PROJECT NARRATIVE

Intimate partner violence (IPV) is a critical problem for pregnant and parenting women. Not only is IPV a significant social determinant of a woman's overall health, safety and well-being, it is a substantial issue for child welfare programs and health care systems in Oregon. On-site advocacy services offer a form of intervention within these systems that supports positive outcomes for both pregnant and parenting women and for the systems in which they are involved. The focus of the Oregon Department of Justice, Crime Victims' Services Division's (CVSD) proposed project is to improve pregnant and parenting women's safety and well-being by increasing access to advocacy services within child welfare and health care systems. Thus, CVSD has titled its proposal "Improving Services in Child Welfare and Health Care Systems for Pregnant and Parenting Women Who Are Victims of Intimate Partner Violence."

Need Statement

To understand IPV in Oregon and across the nation, one must first start with its **definition**. The Centers for Disease Control and Prevention define IPV as "physical, sexual, or psychological harm caused by a current or former partner or spouse." More specifically, IPV "is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social 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."[i]

Oregon statistics indicate that the state struggles with significant rates of IPV. Nearly one third (31%) of Oregon women aged 20-25 who were surveyed in 2004 reported that they had experienced one or more types of violent victimization, including threats of violence, physical

assaults, sexual assaults or stalking.[ii] In 2007, 16.3% of Oregon women reported that at some time during their life someone had had sex with them against their will or without their consent, and 14.1% reported having had injuries as a result of being hit, slapped, punched, shoved, kicked, or otherwise physically hurt by an intimate partner.[iii]

Pregnant and parenting women and their children are especially impacted by IPV. In addition to the immediate injuries sustained by victims during violent episodes, there is overwhelming evidence that links IPV to a number of adverse physical and mental health problems for women.[iv],[v], [vi] Pregnancy-related problems are significantly higher for abused women, such as prenatal fetal injury and complications of pregnancy including low weight gain and infections.[vii] At its extreme, IPV is the leading cause of maternal death. [viii], [ix]

Children are particularly vulnerable to violence inflicted upon their mothers by an intimate partner. There is well-established evidence that high incidences of IPV and child maltreatment co-occur within the same family.[x] In Oregon, 8.5% of mothers with 2 year old children experienced some form of IPV (including a partner who yelled, screamed or threatened, limited contact with friends or family, prevented access to shared income, or was physically or sexually violent). [xi] Similarly, 13.8% of mothers with 2 year old children needed or received services for family violence problems in the past 12 months.[xii] Oregon Child Welfare statistics for 2011 show 35.2% of child protective cases with founded child abuse had domestic violence as a "family stress indicator".[xiii] One in three women who have experienced intimate partner violence report that a child witnessed a physical assault, and one in five witnessed a sexual assault in the previous five years.[xiv] Children exposed to IPV during the toddler years have been noted to experience health, intellectual, emotional and behavioral problems; and higher levels of IPV appear to result in more severe child dysfunction.[xv] The U.S. Advisory Board on Child Abuse

and Neglect suggests that domestic violence may be the single major precursor to child abuse and neglect fatalities in the country.[xvi]

Women who experience violence at the hands of a partner have difficulty maintaining health for themselves and their families simply because safety is a higher priority. A pregnant mother of two may skip a pre-natal care appointment so as to avoid asking her partner for the car. She knows doing so will result in his shouting in front of the children and accusing her of trying to leave him to go see her "boyfriend." A case worker or health care provider may misunderstand why a mother cannot comply with her case or treatment plans. In the Child Welfare system, these misunderstandings can result in blame being placed on a woman for failing to protect the child from the batterer's controlling behaviors or in the child's removal from the home. For health care providers, IPV may go undetected when screening measures are not in place. Symptoms attributable to the psycho-somatic stress of IPV may be misdiagnosed.

It is incumbent upon Child Welfare and health care professionals to assess and identify IPV in their cases, and to then respond appropriately to pregnant and parenting women who are the victims. Oregon's guidelines for child welfare practice promote careful assessment of IPV and its impact on women and their children. Child Welfare case workers who assess for IPV are more likely to recognize a batterer's intentional and harmful actions as the root cause of the child abuse. Case workers can then identify case plan strategies that take account for the mother and child's safety concerns. This is a win-win situation for both the mother and the case worker. Case workers meet their mandate to protect children and to reduce foster care placements. Battered women are offered appropriate services and protection for their families and their batterers are held accountable by Child Welfare for their actions.

