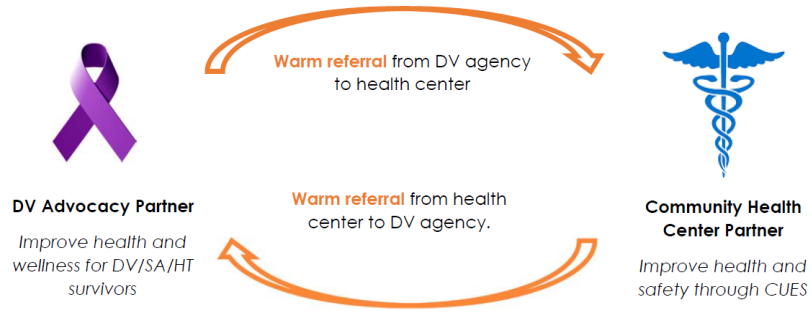
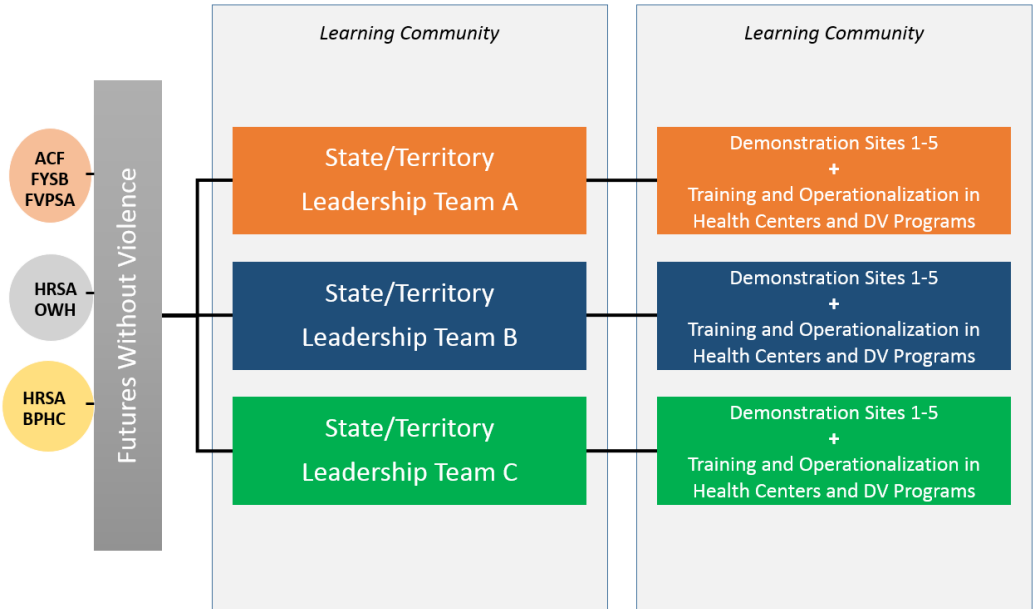
Funding Announcement:
Project Catalyst III: State/Territory-wide Transformation on Health, IPV and Human Trafficking

Futures Without Violence (FUTURES) is soliciting applications for Phase III of Project Catalyst focused on fostering leadership and collaboration at the state or territory level to improve the health and safety outcomes for survivors of IPV/HT as well as promote prevention efforts. This project is supported through a collaboration of U.S. Department of Health and Human Services partners, including the Administration for Children and Families' (ACF) Family and Youth Services Bureau, the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care, and the HRSA Office of Women's Health. Technical assistance and training will be provided by FUTURES. Since 1996, FUTURES has been ACF's funded National Health Resource Center on Domestic Violence (HRC) and in that role promotes model health responses to IPV as well as patient and provider education tools.

Three state/territory leadership teams (consisting of one state's/territory's: Primary Care Association (PCA), Department of Health (DH) and Domestic Violence Coalition (DVC)) will be selected to work closely with FUTURES and with each other to promote state/territory level policy and systems changes that support an integrated and improved response to IPV/HT in community health centers (CHCs) and to other needed services in domestic violence advocacy programs (DVPs) (see Infographic 1 below). As part of that effort, a minimum of five CHCs and five DVPs (in each state/territory) will partner with one another on trauma-informed practice transformation. This includes a vision and strategy to promote policies and practices that support ongoing integration of the IPV/HT response into health care delivery state/territory-wide, and significant inroads into implementation of an action plan to train and engage at least 50% of the HRSA-funded CHCs in their state/territory by the end of the project period. To reach CHCs, State/Territory Leadership Teams will conduct outreach to HRSA-funded health centers across their state/territory to share information on the model developed by FUTURES (via webinar, newsletter, listserv announcement, etc.) to ensure that health centers are aware of the availability of training and technical assistance (T/TA) to implement the model within their community. Investing in meaningful T/TA partnerships is critical to supporting the individuals and families who access health care services through HRSA-funded health centers and FVPSA-funded domestic violence/sexual assault programs.



Infographic 1: Building Sustainable and Fruitful Partnerships Between Community Health Centers and Domestic Violence Advocacy Organizations



Infographic 2: Project Catalyst Phase III Learning Communities

We encourage that applicants demonstrate meaningful state/territory-wide partnerships for training, problem solving service barriers, implementation of Confidentiality, Universal Education, Empowerment, and Support (CUES) evidence-based intervention model for IPV/HT assessment and intervention at CHCs, establishing referral protocols with local DVPs, and featuring IPV/HT and health discussions at upcoming conferences, webinars, workshops and other in-person events and through distance learning.

See Appendix A: Applicant Resources *for more information related to HRSA-funded health centers and FVPSA-funded domestic violence/sexual assault programs; state and regional primary care associations, state and territorial departments of health, and domestic violence coalitions; national hotlines and other T/TA resources.*

Highlights of Funding Opportunity

The period of funding is from December 1, 2019 through September 30, 2020. FUTURES will provide selected State/Territory Leadership Teams a total of $75,000 per state/territory, in addition to hosting one **Kick-off Meeting in San Francisco, CA (Wednesday & Thursday) January 15-16, 2020,** one in-person state/territory Training of Trainers (TOT) (including continuing medical education credits for MDs/DOs) and one in-person administrative meeting, as well as online trainings, free patient and provider tools, and participation in a learning community (see Infographic 2 above) to share challenges and successes, and technical assistance as needed.

Each participating state/territory, FUTURES will work closely with leaders from the state/territory leadership teams (comprised of staff from the Primary Care Association (PCA), Department of Health (DH) and Domestic Violence Coalition (DVC) and any other key stakeholders) to develop sustainable health care and IPV/HT advocacy responses across their respective state/territory.

Selected leadership teams will be geographically diverse and must be able to demonstrate:

- Establishment of an effective leadership team including diverse decision makers from the PCA, DVC and DH with one clearly designated lead staff person to help oversee and implement statewide/territory wide work. **Please note that the PCA, DVC, and DH are required partners for the state leadership teams, and any other key stakeholders that join are supplementary but cannot replace one of the 3 required partners.**
- Identified strong, seasoned trainers to deliver fast-paced in-person and web-based trainings for health centers and IPV/HT programs. These trainers must attend the state/territory TOT to then conduct trainings state or territory-wide.
- History of collaboration, or meaningful intentions to foster new partnerships between the PCA, DVC and DH.
- Commitment that at least one leader from each of the Leadership Team partners (PCA, DVC and DH) will attend the January 15-16, 2020 Kick-Off Meeting in San Francisco, CA.
- Capacity and interest in pursuing a state/territory wide program that is focused on the integration of "CUES" an evidence-based intervention for domestic violence and human trafficking assessment and response at CHCs, in partnership with community based advocates, and systems changes to ensure that response is sustainable.
- Demonstrated commitment to equity and creating culturally responsive programming.
- Engagement of Ryan White Health Center Program dually funded programs, maternal health programs and/or rural/geographically isolated health centers and IPV/HT programs.
- Demonstrated ability to quickly convene local trainings between at least five CHCs and five DVPs (as demonstrated by MOUs from these five combined partnerships).
- Ability to convene clinical staff from the 5 participating health centers for a mandatory 3.5 hour training in each health setting (could be delivered in one session or in (2) 1.75 hour training blocks) and an additional 3.5 hour DV program training for each of the 5 DV programs partnering with the health centers.
- Capacity and willingness to participate in evaluation of the Project Catalyst initiative, including an identified staff person who will partner with the project evaluator to collect pre and post clinic-level assessments, provider and advocate training assessments, as well as facilitate interviews with leads from participating sites; training assessments will be established and monitored by the evaluator.
- Innovative vision for scaling up training and sustaining the program in the state/territory.
- Opportunity and vision for IPV/HT-response integration into existing practice change initiative (i.e., alternate payment plans, social determinants of health initiatives, behavioral health integration into primary care, etc.).

