>> ANNA MARJAVI: Hi, everyone,
we're going to get started in a
few minutes.
Feel free to introduce yourself
in the chat, and feel free to
share whatever weather you're
experiencing.
We were just comparing notes
between our speakers, and it
looks like Jean in Nevada, you
guys have snow, which is
beautiful.
Something we don't get here in
the Bay Area.
There's our faculty member
Kimberly in Honolulu, I'm sure
the sun is shining and beautiful
where you are.
And hello also to others who
have joined.
Northern Nevada folks in the
snow.
And Idaho as well.
Hi, Lisa.
And in Miami, beautiful.
Thanks for joining.
Beautiful New Mexico.
Thanks for joining, David.

How is the weather in Maryland?

And hi, hello from Illinois.

Hi, Erica.

Mississippi, wow.

Folks are from all over.

That's great.

More folks from Minnesota.

>> ANISA ALI: Do you want to go

ahead and get started?

>> Hello, everyone, my name is

Andrea, I'm going to give a

brief set of instructions
regarding language, our
principle for including
interpretation services, and I
will give this instructions
bilingually, so just bear with
me for a few minutes.
[speaking Spanish]
I'm also here with my
cointerpreters, and we will be
interpreting into Spanish for
this session.
[speaking Spanish]
First of all, we would like to
begin by acknowledging all the
languages represented by
everyone here today who will be
speaking, in this case, and
listening, in this case the
languages represented through
interpretation will be English
and Spanish.
But we also have American Sign
Language or ASL, and we will
also have closed captioning
being provided.
Language justice includes a
commitment to making sure that
everyone can participate by

listening and speaking in the
conversation in a more equitable
manner.
[speaking Spanish]
So we will be using for Spanish
interpretation the Zoom
interpreting function today,
which is already active.
You may follow this instructions
if you wish to listen to us in
Spanish.
[speaking Spanish]
If you're using a computer, you
will be able to see a globe icon
at the bottom of your screen
right now.
To select your language of
preference, please press on the
globe icon and then select the
language interpretation.
And choose your language

channel.
If you're on a Chromebook
computer, you will not be able
to access these settings.
If you are calling in, you will
also not be able to make this
selection.
You need the Zoom app.
[speaking Spanish]
Lastly, if you are on a tablet
or phone, just tab lightly on
your screen to bring up the
three-dot menu, usually it has
the word "more" underneath, and
this will display a menu that
says language interpretation.
Just go ahead and select your
language there.
And then tap "done" in order to
activate the interpretation.
I'm just going to take a second
to do the same and make sure
that our listeners in Spanish
are able to hear my
cointerpreter.
[speaking Spanish]
Okay.
I'm able to hear her, so I'm
going to pass it to Anna.

>> ANNA MARJAVI: Thank you.
Thanks to our interpreters today
who are helping to interpret in
ASL and Spanish.
As you just heard from Andrea.
Good morning, from the Bay Area
in California.
And good afternoon for those of
you who are farther away in
Maryland and Miami.
My name is Anna Marjavi, and I'm
a director at Futures Without
Violence.
And I'll tell you a little bit
more about myself and my team in
just a moment.
I want to first thank you for
taking time out of your day to
join us to talk more about
Project Catalyst, which was a
multi-year initiative to improve

health center responses to
survivors of domestic violence
and human trafficking, and to
increase healthcare access for
survivors within community-based
programs.
Next slide, please.
So this is the order of our
presentation for today.
We'll begin with introductions.
And next we'll lift out some
take-aways or tools that we
think are particularly timely
and directly touch on the
American Rescue Program, which I
know much of you are now working
on in terms of increasing access
for folks.
These tools can help you in your
efforts to advance health equity
and improve health outcomes and
medically underserved
communities, including
increasing health access for
clients at domestic violence
programs.
Following we'll discuss the
foundations of Project Catalyst,
and examine the goals and

evaluation outcomes from across
our three phases the work.
And finally, we're going to hear
from three of our state leaders
who took part in Project
Catalyst from Arkansas,
Minnesota, and Ohio.
And they'll join us to share
some of the strategies and
takeaways from their efforts.
And we'll close with additional
resources for you, so thank you
for joining us for this hour.
Next slide, please.
Again, I'm Anna Marjavi, and I
work on Project Catalyst and
direct our new bureau of primary
healthcare funded national
training and technical
assistance partnership, health
partners on IPV and

exploitation, which is a
cosponsor of our webinar today.
On the top of this slide you can
see our primary Futures staff
who work on Project Catalyst.
And today you'll hear from
myself, and Anisa Ali to my
right on the slide, and together
we coordinate this initiative.
And our work at Futures on our
health team is led by Lisa
James, who unfortunately
couldn't join us today.
You're also going to hear from
our evaluation team, which is
located in Pittsburgh,
Pennsylvania, you can see them
on the bottom of the slide.
Led by Dr. Elizabeth Miller, who
is chief of a division of
adolescent and young adult
medicine at Children's Hospital
of Pittsburgh of UPMC, which is
University of Pittsburgh Medical
Center and professor of
pediatrics at the University
Pittsburgh School of  Medicine.
Dr. Miller Is Trained in Medical
Anthropology As Well As Internal

