to children, adolescents and adults across the life span in every community across the Commonwealth. Prevalence rates for domestic and sexual violence are extremely high. According to the Centers for Disease Control and Prevention, nearly 3 in 10 women and 1 in 10 men in the US have experienced rape, physical violence and/or stalking by a partner. These numbers do not account for the many victims who are not represented in studies, afraid to report violence and/or experience other forms of coercive and harmful abuse.

Virtually all victims of violence have contact with the medical setting, whether in primary care, obstetrics and gynecology, medical specialties, or emergency medicine. Hospitals and health care providers are well positioned to identify and connect victims with support services within the community, address the health consequences of violence, increase awareness about domestic and sexual violence, and engage in violence prevention efforts. In addition to fulfilling the Joint Commission standard to “assess the patient who may be a victim of possible abuse or neglect” (PC .01.02.09), evidence-based responses to domestic and sexual violence within the health care setting are essential to providing high quality and accountable care.

The Massachusetts Department of Public Health supports the recommendations of the United States Preventive Services Task Force, the American Medical Association, the Institute of Medicine, and most medical organizations that support routine screening for domestic violence victimization in all health care settings by trained providers. Under the Affordable Care Act, new women’s health guidelines mandate that health insurance cover the costs of screening and brief counseling for intimate partner violence. It is expected that the rates of identification of intimate partner violence and sexual violence will increase as screening is consistently implemented within health care settings and therefore the need for partnerships will increase.

As more victims are identified in the health care setting, it is anticipated that more providers will refer victims to domestic and sexual violence services. Yet, community-based programs in Massachusetts are already stretched beyond capacity in responding to victims and survivors. If the health care system were to appropriately identify all victims interacting with health care providers, the existing infrastructure within community-based organizations is not sufficient to respond to the potential increase in requests for services. Both **technical assistance** to community-based programs and **funding** to increase service capacity within these programs are

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needed to adequately respond to the needs of victims, and strengthen and build meaningful collaborations between domestic/sexual violence organizations and health care settings.

Project Team

Tina Nappi, consultant to the project and author of this report, facilitated the Strengthening Collaborations Project Team. Team members included Erin Miller at Newton Wellesley Hospital, Joanne Timmons at Boston Medical Center, Liz Speakman at Massachusetts General Hospital, Beth Nagy and Carlene Pavlos at the DPH Division of Violence and Injury Prevention, Madeleine Biondolillo and Michele Visconti at the DPH Bureau of Health Care Safety and Quality. Sheridan Haines, Executive Director of the Governor's Council to Address Sexual and Domestic Violence was an Advisor to the Team and a key participant. Sue Chandler, DOVE, Inc. and Lisa Hartwick, Beth Israel Deaconess Medical Center also supported the project's work through consultation and leadership on a day-long Summit for community-based programs on health care reform.

Method

The consultant, Tina Nappi worked 480 hours on this project from March through September 2013. The activities included the following:

- Monthly Team meetings and ongoing communication with team members;
- Phone and in-person discussions with 21 individuals representing community-based programs in Southeastern Massachusetts/South Shore, Cape Cod; Western Massachusetts; Metro West; North Shore/Northeastern Massachusetts; Cambridge and Boston;
- Phone and in-person discussions with 6 individuals representing 5 health-care based domestic/sexual violence programs within Boston;
- Phone and in-person discussions with 3 individuals representing statewide sexual/domestic violence projects and rural health projects;
- Series of three meetings with leadership at Jane Doe, Inc.;
- Planning, facilitation and participation in a full-day meeting with Lisa James, Health Director at Futures without Violence, and Lena James, Policy Consultant to Futures without Violence;
- Participation in planning and attending a full-day Summit, "Keeping Survivors at the Center: How Health Care Reform Will Impact Intimate Partner and Sexual Violence Response Systems in Massachusetts."
- Research, compiling resource materials and analysis of themes and findings of the information gathered for the project.