Please note:
We encourage engaging CHCs to serve as demonstration sites that are PCMH recognized and include the following: Ryan White Health Center Program dually funded programs, maternal health programs and rural/geographically isolated IPV/HT programs and health centers. See links for more information:

- In support of the National HIV/AIDS Strategy 2020, which includes a focus on the intersection of violence and HIV for women, we encourage engaging dually funded health centers with Section 330 and Ryan White HIV/AIDS Program funding.
- In support of FVPSA and HRSA's joint effort: Maternal, Infant, and Early Childhood Home Visiting Program; HRSA's Maternal/Women's Health Program Goals and Maternal Morbidity and Mortality

reduction goals; and to increase domestic violence state coalitions and local programs' capacity to offer their pregnant and parenting clients increased access to maternal health and wellness support (connections to birth and postpartum doulas, information and education about breastfeeding, referrals to health centers for prenatal care, etc.), we encourage engaging such programs.

- In support of rural/geographically isolated CHCs and rural DVPs and other community based organizations serving survivors of IPV/HT, we also encourage engaging such programs as demonstration sites. Visit: https://bphc.hrsa.gov/uds/datacenter.aspx?q=d to identify HRSA-funded health centers by state.

FUTURES has developed a step by step online toolkit (www.IPVHealthpartners.org) and other comprehensive training curricula, health care provider resources, and patient education materials to be used in the selected health settings and DVPs and will oversee the evaluation of the project. In addition, quality improvement tools have been developed that can guide the systems changes necessary to institutionalize policies to assess for IPV/HT, as well as resources to facilitate productive partnerships between the demonstration sites (CHCs and DVPs). Selected State/Territory Leadership Teams will be part of a learning community comprised of leaders dedicated to this issue and will have the opportunity to share experiences and strategies with other participating leadership teams.

See attached application.

Applications are due: Friday, November 8, 2019 by 5:00pm Pacific/6:00pm Mountain/7:00pm Central/8:00pm Eastern and should be emailed to Anna Marjavi at amarjavi@futureswithoutviolence.org.

A one hour webinar for interested applicants to learn more about the project and ask any questions about the funding announcement will be held: Wednesday, Oct 23 (10am -11am Pacific/11am-12pm Mountain/12pm-1pm Central/1pm-2pm Eastern)

To register, please visit the following link: https://zoom.us/webinar/register/WN_Ohu9_nR1mukzjT7_c-cA

If you have questions about the initiative or application, contact:
Anna Marjavi, Program Director, Health at FUTURES amarjavi@futureswithoutviolence.org.

Application

Project Catalyst III: State/Territory-wide Transformation on Health, IPV and Human Trafficking

Overview:

Futures Without Violence (FUTURES) is soliciting applications for Phase III of Project Catalyst focused on fostering leadership and collaboration at the state or territory level to improve the health and safety outcomes for survivors of IPV/HT as well as promote prevention efforts.. This project is supported through a collaboration of U.S. Department of Health and Human Services partners, including the Administration for Children and Families' (ACF) Family and Youth Services Bureau, the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care, and the HRSA Office of Women's Health. Technical assistance and training will be provided by FUTURES. Since 1996, FUTURES has been ACF's funded National Health Resource Center on Domestic Violence (HRC) and in that role promotes model health responses to IPV as well as patient and provider education tools.

How to Apply:

Please review the enclosed information about the project prior to completing the application. Submit an application that addresses each area listed under **"Application Questions"** *(described on pages 17-18).*

Email completed applications to: Anna Marjavi at **amarjavi@futureswithoutviolence.org**
Subject Line: Project Catalyst Phase III Leadership Team Application
Include the following information in the email:

- ✓ Contact information for yourself and key collaborators including: Name, Title, Organization, Address, Phone, and Email Address
- ✓ Six Memoranda of Understandings *(see below)*

Applications are due Friday, November 8, 2019 by 5:00pm Pacific/6:00pm Mountain/7:00pm Central/8:00pm Eastern.

Your application should be no more than 15 pages (does not include the MOUs), 1.5 spaced and single-sided. If you have any questions, contact Anna Marjavi, Program Director, Health at FUTURES amarjavi@futureswithoutviolence.org.

A one hour webinar for interested applicants to learn more about the project and ask any questions about the funding announcement will be held: **Wednesday, October 23rd (10am Pacific-11am Pacific/11am-12pm Mountain/12pm-1pm Central/1pm-2pm Eastern).**

Program Overview:

The Centers for Disease Control and Prevention's *National Intimate Partner and Sexual Violence Survey* (2010 Summary Report) found that men and women who experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health than

men and women who did not experience these forms of violence.[1] Women who had experienced these forms of violence were also more likely to report having asthma, irritable bowel syndrome, and diabetes than women who did not experience these forms of violence.[2] Other research shows significant impacts on reproductive and sexual health.[3] Women experiencing physical abuse by an intimate partner are 3 times more likely to have an STI, while women disclosing psychological abuse have nearly double the risk for an STI compared to non-abused women.[4] A survey conducted by The National Domestic Violence Hotline found that 25% of women said their partner or ex-partner had tried to force or pressure them to become pregnant.[5] Experiences of intimate partner violence during pregnancy has also been linked to maternal mortality,[6][7][8] with disparities based on race and ethnicity.[7] Studies also show that the prevalence of intimate partner violence among women is even higher in rural areas, 22.5% compared to a national average of 16.1%.[9] The health system and domestic violence fields must find ways to work together to implement health interventions that achieve better health outcomes for victims of domestic violence.

The impact of human trafficking in many ways mirrors the health impact of IPV[10] [11] [12] [13]:

- Injuries from physical or sexual violence/ health exposures
- unhealthy weight loss due to food deprivation and poor nutrition
- increased risk of HIV/AIDS

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[1] The Centers for Disease Control and Prevention's *National Intimate Partner and Sexual Violence Survey* (2010 Summary Report) http://www.cdc.gov/violenceprevention/nisvs/ and http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf.

[2] Op. Cit. The Centers for Disease Control and Prevention's *National Intimate Partner and Sexual Violence Survey* (2010 Summary Report).

[3] Chamberlain LB, PhD, MPH and Levenson, R, MA; Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care, A Guide for Obstetric, Gynecologic, Reproductive Health Care Settings (Third Edition), produced by Futures Without Violence. 2013. http://ipvhealth.org/wp-content/uploads/2017/02/FINAL-Reproductive-Health-Guidelines.pdf

[4] Coker AL, Smith PH, Bethea L, King MR, McKeown RE. Physical Health Consequences of Physical and Psychological Intimate Partner Violence. Archives of Family Medicine. 2000;9:451-457.