Medicine and Pediatrics.
And Her Research Has Included the Examination of Sex Trafficking Among Adolescents in Asia, Teen Dating Abuse and reproductive health with a focus on underserved youth populations, including pregnant and parenting teens, and foster homeless and gang affiliated youth.
And we're very lucky to be continuing to work with Dr. Miller and continue our partnership that we expanded on across the last 20 years with her.
And to Dr. Miller's right on the slide is a photo of Sarah Scott.
A public health researcher who works closely with the Catalyst

sites to assist with the
evaluation and to analyze the
results.
And not pictured, just a note,
is our other key faculty
trainers, and folks who helped
us go out and train all of these
different state leaders,
Dr. Kimberly Cheng, and Rebecca
Levinson.
And just to say that Project
Catalyst is a function of
Futures' national health
resource center on domestic
violence, which has been funded
by the family and youth services
bureau at the administration for
children and families since
1996.
So I'd now like to introduce our
state leaders whom you'll hear
from today.
So first you're going to hear
from Meggie Royer, who is a
youth and prevention program
manager at Violence-Free
Minnesota.
You're also going to hear from
Lindsay Weaver, who has a

master's in public health and is
the integrated health program
coordinator at the Ohio
Association of Community Health
Centers and you're also going to
hear from Brady Dailey, who is a
community response facilitator
at the Arkansas Coalition
Against Domestic Violence.
All three of these leaders took
part in different phases of
Project Catalyst.
Brandy was part of the first
phase, and -- I also want to
acknowledge our federal partners
who have been working with us on
this initiative for many years.
And we deeply appreciate their
commitment and approach, and
this work would not have been
possible without the engagement

of all of these federal project officers in an ongoing way. Many of whom came out to the trainings and were part of our curriculum development. They're incredible funders and provided a lot of support, wisdom, and insights across the years of this project.

I also want to lift up that I think the tools we're sharing are timely because last year the Family Violence Prevention and Services Act received an historic investment of $550 million to assist states, territories, and tribes to provide access to COVID-19 testing vaccines and mobile health units, specifically for domestic violence programs.

So for those of you who are on the line from a domestic violence coalition, or domestic violence program, who are now undertaking efforts to increase health access for your survivors, clients, we hope that these lessons learned that we're

going to share with you and
these tools can directly touch
on some of the efforts you're
now undertaking and will be
helpful to you.
Similarly, one billing in
American Rescue Fund program
reached nearly 1300 health
centers from across the U.S.
And territories.
To expand not only the number of
health centers in existence,
building new sites and providing
mobile healthcare, also
advancing health equity and
health outcomes in medically
underserved communities, through
through projects that support
COVID-19 care.
It's just to say that many of
you on the line who are from

health centers and from domestic violence programs have very similar overlapping goals in terms of your ARP work.
And we hope that the lessons that we're going to share with you today inspire you to develop these new partnerships in your community or to expand on the partnerships that you already have.
And so I think the opportunity to elevate health access for survives, both at domestic violence programs and to offer health center staff the same kinds of support through domestic violence programs that they may need, also their ability to refer patients make those warm referral, is here before us.
So we hope the tools we share today will help you as you undertake this work.
Next slide, please.
Sorry, can you go back to the slide with all the logos?
Back a couple?

Thank you.

So Project Catalyst was a multiyear effort that engaged more than a thousand people across 10 states and several Pacific islands.

It was initiated in 2015 with three pilot sites with staff at three health centers and three partnering domestic violence programs.

And is it expanded to seven other communities.

One of our primary aims in doing this work was to foster leadership and collaboration at the state and territory level.

And we I think succeeded through the meaningful engagement of all of these partners that you see listed on this slide.

And these 30 logos represent the states and territory primary care associations, domestic violence coalitions, and public health departments that took place between 2017-2021.
And we highly benefited from their strategic thinking and the close working relationships that they have with their member health centers and domestic violence programs, and it's really a terrific strategy in terms of statewide engagement and quite effective.
So we'll share more of those lessons learned today.
Next slide, please.
This is some of the snapshots that we took from across the years of us going out and meeting each other, and doing trainings, and holding meetings, and really coming together to strategize about how to best reach local domestic violence programs and local community health centers and the ways they partner together.