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SUMMARY OF FINDINGS FROM CONVERSATIONS WITH LEADERS OF COMMUNITY-BASED ORGANIZATIONS WORKING TO ADDRESS DOMESTIC AND SEXUAL VIOLENCE

Community-based program leaders wish to increase collaborations with health care

Domestic and sexual violence organizations have a strong interest in strengthening partnerships with hospitals and health centers. Program directors and leaders in the field recognize the value such collaborations, the benefits to victims/survivors are clear. Increased partnerships have the potential of improving both access to care and the health and well-being of victims. Additionally, partnerships with health care institutions have the potential of opening up funding opportunities for direct services, community outreach, training, and prevention services at domestic and sexual violence organizations.

In conversations with leaders of community-based organizations (CBOs), many expressed a strong desire to be in partnerships with health care organizations that respect and value the expertise of the domestic and sexual violence programs. Community-based organizations want to be called by health care providers when victims need assistance. They want to provide consultation and technical assistance to health care providers to enhance practice. They want to train health care providers to improve their responses to the domestic/sexual violence and trauma. The dilemma is that programs currently do not have adequate funding to provide all of these services. Many are already providing assistance to health care organizations without funding because the CBO program leaders are compelled to fulfill their social justice mission. Being responsive to health care ultimately enhances support to victims. However, much of the added and ongoing consultation and technical assistance provided by domestic and sexual violence organizations to health care institutions has been without financial compensation.

The Domestic Violence Council of COBTH authored a report, *Best Practices in Health Care and Domestic Violence* in 2010. The report included a list of ways that health care organizations could partner with and support community-based programs. Throughout conversations informing the Strengthening Collaborations Project, community-based programs echoed the items in the list including:

- Health care collaborations could assist domestic violence victims/survivors in accessing and navigating the health care system, including medical and mental health services.
- Health care could provide consultation to community-based programs on specific health and mental health conditions, and how to manage these conditions in the context of providing services and/or supporting victims/survivors while in emergency shelter or residential programs.
- Collaborations could increase safety for victims/survivors while in the health care setting.
- Collaborations could lead to increased health education and promotion within community-based programs.
- Collaborations could increase networking and resource sharing for staff.
- Collaboration could lead to more education and prevention initiatives.

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Currently the existence of collaborations between community-based organizations and health care institutions varies widely, particularly when responding to individual victims' need for medical care

There is an extreme variance in how community-based organizations currently interface with hospitals, health centers and health care providers when providing direct services to the organization's victims/survivors of violence.

On one end of the spectrum, there is a complete disconnect between the community-based organization and the hospital or health center. One community-based program director summarized this sentiment by stating, "I don't think it helps our clients to identify as clients from our organization when seeking care at the hospital. It is actually harmful -- a disadvantage to them. The hospital staff is judgmental toward our clients. They blame the victim, and don't understand the complexity of domestic violence."

Most domestic and sexual violence organizations interact with health care providers on a case-by-case basis when advocating for individual clients in crisis who need emergency or acute medical intervention. More often than not in these situations, there is not a consistent pathway for victims of violence to access appropriate, trauma-informed medical care. Community-based programs do their best in advocating for clients, although often they experience frustration about the lack of an "inside" connection within the health care setting to provide a more streamlined and compassionate approach to caring for victims.

On the other end of the spectrum, some domestic and sexual violence programs have forged extremely productive and positive relationships with individual health care providers and hospital staff. Some of the community-based programs are well integrated within the health care context and already use a public health approach to their work. They report on valuable relationships which increase the likelihood that the victims/survivors receive comprehensive, trauma-informed medical care.

Interestingly, one program director commented that she covets her program's relationship with a physician who provides assistance to many of the program's shelter clients. She is hesitant about asking the physician to do any more for the program. She made an analogy to utilizing legal services, "When we know a good lawyer who understands the issues of domestic or sexual violence, we tend to call on that lawyer repeatedly for help with our clients. But, we run the risk of burning out the lawyer by overusing them. The same thing can happen with a doctor. We know we can burn them out because our clients need so much support. It's hard to find many doctors who really understand the impact of violence and trauma."