[5] National Domestic Violence Hotline. Focus Survey Summary: Reproductive Coercion Reports by Callers to NDVH. 2010. http://www.thehotline.org/2011/02/1-in-4-callers-to-the-national-domestic-violence-hotline-report-birth-control-sabotage-and-pregnancy-coercion/

[6] Campbell JC, Glass N, Sharps PW, Laughon K, Bloom T. Intimate partner homicide: Review and implications of research and policy. Trauma Violence Abuse 2007;8:246–269

[7] Palladino CL, Singh V, Campbell J, Flynn H, Gold KJ. Homicide and suicide during the perinatal period: Findings from the national violent death reporting system. Obstet Gynecol 2011;118:1056–1063

[8] Shadigian E, Bauer ST. Pregnancy-associated death: A qualitative systematic review of homicide and suicide. Obstet Gynecol Surv 2005;60:183–190

[9] Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural Disparity in Domestic Violence Prevalence and Access to Resources. *Journal of Women's Health, 20*(11), 1743-1749. doi:10.1089/jwh.2011.2891

[10] Susie B. Baldwin, David P. Eisenman, Jennifer N. Sayles, Gery Ryan and Kenneth S. Chuang, Identification of human trafficking victims in health care settings Health and Human Rights, Vol. 13, No. 1, Natural Disasters and Humanitarian Emergencies (June 2011), pp. 36-49.

[11] Mazeda Hossain MSc, Cathy Zimmerman PhD, Melanie Abas MD, MSc, Miriam Light MSc, and Charlotte Watts PhD, The Relationship of Trauma to Mental Disorders Among Trafficked and Sexually Exploited Girls and Women, American Journal of Public Health (AJPH) December 2010

[12] Cathy Zimmerman, Mazeda Hossain, Charlotte Watts. Human trafficking and health: A conceptual model to inform policy, intervention and research, Social Science & Medicine, July 2011

[13] Understanding and Addressing Violence Against Women and Human Trafficking, World Health Organization (2012) apps.who.int/iris/bitstream/10665/77394/1/WHO_RHR_12.42_eng.pd

- increased risk of cervical cancer and other STIs
- dental or oral problems

Additional clinical indicators for labor trafficked victims includes respiratory or other physical injuries resulting from exposure to unsafe working conditions and chemicals/pesticides, etc. Women who are sex trafficked may have increased exposure to HPV and other sexually transmitted infections (STIs) increasing risk for cervical cancer and HIV, as well as unintended pregnancy and limited decision making about outcomes of a pregnancy. It is not uncommon in federal trafficking prosecutions for the trafficker to be the husband, boyfriend, or romantic partner of the victim and in many cases DV programs are the primary referral for patients experiencing either HT or IPV. Many health centers are committed to addressing their patients' social determinants of health (including poor access to healthy foods or poor nutrition; living in poverty; experiences with homelessness; community violence; access to health care; etc.). Addressing IPV and HT is one facet of addressing and improving patients' social determinants of health.

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of childbearing age for IPV, such as domestic violence, and provide or refer women who screen positive to intervention services (January 2013).[14] In addition, the HRSA-supported women's preventive services include screening for domestic and interpersonal violence and brief counseling as a covered benefit for this same population.[15] Health care providers and hospitals have ICD-10-CM codes to adequately differentiate victims of HT from other abuse victims. The National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) added new data collection fields on HT for FY 2019.

Health care providers, however, have received limited guidance or training on how to provide these services and many are unaware of the extent of services available from their local DVPs. Resources and evidence-based practices exist to help providers meet challenges, and a network of DVPs can offer critical partnership. Providing training and technical assistance (T/TA) to health centers on how to implement practice changes at multiple levels and create stronger, more formal relationships can improve long-term health outcomes for survivors of IPV and HT.

National Health Resource Center on Domestic Violence (HRC):
Since 1996, FUTURES has been home to the National Health Resource Center on Domestic Violence with support from the Administration for Children and Families, and U.S. Department of Health and Human Services. The National Health Resource Center on Domestic Violence has supported health care practitioners, administrators and systems, domestic violence experts, survivors, and policy makers at all levels as they improve health care's response to domestic violence.

The National Health Resource Center on Domestic Violence offers:

- Personalized, expert technical assistance via email, fax, phone, internet, postal mail and face-to-face at professional conferences and meetings around the nation.
- Free, downloadable health care information folios focusing on various specialties, populations and key issues. These include fact sheets, model programs and strategies, bibliographies and protocols.

[14] https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening
[15] https://www.hrsa.gov/womens-guidelines/index.html

- Educational and clinical tools for providers and patients. These include: clinical practice recommendations for adult and child health settings; papers on health privacy principles that protect victims, coding and documentation strategies, and more; screening and response training videos; comprehensive resource and training manuals; clinical reference tools; and patient education materials.
- A Health E-Bulletin highlighting innovative and emerging practices in addition to well-documented and rigorously evaluated interventions.
- Models for local, state and national health care and domestic violence policy making.
- A webinar series with expert presenters, and cutting edge topics.
- Tools, strategies and personalized assistance to help health care professionals and advocates join the annual Health Cares About Domestic Violence Day, which is dedicated to raising awareness about abuse among health care professionals.
- A biennial National Conference on Health and Domestic Violence – a scientific meeting at which health, medical and domestic violence experts and leaders explore the latest health research and programmatic responses to domestic violence.
- A virtual toolkit for health care providers and DV advocates to prepare a clinical practice to address domestic and sexual violence, including screening instruments, sample scripts for providers, patient and provider educational resources; and for CHCs and partnering DVPs: www.ipvhealthpartners.org.

We are inviting proposals to select three state/territory leadership teams to work with us on this exciting initiative. The period of funding is December 1, 2019 through September 30, 2020. FUTURES will provide each selected state/territory a total of $75,000.

Program History:
Given their enormous reach and overarching goals to promote health and safety, community health centers (CHCs) are uniquely positioned to be leaders in violence prevention across the U.S. in partnership with domestic violence programs (DVPs) that offer support, safety planning and coaching to address social determinants of health and promote wellness. State/Territory Leadership Teams (SLTs), comprised of leads from state or territory Primary Care Associations, Departments of Health and DV Coalitions, have demonstrated their significant and meaningful role in supporting CHCs and DVPs partnering on IPV/HT practice change, and with state-wide engagement.

Between 2018-2019, FUTURES continued Project Catalyst: Phase II efforts to spread the evidence-based "CUES" intervention state and territory-wide by working with SLTs from Colorado, North Carolina and Guam (U.S. Territory). This expanded the Project Catalyst work first initiated in 2017-2018 by Arkansas, Connecticut, Idaho, Iowa, and Minnesota[16]. These eight SLTs involved leaders from each state or territory's Primary Care Association, Department of Health, and Domestic Violence Coalition. State-level policy and systems changes were promoted to support an integrated and improved response to intimate partner violence (IPV) and human trafficking (HT) in CHCs and DVPs. Their combined efforts trained more than 60 demonstration sites that partnered with one another on trauma-informed practice transformation. The SLTs made significant

[16] AR, CT, IA and ID were funded to participate in Project Catalyst Phase I. Minnesota took part in Project Catalyst without project funding.

inroads into training and engaging at least 50% of the HRSA-funded health centers during the 10 month project window; in fact, some states engaged all of their CHCs statewide. The Guam Leadership Team offered training and technical assistance for CHCs and DV/women's programs on Guam and other Pacific Islands: Pohnpei, American Samoa and Saipan. Additionally, many convened stakeholders from across their states to consider policy change and inclusion of IPV/HT into social determinants of health initiatives.

This work built on previous phases of work undertaken by FUTURES with HRSA and FVPSA. Between 2014-2016, FUTURES provided training and workflow redesign support to 10 health centers and 10 DV programs across the U.S. as part of the *Improving Health Outcomes Through Violence Prevention Pilot Project*. Identifying promising ways to promote the health and safety of patients, health centers and partnering DV programs tested all steps to address and respond to domestic violence. Key findings are distilled into an actionable virtual toolkit www.ipvhealthpartners.org for other health care providers, administrators, DV advocates, and community partners to easily adapt for their own settings.