These are just a sliver of the
meetings and trainings that took
place, and it's just to say that
sometimes we talk about this
work when we focus on strategies
or resources, but really, this
initiative came to life because
of the people.
The people who took part.
And as these photos reflect,
there were a lot of people
engaged across the years and
these photos don't even reflect
all of the who trainings that
our state leaders gave across
their own states.
So just want to thank, if you're
on the line and took part in any
of these meetings or trainings,
just to thank you, because it
was a huge lift and a lot of

people power behind what we were
able to do together.
Next slide, please.
So I wanted to lift up right
away for you all that we have a
number of free resources for you
to adapt, and replicate in your
communities.
So we offer a package of
adaptable resources, we're going
to give you the URL soon in the
chat so you can see more what
these tools are.
It includes PowerPoints,
training curricula, as well as
the agenda and the speaker
guides that go along with that.
Handouts for folks in the room,
the trainings are crafted for
either in-person or virtual
engagement.
We also have a health intake
tool.
So if you're from a domestic
violence program, and you're
hooking to initiate
conversations with your clients
as they come in about their
health, we have a tool to help

you do that.
And to help recognize the health issues that might be acute and need emergent care, or other issues that you can work with your client in an ongoing way, helping them establish a medical home and find a primary care provider that they like.
We also have a number of other tools just to help you establish those partnerships, like local MOUs, between your health center and domestic violence program, evaluation tools, multilingual patient and population-specific safety cards, and other tools specific to COVID-19 and privacy guidance.
So do check that out.

I'm going to turn it over now to
Dr. Miller, who is going to tell
you more about our evaluation
and the tools we have there.
>> ELIZABETH MILLER: Indeed,
indeed.
So the -- in addition to these
free resources, if we could
advance to the next slide, the
evaluation tools are also part
of the packet, and I see that
Anisa put the link to that.
But the evaluation tools are
really designed to help drive
and support program
implementation.
So include from at the practice
level, referrals, tracking
tools, as well as at the state
level in terms of policy
assessment.
And we will talk about some of
the findings later, so that you
can get a sense of what the
range of evaluation is involved.
Next slide.
The part that brings me the most
joy about --
>> Recording stopped.

>> ELIZABETH MILLER: Oops.

>> Recording in progress.

>> ELIZABETH MILLER: We lost the slides.

There we go.

So at the heart of Project Catalyst and -- is this cross sector collaboration bringing together our domestic violence advocacy partners with community health centers.

And at the core of this is now two decades plus of research showing that the healthcare system is an important place to support survivors of intimate partner violence, in particular because of the physical and mental health consequences of intimate partner violence.

But in addition, we have learned

that among women surveyed about their experiences of intimate partner violence, that in the past year, 17% of them who had been physically abused by an intimate partner also described having their partner interfering with their ability to access and receive care.

And so when survivors come into seeking services within a domestic violence agency, we have an unprecedented opportunity to support their physical and mental health needs, and that is the beauty of this collaboration that is the heart of the model.

Next slide.

In addition to the cross sector collaboration is an intervention that is research-informed, evidence-based, that has been evaluated in several different healthcare settings.

And it's called the CUES intervention, C for confidentiality, U for universal education, empowerment, meaning

that information is offered to
all patients with every visit
and asking our patients to share
the information with others in
their networks.
And then being able to provide
support.
A warm referral to the wonderful
advocates in our victims service
agencies.
And while today on this webinar
we don't have time to go into
the details of the CUES
intervention, this is really at
the core of what was presented
and shared with our community
health center partners.
So next slide is what was so
beautiful about Project Catalyst
is an opportunity to work deeply
with community health centers

that are extraordinary
foundation of our healthcare
delivery system across the
country.
They're community-based,
patient-directed organizations
that deliver no-cost, low-cost
comprehensive primary
healthcare.
And often include additional
services such as pharmacy, and
mental health services,
substance use treatment, oral
health services.
And for the most part are
located in medically underserved
areas reaching populations who
may have difficulty receiving
care.
And it was an incredible
privilege with Project Catalyst
to be able to lift up the work
that community health centers
do.
Next slide.
And none of us anticipated March
of 2020, but wow, I am just
continued to be amazed and so in
awe and inspired by our health

centers and domestic violence programs that pivoted and partnered during this COVID-19 pandemic.

Everything from COVID testing, and vaccinations, health enrollment for clients or staff, helping to establish a primary care provider, and trying to shift away from use of emergency-level care.

Helping our domestic violence programs and shelters operationalize safety protocols related to COVID-19.

And mitigation strategies.

As well as support for health center staff who are themselves experiencing partner violence.

This work really aligned with the American Rescue Plan

priorities to provide access to
COVID-19 testing, to vaccines,
and mobile health units for the
domestic violence programs.
Next slide.
So I am now going to turn this
over to my colleague Anisa.
>> ANISA ALI: Thank you so much,
Dr. Miller.
So we'd like to now tell you
just a little bit more about
Project Catalyst.
And it really aims to center
that CUES approach and the
building partnerships between
health centers and domestic
violence programs that you just
heard Dr. Miller talk about.
And so it aimed to scale up the
impact by developing leadership
and collaboration at the U.S.
state and territory level.
And so each team consisted of
the primary care association,
which is the state or regional
organization that provides
training and technical
assistance, state or territory
or regionwide for community

health centers.
And then the state or territory Department of Health or public health, and lastly, the state or territory domestic violence coalition, which is the membership organization of domestic violence programs in each state or territory.
And so these multidisciplinary teams offer training and technical assistance directly to health center and domestic violence programs across our state and territory.
And so by engaging the state and territory leadership teams, this really helps enable us to create state and territory level policy changes which have broad and long lasting implications, even

after the project period has ended.