Most sexual assault and dual domestic/sexual violence programs reported having a better infrastructure and the necessary mechanisms in place to work well with health care providers because of the connections with the SANE Program. Overall, these programs reported

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satisfaction in having support to foster collaboration, coordinate care and problem-solve as issues arose.

Collaborations between community-based organizations and health care organizations are on a systems/macro level

Throughout the Commonwealth of Massachusetts, domestic and sexual violence organizations have worked with health care organizations through a variety of venues, including:

- Programs routinely receive referrals from health care providers for direct services.
- Community-based organizations (CBOs) have developed positive relationships with in-house healthcare-based domestic and sexual violence program leaders and staff. They report that these connections have helped them address systems issues, such as access to care for clients and sponsorships for community events.
- Community Health Network Area (CHNA): Many directors of domestic/sexual violence organizations are regular participants in CHNAs and/or are leaders of their local CHNA. Only three programs reported applying and receiving funding from CHNAs for specific projects: One received \$1,000; another, \$1500; and the third, \$10,000 for a prevention project. Most programs reported that CHNA priority areas don't match their programming, and/or in some cases the funding requirements are not worth the effort given the small amount of money "mini-grants" available.
- Program directors and staff have already developed relationships with the Community Benefit Directors of hospitals;
- Program directors have submitted requests for hospital funding, sponsorship and donations;
- Many programs have worked in coordination with the SANE program as medical advocates within health care settings;
- A few programs have worked with a physician who has privileges at a hospital and has advocated for individual clients of their organization's;
- Program staff have attended case reviews, and met with hospital/health care staff to explore ways of collaborating;
- Program staff have responded to requests by hospitals and health centers to provide training for their health care providers on domestic and sexual violence.

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Community-Based Organizations' Report on the Barriers and Challenges to Working with Health Care Organizations

- **Community-based organizations lack the current capacity to do more with their current resources.** Often, the program does not have an available staff person who has time to forge a relationship with the health care organization. And, the task of working with health care seems even more daunting and overwhelming because of difficult interactions they have experienced with health care and the perception within community-based organizations that many health care providers lack a deep understanding about the complexities of working with victims/survivors of domestic/sexual violence.
- **Community-based program staff observe a frequent lack of trauma-informed care within health care settings.** On a frequent basis, community programs witness their clients being re-victimized, judged unfairly and blamed for not taking action by health care providers. They have observed first-hand situations where health care providers minimize or deny clients' experiences of abuse and violence. In addition, programs reported that health care providers often require/mandate clients to take action (such as filing for a restraining order) without an understanding about the immediate risks to immediate safety.
- **Community-based programs have observed the need for health care providers to become better trained on compassionate and effective interventions with victims of domestic and sexual violence.** Programs reported health care providers who lacked an understanding about the complexities of violence, especially when other issues such as mental health consequences, substance abuse/use, non-compliance and lack of follow-up to treatment are involved.
- **Community-based programs have observed institutional racism and oppression within the health care system.** Several programs noted examples of health care providers making comments and holding assumptions about certain communities being more tolerant of violence; and how certain victims "allow" violence to occur in their relationships. The programs noted that there was a lack of understanding of the impact of institutional racism and oppression on historically marginalized populations and communities. Even in situations where programs expressed a "positive" working relationship with health care providers, the topic of oppression has been difficult to address.
- **Community-based programs have observed health care providers' who have not screened for violence and do not identify violence, even when it has been obvious.** Health care providers and the general public alike still hold myths about who is impacted by violence and who perpetrates violence. Community-based program staff have encountered health care providers who minimize the experience of violence and/or downplay the reality that violence is a highly prevalent issue facing all communities. There are also disparate

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responses to disclosures of abuse based on factors such as age, race, gender, socioeconomic status, etc.