The progress made in Project Catalyst Phase I and Phase II and Improving Health Outcomes Phase I and Phase II pilots was significant. The next step is continuing the plan to scale up and demonstrate these important interventions state/territory-wide and finalize user-friendly training and education tools. Additionally, we will continue to grow our virtual learning community of all past and future partners of Project Catalyst through an e-list "Catalyst for Change" with announcements, resources and peer-sharing. Together, this will foster sustainable systems level transformation for states/territories, health centers and DV programs to promote health and safety and offer communities a model to effectively address key social determinants of health—IPV and HT.

Background:

Intimate Partner Violence: (also called domestic violence) is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent and are aimed at establishing control by one partner over the other. Sexual violence is any sexual act that is perpetrated against someone's will. It encompasses a range of acts, including a completed nonconsensual sex act (i.e., rape), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal harassment)[17].

Human trafficking is a form of modern-day slavery in which traffickers use force, fraud, or coercion to control victims for the purpose of engaging in commercial sex acts or labor services against their will.
Minors are compelled to perform a commercial sex act regardless of the presence of force, fraud, or coercion.[18]

Values:

- The success of this project depends upon the cooperation and collaboration between the Leadership Team members (PCA, DH and DVC) and the local collaboration and engagement of health care and domestic and/or sexual violence and human trafficking experts. All partners bring unique and important experience and perspectives.

[17] Intimate Partner Violence Definition, Centers for Disease Control and Prevention
https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html
[18] 2013 Trafficking in Persons Report, https://www.state.gov/j/tip/rls/tiprpt/2013/

- In all planning and implementation of programs or policies, input from survivors of trauma and abuse, communities of color, immigrants, lesbian/gay/bisexual and transgender, rural populations, migrant, Tribal, and other underserved communities must be considered. Leadership teams should reflect the diversity of their communities.
- All programs will promote the safety, autonomy and confidentiality of victims of IPV and HT.
- Selected State/Territory Leadership Teams will work closely together to develop and implement a comprehensive and complimentary action plan to create sustainable changes to PCA, DVC and DH program related to IPV and human trafficking.

Roles and Responsibilities:

State/Territory Leadership Team membership, roles and responsibilities:

From its inception, the program will foster leadership and collaboration at the state level by bringing key stakeholders together to create systems changes. At a minimum, the State/Territory Leadership Team shall consist of leaders from their state's/territory's Primary Care Association (PCA), Domestic Violence Coalition (DVC) and Health Department (HD). Additional members may include representatives from local human trafficking programs, local CHCs and/or local DVPs or other health system or public health leaders, academics, Tribal leaders, etc. Each Leadership Team will receive $75,000 to participate in the program and will propose how to allocate those funds to support the project most effectively in their state/territory.

The Leadership Teams will work at multiple levels to develop policy, clinical and advocacy responses to IPV and HT including to:

- Convene a diverse State/Territory Leadership Team (professions and organizations represented, as well as ethnic and cultural diversity) to develop and implement a comprehensive action plan to create sustainable changes to the health center response to IPV/HT and DV program change.
- Develop and implement a comprehensive action plan to create sustainable changes within PCA, DVC and DH programs related to IPV and HT. This includes:
    - Embedding responses to IPV/HT in existing programs, program announcements, evaluation and monitoring efforts and practice regulations (i.e., alternate payment plans, social determinants of health initiatives, behavioral health integration into primary care, etc.);
    - providing training and technical assistance to a minimum of five CHCs and five domestic violence advocacy programs (in each participating state/territory) that are poised to partner with one another on trauma-informed practice transformation;
    - a plan to begin to engage at least 50% of the health centers in your state/territory within the project performance period. This 50% engagement may be done via webinars, workshops, in-person conference/meeting presentations, and other distance learning to promote universal education on IPV and HT in clinical settings and how to build DV advocacy partnerships, disseminating patient education materials on how IPV affects health, and identifying policies that advance systems change.
- Establish formal partnerships between a minimum of 5 CHCss and 5 DVPs to train and implement the trauma-informed IPV/HT intervention model (using sample MOU provided).
- Engage Ryan White funded programs, maternal health programs and/or rural/geographically isolated programs.
- Participate in a learning community including: one staff from each PCA/DVC/DH attend one Kick-off Meeting in San Francisco (January 15-16, 2020), attend one (2-day) in-person state Training of Trainers

(TOT) (including continuing medical education credits for MDs/DOs), and one in-person administrative meeting, as well as monthly Leadership Team webinars (the first webinar is Tuesday, December 3rd 1pm Pacific/2pm Mountain/3pm Central/4pm Eastern – 1 hour long).
- Identify faculty to be trained on the intervention and technical assistance tools.
- Build on the policy strategies and approaches of other initiatives such as Project Connect and Project Catalyst Phase I and II.
- Refer to evidence-informed practices to address human trafficking such as SOAR and the Office on Trafficking in Persons, those offered by HEAL Trafficking, FUTURES, etc.
- Promote the use of www.IPVHealthPartners.org as a primary resource.
- Participate in the evaluation.
- On behalf of the Leadership Team, PCAs will report findings and lessons learned to the HRC in support of their learning community and evaluation efforts. Through the gathering of lessons learned, PCAs will offer support for the implementation and refinement, as needed, to the online toolkit or other materials to support comprehensive, culturally competent responses to IPV/HT.

Each entity in the Leadership Team will designate one to three representatives to oversee their respective contributions related to: training and technical assistance; operationalization; and evaluation. Each Leadership Team must demonstrate a shared capacity and willingness to contribute to the policy, clinical and advocacy responses noted above. The designated roles and responsibilities vary as described below.

State/Territory Domestic Violence Coalitions (DVCs) Roles and Responsibilities:

- Participate in a learning community including: attend one Kick-off Meeting in San Francisco (January 15-16, 2020), join monthly Leadership Team calls beginning in February 2020, attend one (2-day) in-person state Training of Trainers (TOT), and one in-person administrative meeting, as well as monthly Leadership Team webinars (the first webinar is Tuesday, December 3rd 1pm Pacific/2pm Mountain/3pm Central/4pm Eastern – 1 hour long).
- Provide expertise to serve as trainers on the HRC evidence-based curriculum and online toolkit for CHCs and DVPs.
- Provide support to the engaged DV/social service programs to respond to training requests and referrals from health centers to address health issues of their clients and to facilitate bi-directional referrals.
- Facilitate the establishment of MOUs (see sample provided) between health centers and social service organizations working to implement the intervention as well as other prep work for the health centers prior to conducting trainings.

Primary Care Associations Roles and Responsibilities:

- Participate in a learning community including:
    - attend one Kick-off Meeting in San Francisco (January 15-16, 2020)
    - attend one (2-day) in-person state or territory Training of Trainers (TOT), and
    - one in-person administrative meeting, as well as
    - monthly Leadership Team calls beginning in February 2020, as well as
    - monthly Leadership Team webinars (the first webinar is Tuesday, December 3rd 1pm Pacific/2pm Mountain/3pm Central/4pm Eastern – 1 hour long).
- Gain awareness on how to effectively operationalize the curricula in health centers, with the option to be co-trainers with the DVC or DH, PCAs will observe and engage in the state/territory TOT.