Next slide, please.

So here are the main goals of Project Catalyst.

So it worked to promote state and territory policy and systems changes for community health centers and domestic violence programs.

And promote trauma-informed practice transformation in the five partnering community health centers and domestic violence programs, which were participating in each state and territory.

In each phase.

And then the ongoing integration of partner violence and human trafficking response into healthcare delivery statewide or regionwide, and then that also included each state or territory leadership team had an action plan to train at least 50% of the federally funded community health centers in their state or territory.

Next slide, please.

So we had three phases of Project Catalyst, from 2017-2021.

So the photos that you see here on the screen are from Project Catalyst phases I and II, and these were from the kickoff meetings we held a kickoff meeting at the beginning of each phase at our Futures office in San Francisco.

So with each phase we created a funding announcement that we shared with our -- in partnership with our federal funders, and then circulated widely throughout the field.

So for Project Catalyst Phase I, we circulated the funding announcement in the fall of

2017, and that's the group on the left there on the screen.

And for Project Catalyst Phase II, we circulated the funding announcement in the fall of 2018.

And received many competitive applications each time.

So for Phase I, you can see we selected -- go back.

For Phase I we selected four states -- Arkansas, Connecticut, Idaho, and Iowa.

And they each received $75,000 award.

And while Minnesota was not awarded funding, they still participated self-funded in our cohort, and they attended many of our in-person events such as our kickoff meeting, and then our training of trainers.

And then Phase II we selected two states and one territory, so that's Colorado, Guam, and North Carolina.

The teams, each brought in some unique strengths that really kind of shaped how the cohort

looked.
For example, the Connecticut team in Phase I had a really strong history of work around the health and domestic violence across their state.
The Colorado team in Phase II had a wealth of policy experience related to health and domestic violence in their state.
And that really brought in a lot for our cohort and helped inform our curricula and resources as well.
And so as we mentioned, each leadership team has these three partners, and in many of the states and territories who participated, there was already some history of work between two

partners, especially the
domestic violence coalition and
then the Department of Health or
public health.
However, in a lot of cases,
adding in the partner of the
primary care association was
new, and so Project Catalyst
really just offered an
opportunity to bring in an
additional partner, reaching
folks who were attending
community health centers across
the state and territory.
And really helped catalyze the
work after the project period
ended as well, by engaging this
new sector.
I am going to turn it over to
Sarah.
>> SARAH SCOTT: Thank you,
Anisa.
I'm really excited to be able to
share the promising results that
we're seen during phases I and
II, at the state level and the
clinic and domestic violence
program level.
So you can see on the slide just

the incredible reach that the first two phases of Project Catalyst had with six participating states, one U.S. territory, numerous amounts of both programs and staff trained. All which resulted in several significant state level changes. And I want to highlight the work done by one participating U.S. territory of Guam in the second phase of Project Catalyst. The Guam leadership team expanded its reach to include other Pacific island, and in doing so, the leadership team encountered several barriers that were different than the other participating project catalyst states. In particular, the Guam

leadership team determined that the language barriers on Pompeii and American Samoa needed to be addressed, so working with the leaders on each of these islands, the leadership team determined that it would be most impactful to translate the general health safety card and adapt the cover photos and art.

So this is just one example of the numerous long-standing impacts of Project Catalyst.

And so if we go to the next slide, I'm going to discuss some of the highlights of Project Catalyst Phase I and II at the site level.

Again, you can see just the incredible impacts of the first two phases of work.

Over 900 health centers, staff trained, over 200 domestic violence programs staff trained, and there were really substantial impacts on the healing-centered practices and policies at both the health center and the domestic violence

program sites.
And so we see health centers began having staff routinely offer universal education on intimate partner violence or human trafficking, we see that health centers now know an advocate or counselor who can provide on-site follow-up with a patient who discloses intimate partner violence or trafficking.
We see that health centers are now assessing in a private place.
And domestic violence programs now have resource lists that identify clinical referrals and resources for clients who need medical, mental health, and reproductive and sexual healthcare.

So really, these results
highlight the lasting impact of
Project Catalyst on healing
center policy and practice
change, both in health centers
and domestic violence programs.
So now I'm going to pass it back
to Anisa to speak about the
Phase III cohort.
>> ANISA ALI: Thank you so much,
Sarah.
So our third and final phase of
Project Catalyst went a little
bit longer because of the
COVID-19 pandemic.
So we launched in December 2019
and similarly with Project
Catalyst phases I and II, we
circulated a funding
announcement in the fall of
2019.
And the three sites we selected
are up here on the screen.
Georgia, Minnesota, and Ohio.
And the photo that you see here
is again from our kickoff
meeting at our Futures office in
San Francisco in January 2020.
And so what was interesting

about this group participating states is that all three of them had actually previously participated in Project Connect, which was a coordinated public Health Initiative to prevent violence against women, which went through two different phases from 2010-2015.
And it was funded by the office on Women's Health at the U.S. Department of Health and Human Services in Coordination with the Administration for children's and families, also at the Department of Health and Human Services.
So all three of these states had already had a really strong background of work at the state level of supporting survivor

health and safety.
And so they again, just like the other phases, had, each had brought in unique strengths which really shaped our cohort.
So for Minnesota, one of their strengths was that they had a really strong statewide programming in place to support youth experiencing trafficking.
And that really helped inform some of our project catalysts, curricula, and training materials.
And then in Ohio, the Ohio domestic violence network, they're actually home to the Center for Partner-Inflicted Brain Injury which produces a whole host of resources with a wealth of experience around partner-inflicted brain injury.
And so we really brought in a lot of their expertise into our materials and curricula, and it really provided a nice overall strength to our cohort as well.
And so next I'm going to pass it to Dr. Miller.