- **Community-based programs find it challenging to connect with health care organizations when there are frequent changes in health care leadership/personnel.** Without explicit commitments from health care organizations, it is hard to build and maintain relationships across systems. The lack of ongoing staff capacity within programs, and the turnover of staff within health care compound this barrier. Many programs have tried hard to connect with health care organizations over time. They express frustration with the difficulty in establishing and sustaining a relationship with hospital personnel. One program director noted that she spent months trying to arrange a meeting with the Community Benefits (CB) Director at a local hospital. At the meeting the CB Director was excited to help the program director strategize about collaboration. Together, they mapped out a plan to seek funding on a specific project. Soon after, the CB Director left his position. His successor did not honor the commitment made by the previous CB Director, leaving the program director without a contact at the hospital and discouraged about starting over again to find a new contact within the hospital.
- **Community programs express frustration about not having a mechanism to give feedback to their local hospital or health care facility.** Programs identify recurring problems in accessing care, and concerns about the quality of care that clients receive within hospitals and health centers. For example, some hospital personnel frequently call community-program staff to interpret for patients because the hospital lacks the language capacity to serve patients. In some instances, victims of domestic and sexual violence have been coerced to take action or share information that has the unintended consequence of increasing risks to victims. Programs report that they hoped there could be a feedback mechanism for system improvements.
- **Community programs are bound by client confidentiality, and are not always able to follow-up on concerns about quality of care issues because clients will not allow them to contact the health care organization.** In difficult cases where community-programs wanted to follow-up with hospitals to report concerns about the care provided to victims, the programs were unable to do so. Clients were afraid to complain to hospitals for fear of compromising care or relationships with their provider. Unfortunately, most programs did not feel like they had a close enough relationship with hospital personnel to raise general concerns about clinical care, or get advice when clients were feeling unsafe and/or dissatisfied with their provider.

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OVERVIEW OF THE SEPTEMBER 26, 2013 SUMMIT: “KEEPING SURVIVORS AT THE CENTER: HOW HEALTH CARE REFORM WILL IMPACT INTIMATE PARTNER AND SEXUAL VIOLENCE RESPONSE SYSTEMS IN MASSACHUSETTS”

The Summit was intended as a beginning discussion for community-based domestic/sexual violence programs to learn about health care reform. The longer-term goal is to ensure that community-based programs are well positioned so that the health care system can access their expertise in the field of domestic and sexual violence. Ultimately, the hope is that community based programs receive support and acknowledgement as valued partners with health care in order to best care for victims and survivors.

The Summit reviewed the significant impact and costs of domestic and sexual violence within society, and specifically in health care. Speakers talked about patient centered care and how some of the health care reform initiatives align with trauma-informed care in the domestic and sexual violence fields.

Some of the themes discussed by approximately 65 speakers and participants throughout the Summit echoed the interviews conducted with leaders of community-based programs:

- There is a high level of buy-in among community-based programs for building partnerships with health care organizations. It makes sense to build partnerships; it can result (and has resulted) in better supports, care, and outcomes for victims/survivors.
- Over time, it is expected that there will be increased referrals from health care providers to community-based programs. There are many concerns and questions about capacity among community-based programs to manage an increased volume of referrals and requests for consultation, direct services and training.
- Working with the health care system is not easy! It takes staff time, relationship-building and structures to support working with a system that may often approach the issues of domestic and sexual violence differently than community-based programs, given different mandates, organizational cultures and roles.
- Ideas for building stronger collaborations include developing Memoranda of Understanding between health care institutions and community based programs, funding partnerships, and creating mechanisms for monitoring quality care.

Summit Action Plan

Community-based programs expressed an interest in technical assistance and forums to further learn about health care reform. Community-based programs want partnerships with hospitals and health care institutions. One recommended next step is for programs to meet with health care leadership to express a desire to collaborate. Another possibility is to bring together community-based programs regionally to share knowledge and develop strategies for working with the same health care settings. Cross training between local community-based programs and health care organizations is another important action item.