- Identify opportunities to align this project with existing and emergent health center priorities.
- Offer a variety of methods to support the DVC in convening health centers for trainings such as (but not limited to) offering incentives support for travel to trainings, prioritizing and allocating time to address the topic in annual state/territory based meetings.
- For all trained entities, facilitate the establishment of MOUs (see sample provided) between health centers and social service organizations working to implement the intervention as well as other prep work for the health centers prior to conducting trainings.
- Serve as a key resource, along with the HRC, to support the operationalization of the health center online toolkit and other materials to support the integration of response to IPV and human trafficking into standard practice in 5 designated CHCs and to 50% of health centers across the state.
    - Training of 50% of health centers may be done via webinars, workshops, in-person conference/meeting presentations, and other distance learning, and must begin within the project performance period.
    - Operationalization should promote universal education on IPV and HT in clinical settings, how to build DV advocacy partnerships, disseminate patient education materials on how IPV/HT affects health, and identification of policies that advance systems change.
    - PCAs should also identify staff to participate in regular Technical Assistance (TA) calls with the HRC and participating health clinics, and through check-in calls with appropriate staff of each clinic as needed.
    - TA may include activities such as advance consultation on how to prepare the practice, web-based and in-person training, guidance on protocol development and implementation, problem solving, quality improvement measures, warm referrals, collaborative behavior supports, and follow-up services. The HRC will provide tools and TA to support the PCA's effort.
    - Refer demonstration sites to evidence-informed practices to address human trafficking such as SOAR, those offered by HEAL Trafficking, FUTURES, etc.

State Departments of Health Roles and Responsibilities:

- Participate in a learning community including:
    - attend one Kick-off Meeting in San Francisco (January 15-16, 2020)
    - attend one (2-day) in-person state Training of Trainers (TOT), and
    - one in-person administrative meeting, as well as
    - monthly Leadership Team calls beginning in February 2020, as well as
    - monthly Leadership Team webinars (the first webinar is Tuesday, December 3rd 1pm Pacific/2pm Mountain/3pm Central/4pm Eastern – 1 hour long).
- Gain awareness on how to effectively operationalize the curricula in health centers, with the option to be co-trainers with the DVC and PCA, DHs will observe and engage in the DVCs train-the-trainer sessions with the HRC.
- Promote community coordination by connecting local health jurisdiction IPV efforts to health centers and DV/social service programs implementing systems changes.
- Identify related state/territory and local efforts (IPV and human trafficking) for the Leadership Team to align best practices during the project and align with broader state public health related policies and priorities (e.g., State Human Trafficking Task Force).
- Identify strategies and training opportunities to integrate and align IPV and HT responses into state/territory level health initiatives (i.e., maternal and child health initiatives, statewide initiatives to address social determinants of health, health in all policy initiatives etc.).

- Support sustainability of the integration of violence and trauma-informed systems of care by briefing state/territory and local stakeholders on initiative outcomes.

Participating in the Learning Community and Kick-off Meeting:

Once state/territory partners are selected, FUTURES will launch a learning community with an orientation webinar on Tuesday, December 3rd 1pm Pacific/2pm Mountain/3pm Central/4pm Eastern – 1 hour long, followed by monthly Leadership Team webinars through September, 2020. An orientation packet of materials will be disseminated via U.S. mail to every Leadership Team member along with logistics for the in-person Kick-off Meeting in San Francisco (January 15-16, 2020). Leadership Teams will use their funds to send participants to the convening (including covering the costs of travel, lodging and per diem for at least 3 participants: one from the PCA, DH, and DVC).

Convening teams in person provides a critical opportunity to give Leadership Teams the background on the program as a whole, the intervention model that will be used for scale up, roles and responsibilities of partners, strategies for policy and practice change, and tools and TA available through the HRC. Most importantly, the kick-off provides an opportunity to foster peer-to-peer learning and cross-fertilization of ideas, programmatic, and policy solutions.

Each Leadership Team will actively contribute to the learning community, including attendance at the in-person Kick-off Meeting in San Francisco (January 15-16, 2020) and their state's TOT (2-day), participation in monthly webinars, sharing of tools and resources, and acting as partners to their cohort, which will inform national efforts undertaken by FUTURES and other partners.

About the Training of Trainers (TOT):

The TOT will focus on:

- **Promoting education for patients/clients** about the connection between IPV/HT and their health. FUTURES has an evidence-based approach that utilizes a brochure-based intervention to discuss limits of confidentiality to assess for IPV/HT, offer harm reduction strategies, and supported referral to community-based domestic violence programs universally and when victims are identified.
- **Institutionalizing program policy** to support assessment of and coordinated responses to victims of abuse. Participating sites are expected to implement policies requiring partnership between health center and DV/HT programs, including changing clinic protocol to support provider trainings, routine assessment and brief interventions for IPV/HT.
- **Educating providers** on the impact of IPV/HT on health outcomes, how to assess and respond in collaboration with local DV partners, and how to report when required. FUTURES has a standard training program, including in-person training, written guidelines, and distance learning activities.
- **Educating domestic and/or sexual violence advocates** on the connection between violence and coercion on health, and how to integrate health assessment into victim service programs. FUTURES has a standard training curriculum to be used at each DVP and CHC. In each participating CHC, there is an opportunity to implement systems changes that support sustainable responses to violence and improve health.

Pre-training preparation, health center trainings and training of trainers (TOT):

In order to create a cadre of independent skilled trainers (from the DVC, PCA, DH agencies) who are prepared to train and provide TA statewide to CHC and DV programs, HRC staff will conduct a Training of Trainers (TOT) program in each of the three selected states/territories. FUTURES will schedule this TOT in advance with each

Leadership Team and provide a flyer template to help recruit statewide CHC/DV programs attendance (including offering MD/DO CEUs). This TOT is an excellent opportunity to involve at least one representative from each of the 5 participating health centers and 5 DV programs (those with signed MOUs) so they can preview the training each of them will later receive (by the Leadership Team) for their broader staff.

To prepare for demonstration site trainings, SLTs participate in a two-day TOT. On the first day, FUTURES staff models the training for Leadership Team members along with their health center partners, followed by faculty training development (day I). On the second day, FUTURS staff trains advocacy partners on their specific program approaches, followed by faculty training development. It is encouraged that Leadership Teams invite CHCs and DV programs (demonstration sites) to attend one day of the TOT to maximize early engagement and understanding and adoption of the prevention and intervention model. Additionally, engaging CHC staff in this TOT will strengthen Leadership Teams ability to later provide their own in-depth (1- 3.5 hour or 2- 1.75 hour) trainings at the designated demonstration CHCs and DV programs (1- 3.5 hour training). Faculty trained in the TOT (Day 1 and Day 2) would then be responsible for training demonstration sites and/or beginning additional field trainings to other health centers.

Participation as a "demonstration site" requires in-depth preparation prior to the training including: establishing an MOU indicating a formal partnership between the CHC and DVP (template provided), filling out QA/QI tools that prompt program analysis of existing policy practice and protocols (models provided, tool is completed twice), allocating sufficient time for training, and releasing appropriate staff to participate in the training to promote a team based approach to IPV/HT and becoming familiar with www.IPVHealthPartners.org. Health centers participating in earlier project phases found that training all staff from the front desk to physicians promotes team based care and was a key part of their success in sustaining a comprehensive response to IPV. Additionally, working to address staff's own current or past exposure to violence and trauma or vicarious trauma is an important element of prep work the demonstration sites can embark upon.

After the training is complete, CHC and DVP champions must work to change systems that support sustainable practice change including embedding training requirements on IPV/HT for all new staff (to account for turnover), monitoring implementation of intervention through huddles, case consultation, documentation, benchmarking and reflective supervision, maintaining environmental supports to providers (i.e., sufficient patient and provider education tools in stock). It will also be critical that champions work to integrate prompts and resources into the EHR and monitor health IT systems to ensure privacy protections are being enforced to keep patient data safe and secure. Each participating state/territory will involve a minimum of 5 health centers and 5 DV programs to participate in this comprehensive response – trained either by HRC staff at the TOT or trained by Leadership Team faculty.

Training 50% of health centers in the state/territory: In addition to the five CHCs participating in the comprehensive training and TA, Leadership Teams will develop and begin a plan to reach 50% of health centers in the state/territory with training and technical assistance, through online education and/or a plan to conduct in-person training for each health center in the state/territory. Leadership Teams must share information on the model developed by FUTURES with the 50% of health centers they plan to engage in the action plan. This could take place via webinar, newsletter, listserv announcement, at annual PCA meetings, utilizing web based training tools, or be conducted in person over time, etc. Testing the impact of online, or shorter training only vs. comprehensive training and systems change TA will provide meaningful insight into efforts to take the intervention to scale nationally.