>> ELIZABETH MILLER: With Phase III, we also looked at the outcomes at the state leadership level, and what was so tremendous is that for all three of our state leadership teams, very intentional integration of intimate partner violence, human trafficking, and exploitation into other quality improvement initiatives and into other networks.

As you see here on the slide, including behavioral health, substance use prevention, and treatment, healthcare quality improvement networks, and adolescent health promotion networks.

And in addition, the state leadership teams have featured

Project Catalyst interventions
at related trainings.
And all three states integrated
intimate partner violence, human
trafficking, and exploitation
into maternal Health
Initiatives.
And given our national emphasis
on really reducing maternal
mortality, that this level of
state leadership buy-in on the
vital importance of addressing
intimate partner violence,
trafficking, exploitation, in
the context of maternal health
cannot be overemphasized.
Now, Sarah is going to tell you
much more about the details of
our evaluation.
>> SARAH SCOTT: Thank you,
Dr. Miller.
So this slide really speaks to
the impact of Project Catalyst
and the CUES training on staff.
And provider beliefs and
practices.
So you can see among the 121
health center staff and 109
domestic violence programs

staff, that were trained as part of Phase III of Project Catalyst, just incredibly high rates of provider and advocate knowledge and confidence levels around a number of different topics.

Including the understanding of how trauma-informed practices can support both their staff and patients, are advocates that felt hike the training increased our understanding of the impact of intimate partner violence on human trafficking.

Advocates who reported that the training were more like -- after the training they were more likely to assess for human trafficking.

The number of providers who felt

like the training increased
their knowledge of the CUES
intervention, as well as
providers who reported that they
were more confident in referring
a patient to a partnering
domestic violence program.
So if we go to the next slide
I'm going to speak a little bit
more about policy and protocol
changes.
As you can see on this bar
graph, tremendous gains were
made at the health center level
regarding the integration of
trauma-informed healing-centered
practice.
So we see out of the 13 sites
that completed both the baseline
and the follow-up quality
assessment and quality
improvement evaluation tool, a
majority now offer information
about intimate partner violence,
and trafficking, that patients
can take with them.
A majority now know an advocate
or counselor who can provide
on-site follow-up with a patient

who discloses intimate partner violence or trafficking, a majority now have a policy that family members or friends may not be used for interpreting for patients, as well as have a policy to routinely see patients alone during their visit.

And so really, these results signal that health centers are thinking about patients' confidentiality, universal education, empowerment, and support.

And how to best integrate these practices into both their protocols and their practices.

So if we go to the next slide, we'll talk a little bit more about domestic violence programs.

So as you can see here, civil substantial gains were seen in integrating both the trauma-informed and healing-centered practice among the domestic violence program sites.

And so there was advances in sites that had materials available for clients to take on the health impacts of intimate partner violence and trafficking, as well as resources specific to the LGBTQIA+ community.

As well as information about human trafficking and exploitation specifically.

So in addition, there were a number of sites that now provide regular feedback to their staff about their performance regarding assessment and referral for survivors' health and healthcare-related concerns.

So in the next slide I'm going to speak a little bit more about how we saw intimate partner violence and human trafficking

integrated into the state and regionwide healthcare delivery system.

So we saw civil advancements in the ongoing integration of intimate partner violence and trafficking response into the healthcare delivery system, including two states offering technical support like the shared online site to domestic violence programs, and health centers, really to access training tools and resources related to the health impacts.

Of all kinds of abuse and now two states offer technical support on strategies for integrating intimate partner violence and trafficking into other health promotion or system

reform efforts like we saw in
the first two faiths of Project
Catalyst.
And so now I'm going to pass it
to Anisa.
>> ANISA ALI: For the next few
minutes we're going to be
hearing from each of our Project
Catalyst leaders that is joining
us today to hear just how it
looked on the ground from their
perspective, implementing
Project Catalyst in their states
and other stories of impact.
So first we are going to hear
from Meggie Royer from
Violence-Free Minnesota.
>> MEGGIE ROYER: Thank you,
Anisa, and thank you all sites
attending today.
I'd really like to acknowledge
and thank you for participating
in part of this project.
So in Minnesota, we continue to
move our Project Catalyst work
after it ended and we were able
to continue funding four of our
demonstration sites to continue
Project Catalyst.

We were fortunate to continue working with one of our culturally specific domestic violence programs and its partner community health center and another domestic violence shelter and its partner in community health center on this work.