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A FRAMEWORK FOR EFFECTIVE AND SUSTAINABLE COLLABORATIONS BETWEEN COMMUNITY-BASED DOMESTIC AND SEXUAL VIOLENCE PROGRAMS AND HEALTH CARE

The following framework for effective collaborations emerged from various activities in this project, including Team meeting discussions and conversations with community-based programs. The framework is summarized in the following five components:

1. Information-Sharing and Increasing Knowledge

- a. Community-based organizations (CBOs) need to increase their knowledge about health care operations and the implications of health care reform on their programs and victims/survivors' care.
- b. Health care organizations (HC) need to increase their knowledge about community-based organizations', their programs, capacity and operations.
- c. Cross-training Between CBOs and HC should occur to share organizational practices, and philosophical frameworks.
- d. Both CBOs and HC need to be familiar with the COBTH Best Practices Manual, the Futures Without Violence Health Care Toolkit, and the concept and practice of trauma informed care.

2. Technical Assistance

- a. CBOs need increased capacity to develop partnerships with health care. This capacity is in the form of increasing staff hours, financial resources, as well as skill development among staff.
- b. HC need support and a mechanism to reach out to CBOs to explore partnerships.
- c. CBOs need support and a mechanism to reach out to HC to explore partnerships.
- d. Leadership, buy-in and strategic planning are needed to develop and maintain successful collaborations.

3. Emphasis on the Process of Relationship-Building

- a. This cannot be overstated: Time must be invested to build relationships and collaboration. Leaders/decision makers within CBOs and within HC need to come together to explore partnerships that are forthright, strengths-based and realistic given available resources.
- b. CBOs and HC need to have an understanding and appreciation of what each other brings to the table.
- c. Both CBOs and HC need to consider how to maximize the available resources to best address the needs of victims/survivors.
- d. Both CBOs and HC need an understanding of their differences and similarities in practice/operations and the philosophy/assumptions underlying practice.
- e. Each partner needs to be able to articulate strength-based approaches and agree to work through differences.

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4. **Accountability**

- a. Partners in the collaboration need to be clear about roles, responsibilities, available resources, needed resources, and the limitations.
- b. CBOs and HC need to develop Memoranda of Understanding (MOUs) that are meaningful and useful to the process of collaboration. (A guide to developing an MOU can be found in the Appendix.)
- c. CBOs and HC need mechanisms for continuous quality improvement, evaluation of the collaboration, and a transparent feedback loop for concern/complaints.

5. **Financial Support**

- a. Ongoing strategic planning across the Commonwealth is needed to explore funding for community-based domestic and sexual violence programs.
- b. Funding is needed to increase CBO staff hours to develop partnerships with health care, and to respond to the inevitable increase in service and training requests by health care providers.
- c. Explore Accountable Care Organization models and other potential revenue streams, such as reimbursement for community-based program services.

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RECOMMENDATIONS FOR NEXT STEPS OF THE STRENGTHENING COLLABORATIONS PROJECT

Given the importance of strengthening collaborations between community-based organizations and health care, the following are recommendations for next steps in this project:

1. Provide Technical Assistance to Community-Based Domestic and Sexual Violence Programs/Organizations

- a. Individual domestic and sexual violence programs would benefit from consultation and support to develop strategic plans and processes for engaging with their local health care organizations. Plans and processes need to be tailored to address the specific needs of the population and community served, while considering sustainability.
- b. Domestic and sexual violence programs should be well positioned to articulate the value of trauma-informed, survivor-centered advocacy services.
- c. Additionally, technical assistance would support programs in being well informed about health care operations, and the impact of health care reform on patient care.
- d. Technical assistance could help programs create a mechanism to consistently track and collect data about the referrals from health care to their domestic and sexual violence. Baseline data would be useful as the project moves forward.
- e. It would be beneficial to bringing community-based programs together regionally to share experiences and coordinate efforts in reaching out to and working with health care organizations.
- f. Disseminate the MOU Guide (see Appendix C) as a tool for relationship building with health care.