Sharing Lessons Learned for National Dissemination:
All tools, resources and lessons learned about best practices for training programs statewide will inform the national tools developed and disseminated through the virtual toolkit, www.IPVHealthPartners.org and the National Health Resource Center on Domestic Violence.

Length of the Program:
This project covers the period from December 1, 2019 - September 30, 2020.

Funding:
FUTURES will provide selected state/territory applicants a total of $75,000. FUTURES will offer one Kick-off Meeting in San Francisco (January 15-16, 2020) for State/Territory Leadership Teams, provide (one) 2-day in-person TOT in each selected state/territory, and provide the technical assistance and materials for providers and patients, convene webinars, oversee program evaluation, and develop policy guidance to support the work of the Leadership Teams.

Selection Criteria:
Selected Leadership Teams will be geographically diverse and must be able to demonstrate:

- Establishment of an effective leadership team including diverse decision makers from the PCA, DVC and DH with one clearly designated lead staff person to help oversee and implement statewide/territory wide work. History of collaboration, or meaningful intentions to foster new partnerships between the PCA, DVC and DH.
- Identified strong, seasoned trainers to deliver fast-paced in-person and webinar trainings for health centers and DV/HT programs. These trainers must attend the state TOT to then conduct trainings statewide.
- Commitment that at least one leader from each of the Leadership Team partners (PCA, DVC and DH) will attend the Kick-off Meeting (January 15-16, 2020) in San Francisco, CA and their state/ter TOT.
- Identification of faculty to be trained at state/territory TOT that will then conduct ongoing training statewide.
- Capacity and interest in pursuing a state/territory-wide program that is focused on the integration of "CUES" an evidence-based intervention for DV and HT assessment and response at CHCs, in partnership with community based advocates, and systems changes to ensure a sustainable response.
- Demonstrated commitment to equity and creating culturally appropriate programming.
- Engagement of Ryan White Health Center Program dually funded programs, maternal health programs and rural/geographically isolated programs.
- Demonstrated ability to convene clinical staff from the 5 participating health centers for a mandatory 3.5 hour training in each health setting (could be delivered in two 1.75 hour training blocks) and an additional (1) 3.5 hour DV program trainings for each of the 5 DV programs.
- Capacity and willingness to participate in evaluation of the initiative, including an identified staff person who will partner with the project evaluator to collect pre and post clinic-level assessments, provider and advocate training assessments, as well as to facilitate interviews with leads from participating sites; training assessments will be established and monitored by the evaluator.
- Innovative vision for scaling up training and sustaining the program in the state/territory.
- Opportunity and vision for IPV and HT integration into existing practice change initiative (i.e., alternate payment plans, social determinants of health initiatives, behavioral health integration into primary care, etc.).

Eligible Applicants:
All U.S. states and territories are eligible to apply (except for those previously funded to work on Project Catalyst phases I and II).

Please note:
We encourage engaging CHCs to serve as demonstration sites that are PCMH recognized and include the following: Ryan White Health Center dually funded programs, maternal health programs and/or rural/geographically isolated programs and health centers. See links for more information:

- In support of the National HIV/AIDS Strategy 2020, which includes a focus on the intersection of violence and HIV for women, we encourage engaging dually funded health centers with Section 330 and Ryan White HIV/AIDS Program funding.
- In support of FVPSA and HRSA's joint effort: Maternal, Infant, and Early Childhood Home Visiting Program; HRSA's Maternal/Women's Health Program Goals and Maternal Morbidity and Mortality reduction goals; and to increase domestic violence state coalitions and local programs' capacity to offer their pregnant and parenting clients increased access to maternal health and wellness support (e.g., connections to birth and postpartum doulas, information and education about breastfeeding; referrals to health centers for prenatal care, etc.) we encourage engaging such programs.
- In support of rural/geographically isolated health centers and rural DVPs and other community based organizations serving survivors of DV/HT, we also encourage engaging such programs as demonstration sites. Visit: https://bphc.hrsa.gov/uds/datacenter.aspx?q=d to identify HRSA-funded health centers by state.

Futures Without Violence will perform the following tasks:

- **Provide guidance to State/Territory Leadership Teams** by working with each team's leaders to share strategies, tools, and resources to guide the development of an action plan that each state works on to guide training and policy and practice reform activities. This includes providing initial training and TA to the Leadership Team on the clinical intervention and training approach, to PCA's on strategies to support sustainable systems level changes at the health center level, and to DH's on policies that support state level IPV/HT response efforts and coordination with DH programs.
- **Convene face-to-face learning community kick off meeting:** At the meeting in San Francisco (January 15-16, 2020), HRC staff will provide background on the program, on the intervention and tools available for implementation, on roles and responsibilities of the Leadership Teams, and will coordinate the team action planning for state/territory-wide reforms.
- **Conduct site visits and training in-state/in-territory**: HRC staff will conduct a two-day onsite TOT with each Leadership Team and other CHC and DV partners identified by the grantees. This will include one clinical training (including engaging the five CHCs and five partnering DVPs designed to model training for health center staff on the intervention followed by a TOT for faculty who will continue to train other CHCs and DVPs state/territory-wide. The site visit will conclude with an administrative and systems change strategy session with Leadership Team leaders on action plan and program implementation.
- **Provide technical assistance** and other forms of professional and logistical support including helping to plan the TOT, offering tools and TA on prep work for health center and DV staff prior to training, introduction and ongoing TA on quality improvement tools for clinic and DV programs, and support to PCAs, DH, and DVCs on policy and practice changes at the state level.

- **Promote policies that support the health partnerships** through our work at the national level to promote federal, state and Tribal policy initiatives that further support the work of health and IPV/HT partnerships.
- **Disseminate educational materials** for use by sites, and adapt existing resources in response to needs in the field, as identified.
- **Convene leadership team virtually to support communication between leadership teams** by providing a forum for exchanging ideas and strategies, including monthly webinars and online forums.
- **Facilitate and monitor all grantee activities,** including soliciting one final progress report on activities in participating states/territories, administering the funding to teams for program implementation, and working with federal partners to monitor implementation and evaluation.
- **Evaluation**: Working with the evaluation team to measure the impact of the initiative, measure state/territory level change to policy and clinical practice in the DH programs, PCAs, and participating domestic violence coalitions, as well as measurement of outcomes of clinical intervention at the local level.
- **Create a final report and national action plan** that will offer strategies and tools for scaling response statewide, for national dissemination through the National Health Resource Center on Domestic Violence.

It is through these shared responsibilities that project partners work successfully and effectively to improve the health care response to victims of IPV/HT seeking care through CHCs and DVPs. Each site's outcomes, experiences and lessons learned will be shared with peers nationwide as part of the technical assistance and dissemination FUTURES conducts through the National Health Resource Center on Domestic Violence. This has proven to be a very successful strategy in many multi-state initiatives that build state capacity and leadership that informs national efforts on IPV/HT and health.

Application Questions:

Please note: Each leadership team should submit one application and all partners and demonstration sites should be from the same U.S. state or territory.