The impact of IPV on a woman's health may go unrecognized until it is identified through screening. A direct inquiry from a caring health care professional may help a woman disclose her abuse and find the appropriate services. Nationally, screening for IPV has been promoted as a routine part of assessment in health care settings.[xvii] In addition, the Affordable Care Act recently required that health plans cover women's preventive services including screening and counseling for interpersonal and domestic violence.[xviii] However, research suggests that more education for health care providers is needed to increase the rates of screening. One study showed that 42.9% of new mothers reported that no one talked to them during any of their prenatal care visits about physical abuse to women by their husbands or partners (PRAMS, 2007).[xix]

Theory and Evidence-Base for On-Site Advocacy Interventions

Screening by a health care provider is important for opening up a discussion with a pregnant or parenting woman who is a victim of IPV. Yet screening alone does not lead to health or quality of life benefits for women or reduce re-exposure to IPV.[xx] Research suggests that **on-site advocacy interventions have important implications for reducing violence and improving a woman's well-being over time.**[xxi] Following a positive screening for IPV, on-site advocates depend on health care providers to initiate an immediate referral so they can offer services to a woman in a short amount of time. McCaw et al. (2001) reported that documented provider referrals increase two-fold after a positive screening for IPV.[xxii] Additionally, women more readily agree to meet with an advocate when a health care provider makes the referral. Krasnoff and Moscati (2012) reported that 84% of the women who were identified as victims of IPV in a hospital-based setting agreed to an advocacy intervention.[xxiii]

Oregon is fortunate to have a statewide network of non-profit victim advocacy organizations whose advocates are uniquely qualified to help victims of IPV with crisis counseling, safety planning, emotional support, help navigating complex systems, assistance in finding safe housing and parenting support. Access to these services is pivotal for victim advocacy to be effective. When advocates are placed on-site in Child Welfare branch offices and local Public Health departments, it ensures the immediacy of services. This is important given that a pregnant and parenting woman who is a victim of IPV often has a narrow window of opportunity to receive assistance because of her batterer's controlling behavior. Having on-site advocacy services also communicates to a woman that she has the power to make her own decisions about the safety and wellness of herself and her children. Additionally, on-site advocates consult with Child Welfare and Public health staff to determine case plans that promote good health and increase safety for a pregnant or parenting woman and her child as well as hold the batterer accountable for the violence.

Demonstrations of the on-site advocacy model have contributed to the **growing base of evidence that informs the delivery of these services** in Oregon and across the nation. The 'Greenbook', a 1999 publication of the National Council of Juvenile and Family Court Judges, is the foundation for Oregon's first on-site advocacy interventions in Child Welfare.[xxiv] From 2000 until now, Oregon has supported on-site advocacy services in Child Welfare offices through a patchwork of state and federal funds. In 2011, the Oregon Legislature appropriated state funds for on-site advocates in some Child Welfare and TANF offices. The Pregnancy Assistance Funds (PAF) award CVSD received from the Office of Adolescent Health (OAH) have also increased access to these important services. Due to budget shortfalls, the Oregon Legislature recently reduced its appropriation and will now fund only a bare-bones implementation of on-site

advocates in Child Welfare offices statewide. Continued federal funding from PAF will allow CVSD and the Oregon Department of Human Services (DHS) to refine the on-site advocate model and further improve Child Welfare practices in cases with IPV. It will also prevent the State from losing ground on the progress it has made in establishing this model as a significant component of the Child Welfare system.

Two evaluations of the on-site advocacy model in Child Welfare were conducted prior to 2010. During that time, results suggest that after working with an advocate, women/victims 1) better understood the impact that IPV had on the lives of them and their children and 2) were better able to protect their children. The results also pointed to substantial increases in Child Welfare staff knowledge of 1) the impact of IPV on women and children, 2) barriers to women leaving abusive relationships, and 3) batterers' use of control tactics. Child Welfare staff also reported that their practice had changed, including implementation of different case planning strategies that took into consideration the safety of the mother as key to preventing child abuse.

Oregon's 2010 Pregnancy Assistance Award provided CVSD and its state partner, the Oregon Health Authority (OHA), the opportunity to expand the on-site advocacy model into Public Health. The expansion of the model was based on recommendations put forward by the Oregon Title V Maternal and Child Health Five Year Needs Assessment. Through this assessment, family violence, including intimate partner violence and child abuse, was identified as a priority need for pregnant and parenting women. The assessment set a goal to "improve Oregon's systems and services for screening women for domestic and sexual violence and for linking those affected by such violence to adequate services."[xxv]

Since Oregon placed on-site advocates in Public Health, CVSD has observed positive changes in how both on-site advocates and Public Health staff interact with pregnant and

parenting women who are victims of IPV. Advocates have gained knowledge about women's health, including prenatal care, family planning and reproductive health, and about Public Health programs that serve women. Additionally, advocates have learned new health terminology and how to use empirical evidence as a tool to promote advocacy services and screening. Public Health staff benefit from the grass-roots perspective on IPV as presented by the advocate. The advocate is seen as an important communication bridge between the woman and the Public Health practitioner.

CVSD has conducted an evaluation of its current project, which contributes to the evidence-base for the on-site advocacy model. Similar to the previous evaluations, current results included positive changes in Child Welfare and Public Health staff practices related to IPV. Additionally, the current projects appear to reach pregnant and parenting women who would not otherwise have received IPV-related advocacy services. Of the participating pregnant and parenting women surveyed, 96% reported they have more ways to keep themselves and their children safe. One survey respondent wrote "I was so happy (to meet the advocate) because then I realized I wasn't alone; in a maze of bureaucracy, I had found a person who understood me, whose position was made just to help me."