2. Increase Capacity within Health Care Organizations to Promote Collaborations with Community-Based Organizations

- a. Analyze health care organizations' cultural readiness and responses to domestic and sexual violence using the Delphi Assessment Tool.
- b. Organize and host a forum for Community Benefit Directors and/or other designated health care leaders led by health care institutions that have a strong commitment to supporting domestic/sexual violence programming.
- c. Compel health care leaders to reach out to community-based programs and explore pathways to collaboration. Make a strong business case for health care to fully meet its obligations to providing quality and accountable care, thereby improving outcomes for patients.
- d. Disseminate the MOU Guide (see Appendix C) as a tool for relationship building with CBOs.

3. Develop a Metric for Measuring Quality in Health Care Responses to Domestic and Sexual Violence

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4. Develop a Structure for Accountability for Community-Based Programs to Give Feedback about Health Care Responses to Domestic and Sexual violence

- a. Complete and disseminate a Circular Letter to all Hospital leadership in the state.
- b. Send the disseminated circular letter to directors of community-based programs for their review and/or information sharing.
- c. Explore mechanisms for community-based programs to inform the Department of Public Health via Safety and Quality about concerns about medical care and health care interactions with victims of violence.
- d. Develop a model for a Survivor-Advisory Board for this project. Partner with victims and survivors of domestic and sexual violence as advisors to inform the collaboration between health care and community-based programs.

5. Explore Funding Opportunities for Community-Based Programs

- a. Funding is needed for programs to work with health care settings on a variety of activities and systems levels: in direct services; outreach to clients; community collaborations; training of health care providers; and in prevention work.
- b. Review the CNHA priorities areas to align them with Domestic and Sexual Violence Programs.

6. Explore Emerging Models for Collaboration between Health Care Organizations and Domestic and Sexual Violence Programs in the Context of Affordable Care Organizations and Health Care Reform Initiatives

- a. Identify lessons learned/themes emerging from the recent project on collaboration funded by Blue Shield Foundation of California.
- b. Continue to collaborate with Lisa James and Lena O'Rourke from Futures Without Violence to explore models and projects throughout the United States.
- c. Engage with Jane Doe, Inc. in collaboration to support community programs and health care collaborations.
- d. Participate in national forums and meetings to be well-informed and connected to current planning and thinking on the issues

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RESOURCES TO SUPPORT COLLABORATIONS

Resources to promote collaborations between community-based programs and health care organizations are available. The Domestic Violence Council of the Conference of Boston Teaching Hospitals is the primary resource for support within the Commonwealth. Its members have extensive experience working within health care, addressing the complex needs of survivors, and bridging collaboration with community partners. The National Health Resource Center on Domestic Violence at Futures Without Violence holds a wealth of expertise and information about programs and models throughout the country. Appendix A of this document provides online links and selected materials useful to promote collaborations.

Related to health care reform, a June 2013 report “Intersections: Domestic Violence and Allied Organizations Partnering for Health” by La Piana Consulting contains useful information worth noting for domestic and sexual violence programs in Massachusetts. One section discusses lessons learned by Project Coordinator Alison Iser of the Domestic Violence and Mental Health Collaboration Project (the Collaboration Project) in Seattle, Washington, which began in 2007 and is in its third round of funding through the Department of Justice Office of Violence Against Women. The Seattle Collaboration Project’s goal is “to facilitate sustainable systems change within and among partner organizations to better meet the needs of survivors of domestic violence who are also experiencing mental health concerns.” Iser states:

“Take time to plan.”

Iser commented that the planning phase “wasn’t just about what we were going to do, but why and how we were going to do it, our aligned values, shared goal and common ground.”

“Never make assumptions.”

“Sometimes we lose something by assuming we have so much in common and fail to pay attention to what’s different. For example, we may use the same word, like ‘confidentiality’, but we actually use that term somewhat differently.”

“Collaboration requires investment.”