1. **STATEMENT OF NEED:** Highlight your state/territory's readiness, interest and capacity to pursue this project to integrate the trauma informed "CUES intervention" to promote prevention and intervention for IPV/HT into a minimum of 5 CHCs and 5 partnering DVPs across the state/territory, and how you plan to engage 50% of CHCs with information and resources, including plans to conduct outreach regarding availability of training and technical assistance to implement FUTURES' model. Briefly describe why you want to join this project.
2. **SUSTAINABILITY:** What is your vision for state/territory-wide systems change? How will you change your state/territory level infrastructure to ensure that your efforts are sustainable beyond the grant period? Provide a short statement concerning your Leadership Team's capacity to reach that goal.
3. **COLLABORATION/EXPERIENCE:** Briefly describe your state/territory's history of work on IPV/HT and health care highlighting previous efforts and collaborations among and between the PCA, DVC, and DH. If your work together is newer, explain the expected outcomes or strengths of this partnership and how it will be effective.
4. **DEMONSTRATION SITES:** Identify the names of the 5 CHCs and 5 partnering DVPs you will closely work with, describe any previous collaborative efforts between your Leadership

Team agencies and those programs, and include an MOU for each partnering community group (5 total, see MOU sample). Please designate which health centers or DV programs include the following: PCMH designation; Ryan White program funds; Maternal health programs or funds; and/or rural or geographically isolated status or program funds.

5. **COMMUNITY SERVED:** Please briefly describe your state/territory's population, how you plan to identify and integrate the needs of that population in your initiative. Consider race/ethnicity/tribal affiliation, income levels, language, housing status, sexual orientation, population density (rural, urban, frontier, etc.), maternal health and other demographic variables. Please include at least one relevant example of how your Leadership Team agencies have worked successfully with underserved communities.
6. **LEADERSHIP TEAM:** Describe the composition (expertise, capacity to commit time to this initiative, organization represented, diversity, etc.) of the Leadership Team and why they are best positioned to guide this initiative. **Each Leadership Team MUST include a PCA, DVC, and DH (include a signed state/territory partners MOU, see sample**). Identify previous training experience and strengths offered by your designated trainers.
7. **LEAD STAFF PERSON:** Identify the role that each agency (PCA, DVC, and DH) will play and which agency and staff member(s) will lead the Leadership Team, including who will be the fiscal/administrative lead. Please demonstrate your ability to begin this initiative immediately upon notification of an award.
8. **EVALUATION:** Describe your team's capacity to support the evaluation, including previous experience conducting process evaluations, and ability to designate a team member to serve as the liaison with the evaluation team.
9. **ADDITIONAL RESOURCES:** Describe any additional resources or contributions you bring to the initiative or any other information you feel might be relevant to the project.
10. **BUDGET:** Include a draft budget that designates how funds will be distributed to Leadership Team members (and to any participating health centers/DV programs), as well as allocation for training and sustainability efforts. Please include covering the costs of travel, lodging and per diem for a minimum of 3 participants (one person from the PCA, DH, and DVC) to attend the mandatory Kick-off Meeting in San Francisco (January 15-16, 2020). We recommend that each main partner—DVC, PCA, and DH—receive some share of the funds. Demonstrate fair compensation for leadership team partners carrying out training and engagement of the 5 CHC and 5 DV programs. Additionally, consider obligating funds for the 5 CHC and 5 DV Programs to attend your state/territory TOT. For states or territories with multi-lingual patients/clients, consider expenses related to translation or interpretation needs related to in-person trainings, and patient/provider tools.

Memorandum of Understanding (MOU):

Collaboration is the cornerstone of this work—leadership, commitment, and action from all Leadership Team partners, as well as the participating CHCs and DVPs are keys to improving the public health response to violence against women.

- **The application must include 6 signed MOUs *(see samples provided)*:** one between only the three Leadership Team agencies; and another five from the demonstration sites (5 CHCs and 5 partnering DVPs) your state/territory will closely work with; and
- Resources that the organization can bring to the initiative such as additional staff time, materials, or key contacts, etc.

Applications without six MOUs will be considered incomplete.

Timeline for Selection:
Applications are due Friday, November 8, 2019 by 5:00pm Pacific/6:00pm Mountain/7:00pm Central/8:00pm Eastern.

Completed applications should be emailed to Anna Marjavi at amarjavi@futureswithoutviolence.org. Your application should be no more than 15 pages (does not include the six MOUs), 1.5 spaced and single sided. If you have any questions, contact Anna Marjavi at amarjavi@futureswithoutviolence.org.

All applicants will be notified by email no later than Wednesday, Nov. 20th, 2019 5pm Pacific/6pm Mountain/7pm Central/8pm Eastern and State/Territory Leadership Teams selected for funding will also be notified by phone and email by Wednesday, November 20th, 2019.

Project Catalyst III: State/Territory-wide Transformation on Health, IPV and Human Trafficking
Sample Memorandum of Agreement (MOU)

Between (LOCAL DOMESTIC VIOLENCE PROGRAM) and (COMMUNITY HEALTH CENTER)

This agreement is by and between (LOCAL DOMESTIC VIOLENCE PROGRAM) and (COMMUNITY HEALTH CENTER) to enhance the response to individuals and families experiencing intimate partner violence (IPV) and human trafficking (HT).

The parties listed above and whose designated agents have signed this document agree that:

1) (LOCAL DOMESTIC VIOLENCE PROGRAM) and (COMMUNITY HEALTH CENTER) will demonstrate support and engagement from their respective decision makers.
2) Representatives of (COMMUNITY HEALTH CENTER) and (LOCAL DOMESTIC VIOLENCE PROGRAM) will meet with each other at least once to understand the services currently provided by their respective programs and review referral policies between agencies.
3) Representatives of (COMMUNITY HEALTH CENTER) and (LOCAL DOMESTIC VIOLENCE PROGRAM) will participate in a one day Training of Trainer's provided by FUTURES in a location/date TBD (in their state/territory).
4) Representatives of (COMMUNITY HEALTH CENTER) and (LOCAL DOMESTIC VIOLENCE PROGRAM) will participate in one technical assistance and training site visit delivered by faculty from their Leadership Team (a minimum of one 3.5 hour training or two 1.75 hour trainings for CHCs; and one 3.5 hour training for DV programs).
5) (COMMUNITY HEALTH CENTER) will develop and implement a policy to assess for IPV/HT with all adult female patients, offer health education and harm reduction strategies on site, and make referrals to (LOCAL DOMESTIC VIOLENCE PROGRAM), or other appropriate DV/HT programs when necessary.
6) (LOCAL DOMESTIC VIOLENCE PROGRAM) will receive referrals from (COMMUNITY HEALTH CENTER), and will develop and implement a policy to ask clients about their health needs, and make referrals to (COMMUNITY HEALTH CENTER) as appropriate.
7) (LOCAL DOMESTIC VIOLENCE PROGRAM and COMMUNITY HEALTH CENTER) staff will participate in ongoing technical assistance with their Leadership Team on identifying and responding to IPV and HT.
8) (COMMUNITY HEALTH CENTER) agrees to use the model intervention identified by FUTURES for assessment and response to IPV and HT, and to participate in evaluation activities and quality improvement activities.
9) (LOCAL DOMESTIC VIOLENCE PROGRAM) agrees to provide every individual seeking services as a result of a referral from (COMMUNITY HEALTH CENTER) with appropriate safety planning and support services to address IPV or HT.

We, the undersigned, approve and agree to the terms and conditions as outlined in this MOU.

_____	_____
(Name and Title)	(Name and Title)
_____	_____
(Name of Domestic Violence Program)	(Name of Community Health Center)
_____	_____
Date	Date

Project Catalyst III: State/Territory-wide Transformation on Health, IPV and Human Trafficking
State/Territory Leadership Team Memorandum of Agreement (MOU)

Between one state or territory's: Primary Care Association (PCA), Department of Health (DH) and Domestic Violence Coalition (DVC)

This agreement is by and between (NAME OF STATE or TERRITORY)'s (name of PCA) (name of DH) and (name of DVC) to enhance the response to individuals and families experiencing intimate partner violence (IPV) and human trafficking (HT).