So this additional funding has really focused on integrating health assessments into the domestic violence programs' intake procedures as well as assisting the community health centers with implementing a domestic violence and human trafficking response protocol into their procedures.

Dr. Miller had previously mentioned maternal Health

Initiatives, so as part of our Project Catalyst work, we've also been fortunate to receive five-year funding from the office on women's health to actually focus specifically on preventing and reducing maternal deaths in Minnesota to -- due to violence, including homicide and suicide.

As part of this office on women's health funding project, we're going to be looking at adapting the CUES intervention, confidentiality, universal education, empowerment, and support for Black and Indigenous communities in order to prevent maternal deaths.

This project will be a collaboration between be several community-based programs as well as the Minnesota Department of Health, violence-free Minnesota, the Minnesota association of community health centers, and the Minnesota perinatal quality collaborative.

So we're excited to begin that

work.
Another project we've worked on
is the creation of telehealth
resources.
So when the pandemic started, we
had been hearing more about some
safety concerns around assessing
for domestic violence and human
trafficking in telehealth
visits, just because providers
and advocates might not always
be aware of who is actually in
the room with the patient at the
time of the visit, perhaps their
partner might be in the room and
there could be concerns around
domestic violence.
So our team has focused on
creating resources for
healthcare professionals and
domestic violence advocates

specific to telehealth visits.
And those materials have
included scripts for providers,
pandemic-related safety cards,
resource posters, and Zoom
backgrounds.
And we were able to translate
those materials into Hmong,
Spanish, and Somali, as well as
make them available in English.
Next slide, please.
And these are just some examples
of the teleresources that I just
mentioned.
So the resource on the top left
is a Zoom background, it's
available in a couple different
colors.
But the background has our
statewide domestic violence and
sexual violence and human
trafficking hotline available.
So the background is intended
for a provider to have during a
telehealth visit.
And then on the bottom right
you'll notice a poster.
So these posters are pretty
large.

They can be printed and actually displayed on the wall behind a provider or an advocate during a telehealth visit.

And they also have our statewide crisis hotline on them, as well as our United Way 2-1-1 health line, which focuses more on general resources such as for food, housing, and mental health.

Next slide, please.

On the top left of this slide we have a couple more telehealth resources.

So the one on the top left, the text is small, but this is a portion of our provider scripts which actually kind of offers healthcare professionals and domestic violence advocates kind

of a guide in how to actually initiate conversations with patients about domestic violence and human trafficking.

And then on the bottom right we actually adapted the Futures Without Violence safety cards to be more specific to a public health crisis.

So I will put the link in the chat to those resources and turn it over to Brandy.

>> BRANDY DAILEY: My name is Brandy Dailey, I want to give you a brief overview of Project Catalyst in Arkansas.

So we were part of Phase I, and as you can see here, this is the summary of our core partners and our pilot sites.

The pilot sites were both urban and rural, so we had a pretty good mix of populations that we were serving.

We trained 340 professionals during the initial 10-month period.

And we did that in person.

This was pre-pandemic, so we

were privileged in that we were
able to do that.
Next slide, please.
One of the biggest lessons that
we learned from Project Catalyst
is just how powerful these
relationships truly are.
Of our five pilot sites, the
meet and greets we hosted, to
mingle and have each champion
from the health entity and
the -- revealed tons of new
connections, a lot of times
people knew each other in the
community, but they were not
aware of what each organization
did for the community, what the
available resources or services
were.
We also when we held our
full-site trainings, the 3½-hour

block, we would invite the
champion from the partner agency
to attend, so they could see
what the material was, as well
as answer questions when it came
time to what did the DV advocate
do or community health center do
for the community.
And finally, we also hosted
follow-up meetings.
This is a great check-in point.
The typically one to three
months after the full-site
training, when we could just
check in as facilitators, maybe
ask for surveys back from the
evaluation perspective, and
really just help answer
questions from champions.
Next slide, please.
I wanted to share two really
powerful stories with you today.
One is from our health partners,
one of our community health
centers shared that through the
referrals from Project Catalyst,
they had a very powerful story
of a woman who was able to leave
an abusive relationship and

actually utilize that warm referral process to obtain a permanent order of protection and get some safety from her partner.

On the flip side of that, in shelters, since we started training on coercion, the health impact of violent relationships, all of the advocates started asking very important health screening bees upon intake, and educating members of the community on some of these topics, so from a client we got their perspective when it came to reproductive coercion and just how they didn't realize they were actually victim of reproductive coercion themselves.

Very powerful things were going on.
Ongoing impact in Arkansas, we actually applied at the coalition level the state domestic violence coalition, we applied for and received $8.6 million in the American Rescue Act program funding.
This money will be given back to our domestic violence shelters through an RFP process or a request for funding proposal process.
The shelters we required to receive training on the CUES intervention and have an active health partnership.
Just to help maintain the Project Catalyst lessons.
We are integrating public health into all of the domestic violence trainings, education, programs, etc., statewide.
For example, all of our domestic violence shelters are now trained on the various health impacts of intimate partner violence in human trafficking.