The current evaluation findings and feedback from stakeholders have been key to informing the design of the intervention presented in this application. If awarded, CVSD will continue supporting on-site advocacy services in both Child Welfare and Public Health with additional Pregnancy Assistance Funds. Additional resources are needed to further develop and establish the on-site advocacy model in Public Health, including more FTE for advocates to provide direct services. More training is needed for both Child Welfare and health care

professionals to increase their knowledge about IPV and to improve their skills in assessment, identification and response to IPV.

Through this project, non-profit victim advocacy organizations and their Public Health partners will also develop new partnerships with Oregon's newly formed Coordinated Care Organizations (CCOs). These locally organized networks represent providers who serve people receiving health care coverage under the Oregon Health Plan (Medicaid). CCOs are tasked with the "triple aim" of promoting better health and better care while lowering costs. CCOs have flexibility to support new models of care that are patient-centered, team-focused and reduce health disparities. This project will foster connections with CCO provider networks, with the goal of increasing the frequency of high quality screening and access to IPV advocacy services in health care settings.

Lastly and significantly, more resources are needed for on-site advocacy services for pregnant and parenting teens and for culturally specific populations. For example, the highest teen pregnancy rate in Oregon is with Latinas at 53.7 per 1,000 pregnancies compared to 16.8 per 1,000 pregnancies for non-Latino whites. This population is also more likely to be uninsured (17% of Latino children and young adults age 18 and younger compared to only 7% of non-Latino whites).[xxvi] Of the pregnant and parenting women served through the current projects, 18% are teens 12-19 years of age. Additionally, five of the 14 project sites have Spanish-speaking, bi-cultural advocates providing services to pregnant and parenting Latinas. CVSD will prioritize funding to teens and marginalized populations for future projects like these to increase outreach and services.

Organizational Capability

The Crime Victims' Services Division (CVSD) is one of eight divisions within the Oregon Department of Justice (DOJ). Three sections comprise CVSD, including Crime Victims' Compensation, Revenue and Victim Response. The Victim Response Section (VRS) administers state and federal grant programs and coordinates activities under these programs. In addition to the current PAF federal award, CVSD administers federal Victims of Crime Act and Violence Against Women Act grants. CVSD also administers state funding through the Oregon Domestic and Sexual Violence Services Fund, the Child Abuse Multidisciplinary Intervention Account and the Criminal Fines Assessment Account. All of these federal and state funds are awarded directly or through subgrants to a diverse group of victim service providers. These providers include non-profit victim advocacy organizations, child abuse intervention centers, and victim assistance programs within District Attorneys' offices and law enforcement. The funds that CVSD administers support its mission increase victims' safety and to reduce the impact of crime on victims' lives by supporting statewide victim services programs, promoting victims' rights, and providing victims access to information and resources in a compassionate, responsive and dedicated manner.

Six program coordinators within VRS manage 330 contracts and subawards to 130 programs totaling $17.5 million. Christine Heyen is the Fund Coordinator for Oregon's current PAF grant. Ms. Heyen is employed at .65 FTE and manages 14 subgrants through the federal PAF grant. Ms. Heyen is also responsible for coordinating the evaluation of the subgrantees' project activities and for providing the projects training and technical assistance. Ms. Heyen has a Master of Arts in Counseling degree and brings nearly 15 years of victim services experience to the job. After eight years with CVSD, Ms. Heyen has developed strong skills in grants

management and a wealth of expertise in victim services programming. She has also built highly productive working relationships with the victim services community in Oregon. Her skills and expertise will ensure the successful development and implementation of the next set of subgrantee projects through the PAF grant.

Project Management

If CVSD receives a second PAF award, Ms. Heyen will continue coordinating the grant program and the local project activities as described in the "Proposed Intervention" section of this application. She will work at .65 FTE and her position will include: executing and monitoring contracts and subgrant awards; overseeing grant program activities; coordinating trainings for subgrantees and their community partners; partnering with key stakeholders to encourage their investment of resources in the program; and, working closely with the evaluator to evaluate progress in meeting short and long range goals for the program.

CVSD will hire a .5 FTE Administrative Specialist to assist Ms. Heyen in her prescribed duties. This position will provide support to Ms. Heyen by conducting administrative tasks that ensure the efficient flow of work. Such tasks will include: coordinating conference and meeting preparations; providing support during meetings and conference calls; assisting in grant agreement and report preparation, and; tracking and compiling statistical data related to the program activities.

Subgrantee monitoring is conducted internally by CVSD staff who reviews monthly financial reports and semi-annual statistical and progress reports. Monitoring activities assure that each subgrantee is implementing the project as agreed, working toward its objectives, following appropriate fiscal procedures and receiving necessary technical assistance and project development guidance. Semi-annual progress reports from subgrantees must address the project

goals, objectives and performance measures outlined in the subgrantees original application in sufficient detail for the reporting period. Reports include narrative information and quantitative data to demonstrate progress made, activities linked to specific outcomes and efforts to collaborate with community partners.