The parties listed above and whose designated agents have signed this document agree that:

1) (PCA), (DH), and (DVC) will demonstrate support, commitment, and engagement from their respective decision makers.
2) (PCA), (DH), and (DVC) will facilitate the establishment of MOUs (see sample provided) between health centers and DV programs working to implement the intervention as well as other prep work for the health centers prior to conducting trainings.
3) Representatives of (PCA), (DH), and (DVC) will meet with each other at least once in November or December, 2019 to understand the programs/services/policies currently provided by their respective programs and to review next steps for collaborating on the project, *Project Catalyst III: State-wide/Territory-wide Transformation on Health, IPV and Human Trafficking* (suggestion: monthly group calls and at least 3 in-person meetings held in the ten month project window).
4) At least one representative of (PCA), (DH), and (DVC) will participate in the following: attend the Kick-off Meeting in San Francisco (January 15-16, 2020); attend a two-day Training of Trainer's provided by FUTURES in a location/date TBD (in their state/territory); participate in ten monthly Leadership Team webinars convened by FUTURES (December 2019-September 2020; the first webinar is Tuesday, December 3rd, 2019 at 1pm Pacific/2pm Mountain/3pm Central/4pm Eastern – 1 hour long).
5) Representatives of (PCA) will identify opportunities to align this project with existing and emergent health center priorities; offer a variety of methods to support the DVC in convening health centers for trainings; and serve as a key resource along with the HRC to support the operationalization of the online toolkit, www.IPVHealthPartners.org and other materials to support the integration of response to IPV and HT into standard practice in 5 designated community health centers and to 50% of health centers across the state/territory.
6) Representatives of (DH) will promote community coordination by connecting local health jurisdiction IPV/HT efforts to health centers and DV programs implementing systems changes; identify related state/territory and local efforts (IPV and HT) to align best practices during the project to align with broader state public health related policies and priorities (e.g., State Human Trafficking Task Force); identify strategies and training opportunities to integrate and align IPV and HT responses into state/territory level health initiatives (i.e., maternal and child health initiatives, statewide initiatives to address social determinants of health, health in all policy initiatives); and support sustainability of the integration of violence and trauma-informed systems of care by briefing state and local stakeholders on initiative outcomes.
7) Representatives of (DVC) will provide expertise to serve as trainers on the HRC evidence-based curriculum and online toolkit for health centers and domestic violence program partners; and provide support to the engaged social service organizations to respond to training requests and referrals from health centers to address health issues of their clients and to facilitate bi-directional referrals.

8) Representatives of (PCA), (DH), and (DVC) will provide expertise for technical assistance and/or training on IPV and HT to the demonstration sites to address health issues of their clients and facilitate bi-directional referrals (a minimum of one 3.5 hour training or two 1.75 hour trainings for CHCs and a 3.5 hour training for DV programs).
9) Representatives of (PCA), (DH), and (DVC) agree to use the model intervention identified by FUTURES for assessment and response to IPV and HT, and to participate in evaluation activities and quality improvement activities.

We, the undersigned, approve and agree to the terms and conditions as outlined in this MOU.

_____	_____
(Name and Title)	(Name and Title)
_____	_____
(Name of PCA here)	(Name of DH here)
_____	_____
Date	Date

_____
(Name and Title)

_____
(Name of DVC here)

_____
Date

Appendix A: Applicant Resources

For millions of Americans, including some of the most vulnerable individuals and families, health centers are essential patient-centered medical homes that promote health, and diagnose and treat chronic disease and disability. One in 12 people nationwide rely on a HRSA-funded health center for their health care needs. Given their enormous reach and overarching goals to promote health and safety, health centers are uniquely positioned to be leaders in violence prevention across the U.S. in partnership with domestic violence/sexual assault services or programs.

The ACF Family Violence Prevention and Services (FVPSA) program supports a network of intimate partner violence (IPV) services agencies within local communities that provide a comprehensive range of services including crisis counseling, information and referrals, legal and other advocacy, shelter and additional support services. Community health centers' partnerships with these community based programs is a critical component to a comprehensive response to IPV.

Social service organizations include domestic violence programs, local domestic violence shelter programs, tribal domestic violence programs, and other culturally specific community based organizations are an integral part of any coordinated health care and social service response to DV.

Each State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands and American Samoa, has a FVPSA funded Domestic Violence Coalition. These coalitions are connected to more than 2,000 local DV programs receiving FVPSA funding across this country. Every Coalition provides comprehensive training and technical assistance on a multitude of social, legal, and economic issues that affect victims' safety and well-being. Coalitions partner with government, private industry, non-profit and faith-based communities, and other stakeholders to effectively coordinate and improve the safety-net of services available to victims and their dependents.

For more information about HRSA-funded health centers see: https://bphc.hrsa.gov/about/healthcenterprogram/index.html and visit https://bphc.hrsa.gov/uds/datacenter.aspx to locate health centers in your state or territory that are eligible to apply for this grant. Visit https://findahealthcenter.hrsa.gov/ to find primary care services in your community.

For more information about HRSA-funded Ryan White programs, see: https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program and visit https://findhivcare.hrsa.gov to find HIV-related care in your community.

For more information on maternal health programs see: Maternal, Infant, and Early Childhood Home Visiting Program; HRSA's Maternal/Women's Health Program Goals and Maternal Morbidity and Mortality reduction goals; and domestic violence state coalitions and local advocacy programs.

Learn about the Centers for Medicare and Medicaid's Rural Health Clinic Program.

For more information about FVPSA's programs see http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services/ .

Primary Care Associations (PCAs) are state or regional nonprofit organizations that provide T/TA to safety net providers, click here to learn more.

Every U.S. state and territory operates a Health Department, click here to learn more.

For more information about FUTURES and the National Health Resource Center on Domestic Violence, see https://www.futureswithoutviolence.org/health and the online toolkit developed by and for community health centers in partnership with domestic violence programs: https://www.ipvhealthpartners.org.

For more information on evidence-informed practices to address human trafficking see the HHS SOAR training program: https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training (administered by OTIP in partnership with the HHS Office on Women's Health, through the National Human Trafficking Training and Technical Assistance Center); Heal Trafficking https://healtrafficking.org/; and Futures Without Violence https://www.futureswithoutviolence.org/human-trafficking/.

National Hotlines

Free and confidential help is available for victims of domestic violence 24 hours a day. These hotlines can help victims of domestic violence and sexual violence find support and assistance in their communities:

- National Domestic Violence Hotline - 1-800-799-7233; 1-800-787-3224(TTY) or 1-855-812-1001 (Video Phone); Secure online chat: https://www.thehotline.org/what-is-live-chat/
- StrongHearts Native Helpline - 1-844-7NATIVE (1-844-762-8483) Mon-Fri, from 9:00am- 5:30pm CST, a culturally appropriate, confidential service for Native Americans affected by domestic violence and dating violence.
- National Dating Abuse Helpline - 1-866-331-9474
- National Sexual Assault Hotline (RAINN) - 1-800-656-4673
- National Human Trafficking Hotline - 1-888-373-7888; SMS: 233733 (Text "HELP" or "INFO")

HRSA National Health Center Training and Technical Assistance Partners (NTTAP)

HRSA maintains national cooperative agreements (NCAs) with national organizations that provide free training and technical assistance to support health centers in a manner that increases patient safety and health outcomes, effectively serves diverse special, vulnerable, and underserved rural, frontier, and urban populations. This T/TA often takes the form of learning collaboratives, state/regional/national trainings, webinars, newsletters, toolkits, and fact sheets. HRSA will award 21 new NTTAPs in July 2020.

Current NCAs provide T/TA that address the following special/vulnerable populations and topics:

- Asian American, Native Hawaiian, and other Pacific Islander Communities
- Capital Financing
- Health Information Technology
- Individuals or Families Experiencing Homelessness
- Lesbian, Gay, Bisexual, and Transgender (LGBT) People
- Medical-Legal Partnership
- Migratory and Seasonal Agricultural Workers
- Older Adults
- Oral Health
- Residents of Public Housing
- School-Aged Children
- All Underserved Populations
- Workforce

More information: https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/natlagreement.html