Ensuring that there is dedicated staff time to coordinate project activities is essential to success. Although it can take time to get a project started, it will be more successful and “ultimately save time in the end” according to Iser.

(Excerpted from “Intersections: Domestic Violence and Allied Organizations Partnering for Health”, La Piana Consulting, June 2013, Pages 14-15)

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APPENDIX A: SELECTED RESOURCE MATERIALS

The following online resources are useful for community-based programs in developing collaborations with health care organizations:

Conference of Boston Teaching Hospital, Domestic Violence Council

www.cobth.org

Best Practices on Health Care and Domestic Violence Manual:

http://cobth.org/dom_violence.html

Futures Without Violence

www.futureswithoutviolence.org

Health Cares about IPV: Screening and Counseling Toolkit:

<http://www.healthcaresaboutipv.org>

The following articles and materials are available online, or can be accessed through the Conference of Boston Teaching Hospital Domestic Violence Council as they were provided to community-based programs in a flash drive at the September 26, 2013 Summit: “Keeping Survivors at the Center: How Health Reform Will Impact Intimate Partner and Sexual Violence Response Systems in Massachusetts”:

Articles about the Health Impacts/Health Care Responses to Violence

- Massachusetts Public Health Advisory on Domestic Violence, Massachusetts Department of Public Health, 2008.
- Health Care Costs of Domestic and Sexual Violence, Futures Without Violence, 2010.
- Intimate Partners Violence: The Clinician’s Guide to Identification, Assessment, Intervention and Prevention (Fifth Edition), Elaine J. Alpert, MD, MPH, Massachusetts Medical Society Committee on Violence Intervention and Prevention, 2010.
- Understanding IPV: Fact Sheet, Centers for Disease Control, 2012.
- Bridging the Gap, Screening and Counseling for Intimate Partner Violence in Health Care Settings, PowerPoint Presentation, 2012.
- Making the Connection: Intimate Partner Violence (IPV) and Public Health, Linda Chamberlain, PhD, MPH, Family Violence Prevention Fund (now Futures Without Violence), PowerPoint Presentation, 2010.
- The Medicalization of Domestic Violence by Ana Clarissa Rojas Durazo (chapter 21) in *The Color of Violence, The INCITE! Anthology*, South End Press, 2006.

Articles about Developing Effective Health Care Responses to Domestic and Sexual Violence

- Conference of Boston Teaching Hospitals Domestic Violence Council, Best Practices in Health Care and Domestic Violence, manual, Boston, 2011.

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- Building and Strengthening Health Care Based Domestic Violence Programs, Futures Without Violence, Pre-Conference Presentation/PowerPoint, 2012
- The Business Case for Intimate Partner Violence Intervention Programs in the Health Care Setting, Physicians for a Violence-Free Society and the Family Violence Prevention Fund (now Futures Without Violence).
- Hanging out or Hooking up: Clinical Guidelines on Responding to Adolescent Relationship Abuse: An Integrated Approach to Prevention and Intervention, Elizabeth Miller, MD, Rebecca Levenson, MA, Futures Without Violence, 2013.
- Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings, Third Edition, Linda Chamberlain, PhD, MPH and Rebecca Levenson, MA, Futures Without Violence, 2013.

Articles about Enhancing Collaboration Between Community-Based Programs and Health Care Organizations

- *Intersections: Domestic Violence and Allied Organizations Partnering for Health*, a report by La Piana Consulting, 2013.
- *Preparing Community-Based Providers for Successful Health Care Partnerships: Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships*, Victor Tabbush, The Scan Foundation, August 2012.

Fact Sheets about the Impact of Health Care Reform on Women's Health

- Health Care Providers' Role in Screening and Counseling for Interpersonal and Domestic Violence, Frequently Asked Questions, US Department of Health and Human Services Office on Women's Health, 2012.
- Futures Without Violence: Memo on "Interpersonal and Domestic Violence Screening and Counseling: Understanding new Federal rules and providing resources for Health Providers," Lisa James and Sally Schaeffer, 2012.