CVSD staff will conduct at least two in-person site visits per site over the four year project period. During the visit, CVSD staff will meet with project staff and partners to experience first-hand how the project operates in its community context. Site visit questions will cover the subgrantee's overall management of the project including: services provided to pregnant and parenting women who are victims of IPV; collaboration with project leadership teams and partner agencies; outreach to culturally diverse and underserved populations; participation in and delivery of trainings; compliance with state and federal guidelines; fiscal controls and budget management; progress in meeting the goals and objectives of the project, and; need for technical assistance. Information gathered during these site visits will be shared with CVSD's evaluators for inclusion in their report of findings and lessons learned.

The selection of subgrantees will take place within the first three months of CVSD's federal notice of award so that projects may begin on October 1, 2013. CVSD will first convene an advisory committee of key stakeholders that will guide CVSD in its construction of the competitive request for applications (RFA). A RFA will include amount of funds available, eligibility criteria and grant requirements, application instructions, and review process and criteria. Applications submitted through CVSD's online E-Grants system will be reviewed on the following criteria: does the applicant have expertise in providing services to pregnant and parenting women who are victims of IPV; what is the strength of their partnerships in accomplishing the prescribed activities; does the applicant have a well thought out plan for

launching the project and then sustaining the activities through the end of the period; what is the capacity for the project to participate in an evaluation, and; is the applicant's proposal rooted in advocacy services and partnership collaboration? Once applications are selected for funding and reviewed by Oregon's Attorney General for final approval, applicants will be notified of their awards and sent a grant agreement for signature.

CVSD will contract directly with non-profit victim advocacy organizations to execute the prescribed project activities. The first year of subgrants will be allocated through a competitive process and subsequent years will be administered through a non-competitive update process subject to the availability of federal funds. CVSD will monitor the projects through monthly financial reports, semi-annual statistical and progress reports (all submitted via the CVSD E-Grants system), phone reviews and regular meetings with the project sites. CVSD will also assist in starting up projects within their first three months to ensure staff is hired and trained and local leadership teams are in place.

CVSD will convene its advisory committee to finalize training and evaluation plans that support successful outcomes, project implementation and sustainability, and ability to replicate the projects if additional funding became available. CVSD and its training partners will provide expertise, resources and guidance to the project sites throughout the life of the federal funding. Findings from CVSD's evaluation of the project will be shared regularly with CVSD's advisory committee and with the subgrantee project sites to promote learning and to support improvements in the delivery of services to pregnant and parenting women who are victims of IPV.

As a state agency, the Oregon Department of Justice (DOJ) already has effective mechanisms in place to ensure that the federal funds are used with integrity to support the

proposed project activities. CVSD relies on the DOJ Fiscal Services Office to perform accounting duties and prepare financial reports. An Accountant from this office is assigned to work with CVSD and maintains accounting records and transactions in compliance with statewide accounting policy as prescribed in the Oregon Accounting Manual and in compliance with generally accepted accounting principles.

DOJ uses an account structure called the Statewide Financial Management Application (SFMA). The SFMA generally includes separate accounting codes for different types of funds, including streams of federal funding awarded to CVSD. The DOJ Accountant is responsible for preparing federal financial reports, including the SF 425. After filing these reports quarterly through GrantSolutions, the Accountant provides a copy to the CVSD Director and Fund Coordinator along with detailed accounting reports of revenues and expenditures supporting the reports. The DOJ Accountant also works with CVSD staff to draft annual federal budget requests, which are reviewed and finalized by the CVSD Director.

The DOJ Accountant and CVSD have established fiscal practices and procedures which provide controls for the CVSD Director's requisite oversight of the Pregnancy Assistance Funds. These controls are based on a system of checks and balances that take place among the DOJ Accountant, the CVSD Director and the Fund Coordinator. These controls include preparation, review and approval of monthly budget reports, time sheet records and personnel expenditures, supply and equipment purchases, requests for in and out of state travel reimbursement, and payments on contractor and subgrantee invoices. DOJ's financial records, including those for CVSD are reviewed by the Oregon Secretary of State's Audits Division as a part of Oregon's annual Single Audit Act audit.

Goals, Objectives and Logic Model

The goals, objectives and logic model for this application show clearly how CVSD will measure the impact of its on-site advocacy services on pregnant and parenting women who are victims of IPV. Additionally, CVSD wants to measure how the on-site advocacy services will increase knowledge and change the practice of Child Welfare staff and health care providers when working with pregnant and parenting women who are victims of IPV.

The goals and their corresponding objectives are as follows:

Goal A: Increase the safety and well-being of pregnant and parenting women who are victims of IPV by increasing access to advocacy services in Child Welfare and health care systems.

Objective #1: For each year of the project, advocates will deliver services to 630 pregnant and parenting women who are victims of IPV, 20% of whom will be 12-19 years of age.