We also have a collaboration that the sexual assault coalition for Arkansas, so we can work on human trafficking between the two coalitions statewide.

And finally, we have continued to expand the curriculum that Project Catalyst first introduced us to.

We've provided training to child welfare agencies, entire hospital systems, pregnancy resource centers, law enforcement agencies, nurses, veterinarian technicians, and a whole lot more folks who never really made the connection between health and domestic violence.

Our final slide, if you have any

questions or comments, you are
welcome to email me directly or
put it in the chat and we can
talk offline.
Or at the end of this
presentation.
I'm going the turn it over to
the next presenter.
>> LINDSAY WEAVER: Hi, everyone,
thank you so much, Brandy.
So I'm just going to share some
maps here, just to share the
impact of Project Catalyst, or
rather the scope of service that
federally qualified health
centers and domestic violence
coalitions have among the state,
but also sharing the overlap in
the communities that we serve.
We serve a high metropolitan
population in Cincinnati,
Columbus, Cleveland, but we also
serve a large Appalachian and
rural population in northwest
and the southeast parts of Ohio.
Next slide, please.
So I know this is bare bones
compared to the other
presenters, but I'm going to

walk you through a little bit of narrative as far as different aspects of the impact of Project Catalyst.

So on the direct service line level, we had a number of participating domestic violence programs and federally qualified health centers that were already doing amazing work.

So prior to Project Catalyst, all of the participating domestic violence programs had included comprehensive health screenings at some point during the client intake.

And that included you screening for traumatic brain injury, and strangulation, and that is thanks primarily to Rachel Ramirez, the founder and

director for the center.
We also had several
participating health centers
that are working on integration
of care related to substance use
disorder and medication for
opioid use disorder.
Many of the screening for
intimate partner violence and
human trafficking was already
happening, but targeted towards
patients that were receiving
behavioral health or substance
use disorder services.
And I really have to thank our
own Dr. Dana Falanchin, the
chief medical officer, she's
been tremendously helpful in
helping health centers move
towards primary care integration
including behavioral health and
substance use disorder services.
And finally, referrals were
already happening.
So the importance of Project
Catalyst at least on a direct
service level was strengthening
those pathways, strengthening
referrals, strengthening

relationships, but also understanding the scope of services after completing the project catalyst trainings.

For one example, when we did the domestic violence advocacy trainings, and I presented on behalf of the association of community health centers on the scope of services that health centers provide including enrollment in Medicaid, and many of the domestic violence advocates online were at some -- the light bulb clicked in their heads.

That they realized, this is a way we can further coordinate care with our clients and make sure that they're getting the wrap-around services they need.

Beyond Project Catalyst, we had the opportunities to expand this Project Catalyst training through an extension of the funding through the Ohio Department of Health, so I believe Deborah seltzer is on the line, as she's the program administrator for the sexual assault and domestic violence prevention program at the Department of Health, and she offered us to apply to use some unused state program funds to conduct the Project Catalyst trainings throughout the state level.

So not just limited to the original partnerships, but throughout the state.

So as you can see here, we had an extremely broad reach.

We opened it up to as many folks who were interested as we could, actually as we could -- if we could back to the slide, pardon.

We had 120 attendees for the domestic violence efficacy trainings, nearly 44 at the

health center trainings, so the technical adaptations by -- that we had to adapt due to COVID, that allowed us to train -- facilitate those trainings with that new set of funding.

Additionally, part of that extended funding allowed us to conduct debriefs in three additional counties.

So again, furthering that philosophy of work in building those partnerships in those additional counties.

And finally, many of us that were on the Ohio leadership team are now a part of the Ohio council to advance maternal health, which is a statewide, multidisciplinary and multipronged initiative to

improve the health outcomes of
birthing people, specifically
we're working on strategy seven,
which aims to improve quality
and access to trauma-informed
care, the group was very
interested in developing some
kind of trailblazing to local
health -- training to local
health departments, qualified
health centers, to improve
health outcomes and address the
needs of survivors and folks who
were exploited.
So I brought forward the Project
Catalyst curriculum to use as a
guide, whether we wanted to have
things more general or if we
wanted to narrow our focus to
support organizational change to
prevent -- to address prevention
or direct service to survivors.
So when I think of Project
Catalyst, just to sum up what
everyone has been saying, I
really think about standing on
the backs of giants.
Because already our health
centers, our domestic violence

advocates, even in Ohio, our regional human trafficking coalitions are already doing great work, they're just in silos.

So the idea of Project Catalyst is really bringing everyone together to coordinate, collaborate, and -- I can't think of the word -- to coordinate the already great work and to really build on top of everything that's going on.

And I believe I'm handing it back to Anisa.

>> ANISA ALI: Thank you, Lindsay.

And thank you to all of our Project Catalyst leaders.