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APPENDIX B: GUIDE TO DEVELOPING A MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING GUIDE For Hospitals/Health Care Settings and Domestic and/or Sexual Violence Service Organizations

The following guide describes key elements of a Memorandum of Understanding that is intended as a first step in strengthening collaboration between health care settings and community-based domestic and sexual violence organizations. In addition, some template language is provided.

A Memorandum of Understanding (MOU) should include the following title and a similar introduction:

Memorandum of Understanding

Current date/range of dates for this MOU (a one-year time frame is suggested)

Name of Hospital/Health Care Setting

Name of Domestic and/or Sexual Violence Organizations

Introduction:

Domestic and sexual violence impacts the health, well-being and safety of individual victims and their families. The impact of violence is severe and complex. Effective responses to victimization require a coordinated approach to care for victims that addresses the:

- (1) acute and chronic health consequences of violence;
- (2) ways in which violence exacerbates existing medical and mental health conditions and often limits access to appropriate medical care and treatment, and;
- (3) immediate and ongoing risks to safety for victims and their families as a result of violence.

Hospitals and health care providers are required to identify and respond to domestic and sexual violence. In order to provide quality care a range of effective responses to victims of violence, hospitals and health care providers are better positioned if they develop collaborative partnerships with their local domestic and/or sexual violence organizations.

The MOU will outline the process of establishing a collaborative relationship between the health care and domestic/sexual violence organization(s). At the beginning of a successful collaboration they will each learn about each other's organization's roles and capacities:

Establishing a Collaborative Relationship:

[Insert name of the hospital/health care setting] and [Insert name of the domestic and/or sexual violence organization] enter into a collaborative agreement as partners to ensure that all

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victims of stalking, dating violence, and/or sexual/domestic violence are provided with a health care response guided by a trauma-informed approach¹ and best practice in the field.

To this end, the partners will establish a series of *[three to six]* monthly planning meetings to discuss current practices in responding to victims of violence. Planning meeting participants will be decision-makers, representing key leadership roles within each organization.

During the planning meetings, the partners will make a commitment to candidly share:

- Current capacity, responses and services to victims;
- Training needs among staff;
- Information about strengths, resources and internal champions to respond to violence within the health care setting;
- Barriers to working together, including financial constraints and time/staff limitations;
- The impact on practice of health care reform's mandates to screen for and respond to violence;
- Potential opportunities for partnerships in direct service responses, system/policy development, program development and staff education and training.

The MOU will outline a plan for strengthening collaboration to improve the responses across systems to victims of violence:

Based on discussions during planning meetings, the partners will commit to the following next steps to be completed by the end of the year *[specify date]*:

1. Work together to identify funding to increase the community-based program's service and training capacity to respond to referrals from the health care organization;
2. Provide cross-training opportunities for staff in both partner organizations (community and health care) based on the following schedule *[include details]*;
3. Develop a mechanism for regular meetings and communication to continue to build this partnership;
4. Develop a protocol for supported direct care/service referrals across partners' programs and organizations;
5. Identify quality measures to assess health care responses to victims of violence, and to evaluate the effectiveness of this partnership;
6. Develop a training plan for increasing the knowledge, skills and attitudes of hospital staff and health care providers in their responses to violence;
7. Collaborate with the hospital's Employee Assistance Program, Occupational Health or other appropriate entity to attend to the needs of employees of the hospital who may

¹ A trauma-informed approach normalizes human responses to violence, avoids pathology of victims, understands the context of violence, holds offenders accountable, and emphasizes a social justice framework (Warshaw, 2013. For more information, see Appendix of Resources.)

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be survivors and perpetrators of interpersonal violence or closely impacted by the issues personally within their families, workgroups or communities.

We, the undersigned, approve and agree to the terms and agreements as outlined in this Memorandum of Understanding.

Executive Director, local Sexual/Domestic
Violence Service Provider

President, Local Hospital

Date

Date