Objective #2: At the end of the four year project period, 90% of pregnant and parenting women who respond to a survey will report that working with the advocate improved their overall safety and well-being.

Goal B: Improve health care provider identification of and response to women who are pregnant and parenting and who are victims of IPV.

Objective #1: Training & Partnership Development Coordinators will provide three trainings a year (except in Year 1) to local health care providers on screening, identification and appropriate response to IPV, including referrals to an advocate.

Objective #2: In the fourth year of the project, the on-site advocates will receive at least 80% more referrals from local health care providers than they received in year one.

Goal C: Build non-profit victim services organizational capacity and advocate competency for providing IPV advocacy services to pregnant and parenting women in health care systems.

Objective #1: Before December 31, 2013, key personnel from the Health Care cohort project sites will receive training on issues concerning advocacy in health care.

Objective #2: Following the training, 90% of participants will report an increase in knowledge about the adverse impacts of IPV on health and better ways to advocate in health care settings.

Goal D: Improve Child Welfare interventions in cases with pregnant and parenting women who are victims of IPV through training and a study of institutional processes.

Objective #1: In Years 2 & 3, each project site within the Child Welfare cohort will participate in a four to six-month long institutional analysis.

Objective #2: At the end of each institutional analysis, the local leadership team in each of the Child Welfare project sites will identify at least three areas of improvement for processing cases with IPV.

The logic model found on the following page displays the relationship between CVSD's goals, activities and anticipated outcomes. CVSD bases this logic model on the theory that on-site advocacy services offer a form of intervention within Child Welfare and health care systems that improves pregnant and parenting women's safety and well-being by increasing access to advocacy services.

Goals	Inputs	Activities	Outputs	Short term outcomes (process)	Intermediate outcomes	Long term outcomes
Increase the safety and well-being of pregnant and parenting women who are victims of IPV Improve health care provider identification of and response to IPV Build capacity and advocate competency for providing IPV advocacy services in health care systems Improve Child Welfare interventions in cases with pregnant and parenting women who are victims of IPV	1.0 FTE on-site advocate 1.0 FTE TPD Coordinators State advisory committee and local leadership teams Annual cohort summits, training and technical assistance from state and national experts Existing screening/assessment tools and guidelines CVSD site visits	• Hire and train staff • Create sustainability plan • Develop protocols/forms to guide provider referrals • Provide advocacy services • Leadership teams meet quarterly • Participate in online training & communication forums • Attend annual project summits *Child Welfare cohort* • Participate in an institutional analysis *Health Care cohort* • Research & develop locally appropriate tools for IPV screening and referral • Deliver 3 trainings annually to health care providers	2,500 women served 4,000 referrals received from providers 8,000 consultations with providers Annual trainings provided to health care providers, Child Welfare staff and advocates Local referral protocols developed Resource Manual for Oregon Health Care Professionals on IPV developed Training video for on-site advocacy in health care Child Welfare core practice documents updated	Plans/timelines for sustaining projects developed Initial advocate and provider training completed Clients receive initial services and complete surveys Learning from focus groups and preliminary evaluation/analysis applied	<u>Client level</u> Clients satisfied with intervention; clients report increased knowledge about IPV and strategies to reduce harm, awareness of services, increased self-efficacy <u>Provider level</u> # and types of providers trained; Providers report increase in knowledge, self-efficacy, skills <u>Program level</u> Providers increasingly refer victims to and consult with the advocate <u>Policy level</u> New statewide training curriculum, and resources available to support providers in their practice	<u>Client level</u> Increased safety and well-being <u>Provider level</u> Changes in local health care practice regarding IPV identification and response; Changes in how CW staff processes cases with DV <u>Program level</u> Increased advocate self-efficacy for educating clients on health and IPV; Improved DVSA capacity to advocate for women in local health care systems <u>Policy level</u> New policies and protocols adopted that institutionalize improved services, tools and practice; Funding through CCOs and DHS increases for on-site advocates

Proposed Intervention

Through funds awarded under Category 3 of this federal grant, CVSD will implement its program titled "Improving Services in Child Welfare and Health Care Systems for Pregnant and Parenting Women Who are Victims of IPV." CVSD will fund up to seven non-profit victim advocacy organizations to **place advocates on-site at Child Welfare branch offices and at local Public Health departments**. CVSD anticipates reaching up to 630 pregnant and parenting women who are victims of IPV per year through the on-site advocacy services provided at Child Welfare and Public Health offices. In addition, CVSD will fund **training and technical assistance** related to IPV for Child Welfare staff and health care professionals to increase their knowledge of IPV and to improve their assessment, identification and response to IPV. CVSD will also **develop other health care partnerships** beyond local Public Health programs for the purpose of expanding the reach of advocacy services within the health care community. Lastly, all project sites will **engage in an evaluation** to refine CVSD's understanding of on-site advocacy services in Oregon based Child Welfare and Public Health program settings and to inform development of and improvements to local and state policies concerning IPV assessment, identification and response.