It's incredible to hear about the work you all did and the

work you're continuing to do,
even after Project Catalyst.
So to give us a sense of the
whole reach of Project Catalyst
throughout our three phases, we
have had participation from 10
states and territories.
And then throughout the three
phases, in terms of the
demonstration sites that were
trained, we had 45 domestic
violence programs or
community-based organizations.
Almost 400 domestic violence
program community-based
organization staff, 51 community
health centers, and over 1,000
community health center staff.
So really incredible reach that
we had.
We reached 11 primary care
associations, 11 domestic
violence coalitions, and 10
departments of health and public
health.
Next slide, please.
And this is sort of a visual of
the reach that we had throughout
the three faiths of Project

Catalyst.
And also the pie hot project
that preceded it, improving
health outcomes through violence
prevention.
Which we had two faiths of that
from 2015-2016.
So you can see there's just a
wide reach across the country
and to Guam as well.
So that gives you a sense of
kind of how wide-reaching it
was.
Next slide, please.
And then we also wanted to share
with you our online tool kit,
IPV health partners.org, and
we'll drop that into the chat.
Which was really an outcome from
our pilot project that improving
health outcomes project.

We got a lot of input from our participating partnering health centers and domestic violence programs, so it has a lot of partnership building tools here, a lot of information about CUES, a lot of information about supporting patients during COVID-19, so feel free to check that out and we'll drop the link in the chat as well.

And next I'm going to hand it over to Anna.

>> ANNA MARJAVI: Thank you so much to all of our presenters from our state leaders, just exceptional work, and always something new that we're learning in terms of how they're innovating.

So in terms of the work that was initiated with Project Catalyst, and working with primary care associations as well as community health centers, we've now been able to scale that up to a national training and technical assistance partnership, NTTAP, which is

funded through the bureau of primary healthcare, and we are there to offer training and technical assistance to community health centers, primary care associations, and other HRSA grantees, just on the topics we've been presenting today.

We have a lot of resources and tools, including activities that health center staff can take part in, like learning collaboratives and national webinars like this.

Really centered to increase the staff capacity for health center staff to take on this kind of work, and to partner meaningfully with local domestic violence programs.

So check it out, you can see the URL on the bottom of the slide.
And we hope that you join us in our activities on that side, our new training and technical assistance center.
Next slide, please.
There's been a little bit of chatter in the chat box just about where to access our tools and resources that we've described today.
You can find them on our Futures Without Violence website.
The URL is listed on the slighted.
And there you'll see -- on the slide.
There you'll see the tremendous½-hour training curricula that we described today.
There's one set for local domestic violence programs and another set just for health centers.
And these are tools that can be used not only by those specific organizations, but also by the

state partners that we've
mentioned who are aiming to
develop these kinds of
partnerships and to put these
kinds of systems change pieces
into practice.
So do check that out.
In addition to curricula, we
also have all of the other tools
that you would need to put on
and to host a training, whether
it's in person or virtual,
including flyers, agendas,
reminders for your speakers,
reminders about how to set up
day of, things to keep in mind.
As well as other handouts and
tools for folks to use and
adapt.
Next slide, please.
So I just want to say a special

thank you to my team at Futures Without Violence who are listed on this slide, and our partners, our evaluation partners at the University of Pittsburgh Medical Center.

It's been a wonderful six years that we've journeyed across these states and with the local programs.

And also to thank again our federal.

>>> Proper President Nixon officers and funders who envisioned this at the federal level.

And remember, it's an interagency project.

So it was supported by folks who at the health resources and the services administration, the office on women's health, and the bureau of primary healthcare that primarily worked with health centers and primary care associations and others, and then our folks under the Administration of Children and Families, Family Violence

Prevention and Services Program, that funds all the domestic violence programs and national hotline coalitions, and so that partnership that we're envisioning locally between domestic violence programs and health centers, is also taking place nationally in terms of our federal partnerships.

And just a shout out to the national hotline on domestic violence that now is continuing some of these efforts with that interagency support from ACF and HRSA, check out the national hotline and go to their search tab and put in "health" and a whole range of tools will pop up.

And they are also training

advocates so they know how to
route a client to community
health centers for support.
And they're also working with
community health center staff to
help them know more about what
advocates offer at the national
hotline.
So without further ado, please
complete our evaluation, we'll
put it in the link.
If you please let us know how we
can be helpful moving forward,
and again, just to thank
everyone involved in Project
Catalyst over the last six
years, many of you I think are
here listening and just to thank
you for your ongoing efforts and
the leadership of all of our
state leaders, our evaluation
team, our funders, and everyone.
So I'll turn it over to Anisa
who I think also wants to say
some words.
>> ANISA ALI: Thank you so much,
Anna, thank you so much everyone
at our Futures staff and our
Futures faculty to our

University of Pittsburgh
evaluation team, we couldn't
have done this without you.
And to all of our really
incredible Project Catalyst
leaders, all the other state and
territory leadership teams,
demonstration sites, we so
appreciate all your hard work.
And it's just such a pleasure to
work with you all.
And thank you so much for
joining us today.
We will follow up with the link
to the evaluation, which is
already -- also in the chat, and
we'll follow up over email along
with the recording and the
slides, and the links that were
included in the chat today.
So thank you so much, everyone.

Hope you have a wonderful day.