CVSD will establish **two project cohorts**. The first cohort will have three projects that work in collaboration with Child Welfare. The second cohort will have four projects that work in collaboration with Public Health. Both cohorts will focus on the specialized needs of pregnant and parenting women who are victims of IPV and who are engaged in those programs. The work of each cohort will consist of **three main strategies** 1) advocacy intervention, accompaniment, and supportive services provided by the on-site advocate, 2) case consultation and provider training and technical assistance, and 3) capacity building efforts designed to sustain the project

beyond the grant funding. Each cohort will have at least one culturally specific project that will focus on providing culturally and linguistically appropriate services to the population it serves. Projects within each cohort will execute their activities in two phases. The start-up phase will take place within the first three months of the project after which time implementation will begin. Both cohorts will follow a similar pattern of activities as shown in the section titled "Work Plan".

The design of the first cohort, hereafter the **Child Welfare Cohort**, will include 1) on-site advocacy services and case consultation provided by a 1.0 FTE advocate located at a Child Welfare branch office, and 2) support for training, technical assistance, evaluation and analysis provided by a .25 FTE Project Manager. In addition, these project sites will participate in an *institutional analysis* that will focus on identifying and understanding the ways in which institutional practices do or do not support victims' and children's safety and holding perpetrators accountable. The institutional analysis will be grounded in the practice of Institutional Ethnography, and will borrow heavily from the Safety and Accountability Audit process developed and pioneered by Praxis International. The institutional analysis will involve examining the structure of case processing and management by mapping the system, interviewing workers and survivors, observing workers, and analyzing paperwork and other texts generated in the handling of child welfare cases that involve domestic violence. The focus will be on the fit between what victims and their children need and what the child welfare system provides. Project sites will have opportunities to locate how problems are produced by institutional practices, while simultaneously discovering how to solve them. Recommendations will inform the creation of new rules, policies, procedures, forms, and training at both the local and State levels that will enhance victim and child safety and batterer accountability.

The design of the second cohort, hereafter the **Health Care Cohort**, includes 1) on-site advocacy services and case consultation provided by a 1.0 FTE advocate located at the local Public Health department, 2) support for training, technical assistance and evaluation provided by a 1.0 FTE Training and Partnership Development (TPD) Coordinator, and 3) project management provided by a .15 FTE Project Manager. Projects will develop partnerships with local Public Health departments and local CCO provider networks to offer providers accurate information about IPV and to increase their awareness of the cultural contexts impacting a woman's engagement in the health care system.[xxvii] The TPD Coordinator is responsible for delivering this information to health care providers through individual contacts, meetings and trainings. Before any such training takes place, it will be important to gain an understanding of the organizational contexts and structures of the local health care systems.[xxviii] OHA will support the TPD Coordinators in mapping the local health care system's current practices for assessing IPV and IPV interventions. Within the first 12-18 months of the project, TPD Coordinators will 1) identify key informants within the health care system (namely within the CCO provider networks), 2) conduct interviews with public health and health care providers regarding their current practices around IPV, and 3) conduct focus groups with victims to understand their experiences with the local health care system and the cultural context in which they experience IPV. The findings from these surveys and focus groups will inform development and delivery of local trainings to public health and health care professionals in the latter two years of the project period.

Project sites from both cohorts will convene **local leadership teams** comprised of key stakeholders and collaborators who will participate in these trainings and evaluation of the projects. The leadership teams are also the mechanism by which the funded sites will ensure the

success of the project. By the end of the first year of the projects, each team will be tasked with 1) developing a sustainability plan which will include implementation strategies focused on sustaining the project to its end, and 2) developing new or improving existing protocols and forms for partners to use in referring victims to the advocate. Over the course of the four year project period, leadership teams will also 1) explore how the project can improve and expand on-site advocacy services, especially for reaching teens and underserved populations, 2) adapt new or existing tools used for assessing and identifying IPV, and 3) implement the lessons learned from the evaluation into practice.

Each site within the cohort will participate in a **process evaluation** conducted by the Portland State University's Regional Research Institute (PSU RRI). During the four year project period, the DHS state office will incorporate the findings from the process evaluation and institutional analysis conducted in the Child Welfare Cohort into two of its core policy documents, the *Child Welfare Guidelines for Cases with Domestic Violence* and the *Working Together – A Desk Guide for Domestic Violence Advocates Co-Located at DHS*.

Training will be provided to projects within both cohorts. All project funded staff will receive 40-hour core advocacy training before the delivery of services begins. Following this training, advocates will understand basic skills for delivering advocacy services, the theoretical dynamics of oppression, the dynamics and effects of IPV in diverse populations, and strategies for providing culturally and linguistically appropriate services.

Each cohort will have specific training focus. For the Child Welfare cohort, the training focus will be on improving collaborative interventions in cases with pregnant and parenting women who are victims of IPV. For the Health Care cohort, the training focus will be on improving health care provider assessment, identification, and response (including a referral to

an advocate) for pregnant and parenting women who are victims of IPV. Such training is important given that many Child Welfare staff and health care professionals have received very little information regarding appropriate interventions in IPV cases through their undergraduate or graduate level coursework.[xxix]

CVSD will contract with a consultant to develop and execute training for advocates and Child Welfare staff that further strengthens Oregon's Child Welfare best practices in cases involving IPV. Training will have a particular focus on increasing effectiveness of Child Welfare and co-located advocacy interventions that support pregnant and parenting women who are victims of IPV. CVSD will convene its statewide advisory committee within the first month of the project to finalize the framework for this training. The framework will be designed to build training capacity within the Oregon Child Welfare system. Through this framework, learning will be shared across the three project sites and both Child Welfare staff and advocates will have the tools, skills, knowledge and values necessary to support the collaboration.

The Oregon Health Authority, Public Health Division, Center for Prevention and Health Promotion (OHA), the Oregon Coalition Against Domestic and Sexual Violence (OCADSV) and Futures Without Violence (FWV) will collaborate to provide training and technical assistance for the non-profit victim advocacy organizations and their health care partners within the four cohort sites. The trainings will promote the integration of appropriate and effective assessment, identification and response to IPV within the public health and local health care systems. The trainings will also communicate with health care partners that on-site advocate interventions are effective at reducing violence and improving a woman's well-being over time.[xxx] OHA, OCADSV and FWV will also offer technical assistance to TPD Coordinators, including help in 1) identifying screening and assessment tools to share with local health care providers, 2)

developing protocols that outline steps for local health care providers to refer a victim to an advocate, and 3) developing localized training on IPV for health care providers.

CVSD intends to use several training methods to reach advocates, Child Welfare staff, and health care providers through the local project sites. These methods will include Learning Circles, which encourage peer to peer learning and support the transfer of learning into practice. CVSD and its training partners will also offer webinars, conventional classroom trainings and conferences. In addition to the grant funded project staff, CVSD expects to reach as many as 75 non-profit victim advocacy staff, 300 Child Welfare staff, 400 public health and health care providers through its trainings over the four year project period. Participants in the project will also have access to a blog site and listserv in order to receive timely communications and information.

Work plan

The work plan reflects CVSD's overall goal for improving the safety and well-being of pregnant and parenting women who are victims of IPV by increasing access to advocacy services and improving services within child welfare and health care systems. The work plan accounts for a start-up period that ends December 31, 2013 and an implementation period from January 1, 2014 to June 30, 2017. The work plan for CVSD, its partners and the two cohorts is as follows:

CVSD and its partners
Start-Up: July – December 2013
Finalize MOUs; convene advisory committee; award subgrants; prepare and deliver initial cohort trainings; finalize evaluation/institutional analysis plan; develop data collection tools; develop sustainability plan; launch blog sites and listserv; attend federal grantee conference
Implementation: January 2014 – June 2017
Visit each project site twice; collect data; conduct evaluation; provide training and technical assistance; meet twice yearly with advisory committee; attend annual federal grantee conferences; maintain blog sites and listserv
Notable benchmarks by date
• Spring 2015 – CVSD and project staff from the Health Care cohort attend the National

Conference on Health and Domestic Violence

- October 2015 – Complete and distribute the training video for on-site advocacy in health care settings
- June 2016 – Complete and distribute the resource manual for Oregon health care professionals
- June 2017 – Complete and distribute final updates to the DHS Advocate Desk Guide and the Child Welfare Guidelines
- Years 3 & 4 – Futures Without Violence provide four trainings for health care providers (one training per site in the Health Care cohort)

Child Welfare and Health Care cohorts
Start-Up: July – December 2013
Hire and train advocate; convene local leadership team; attend annual summit; begin evaluation activities and data collection; begin developing sustainability plan and protocols/forms to facilitate provider referrals
Implementation: January 2014 – June 2017
Deliver advocacy services; collect data; participate in evaluation activities, online training opportunities and communication forums; meet quarterly with leadership teams; attend annual summits; participate in CVSD site visits; review and update sustainability plan, protocols and forms
Notable benchmarks by date

• June 2014 – All cohorts submit completed sustainability plan and protocols/forms to facilitate provider referrals
• For the Child Welfare cohort –
  ○ Participate in an institutional analysis in either Year 2 or 3
• For the Health Care cohort –
  ○ By December 2014, complete survey and mapping of local health care system
  ○ Provide three trainings per year in Years 2, 3, & 4 to local health care providers
  ○ Ongoing - research and develop locally appropriate screening tools for IPV

Stakeholder Organizations and Partners

Collaboration among Oregon stakeholders in the field of victim advocacy is long standing and effective. CVSD is confident that its state partners will support the activities of the project and ensure its success. CVSD has secured commitments from partner organizations in support of the Child Welfare and Health Care Cohorts. These commitments are largely for training and technical assistance support for implementing the project activities described for each of these cohorts. Prior to implementation, the partners will assist in the start-up of the proposed project. CVSD will convene an advisory committee comprised of leaders in the field. CVSD will also invite representatives from organizations like Planned Parenthood and Insights Teen Parenting Program. Partner organizations provide valuable expertise regarding the field of victim advocacy and services to pregnant and parenting women who are victims of IPV.

Project sites within the Child Welfare Cohort will receive support for the implementation of on-site advocacy services and the institutional analysis. DHS Child Welfare and Field Services Sections are invested in the success of on-site advocacy services in Child Welfare branch offices. On-site advocates are a means to enhance system responses to pregnant and parenting women and their families who are victims of IPV. With the high co-occurrence of IPV and child maltreatment, Child Welfare sees on-site advocates as a resource for enhancing victim safety and promoting the stability and well-being of participants and their families. Non-profit victim advocacy organizations are also seen as a resource for training and education for Child Welfare case workers on the adverse impact of IPV and a voice for holding batterers accountable for their actions.

Though the benefits of on-site advocacy far outweigh the challenges, challenges do exist. Child Welfare and non-profit victim advocacy organizations sometimes find themselves at odds

with one another around differences in mission, mandates, policies and practices. Such conflicts may lead to failures in communication and collaboration despite a common commitment to ending violence in the home. CVSD and DHS will work together to respond to these differences and to support understanding and smooth collaborations within the local project sites.

To this end, DHS commits in kind staff resources to help in the design and implementation of the Child Welfare Cohort. DHS will participate in the development of the competitive request for applications for making subawards. Once projects begin, DHS will work with the subgrantees in pulling together the local leadership teams. These teams will include key staff from the local Child Welfare branch office where the advocate is placed. Throughout the course of the project, DHS will serve as a technical assistance and training partner for CVSD and its local project sites. DHS will offer expertise on issues such as information sharing, confidentiality (as it practiced and understood by Child Welfare staff and advocates), referrals to the advocates, and placement/accessibility of the advocates within the offices.

In the first month of the federal grant award, CVSD and DHS will finalize its training plan for the Child Welfare cohort. In particular, CVSD will consider strategies and curriculum for classroom and webinar training for Child Welfare branch office staff on the *Child Welfare Practices for Cases with Domestic Violence*. CVSD and DHS will also create classroom and webinar training on the *Working Together – A Desk Guide for Domestic Violence Advocates Co-Located at DHS.* Current DHS Child Welfare and local advocate training formats omit these key documents from curricula. CVSD and DHS consulted with Portland State University's Child Welfare Partnership and David Mandel and Associates, LLC regarding the development of training for the Child Welfare cohort. Both consultants offered comprehensive training proposals that CVSD and DHS will consider for the final training plan.

Lastly, DHS commits to releasing updates of its *Child Welfare Practices for Cases with Domestic Violence* and *Working Together – A Desk Guide for Domestic Violence Advocates Co-Located at DHS.* The updated documents will include recommended changes in practices and policies that are identified by the process evaluation and institutional analyses. DHS will release updates to these two documents as they become available.

Given the relative newness of the on-site advocacy model in local Public Health departments and the unchartered landscape of advocacy within CCO provider networks, CVSD asked its state and national partners to provide training and technical assistance to support the **project sites within the Health Care Cohort**. CVSD turned to its adolescent health and family planning program contacts at the Oregon Health Authority (OHA), Center for Prevention and Health Promotion for guidance in the development of this application. Through these OHA contacts, CVSD was able to connect with Futures Without Violence (FWV).

CVSD, OHA and FWV all recognize the shared value of the on-site advocacy model in Public Health departments and health care settings. This is in large part because advocacy and health care are in alignment on basic principles of social equity and wellness for women and their families.[xxxi] CVSD will rely on OHA's expertise in youth sexual health, reducing unwanted pregnancy and sexual coercion, and improving maternal and child health. CVSD will also rely on FWV's expertise in promoting routine assessment for violence and abuse and effective responses to victims in health care settings.

CVSD will fund OHA staff time through its Adolescent Health and Women's Health and Family Planning Programs to train advocates and local Public Health and health care professionals at each of the project sites. OHA staff will ensure that CVSD's project sites will have adequate training, resources, and tools to implement the proposed project activities.

Specifically, OHA staff will provide consultation and technical assistance on working with the local Public Health department and CCO provider network on integrating appropriate and effective screening and referral for victims of intimate partner violence, sexual coercion, and/or teen dating violence. Assistance will be provided to the funded project sites on building effective collaborations with local Public Health departments' family planning and reproductive health clinics and providers, and for developing new partnerships with local CCOs. OHA staff will advise project sites on how to incorporate evidence-based screening tools and referral processes into local health care provider practice. OHA staff will also help guide partnerships with local Public Health departments and CCO networks to ensure the goals of the grant are accomplished.

CVSD will contract with FWV to develop and implement in-person trainings for healthcare providers and on-site advocates on strategies to improve the healthcare response to IPV. A total of six trainings will be offered over the course of the project. In the first year of the project, FWV will provide a Train the Trainer session for the on-site advocates, TPD Coordinators, and other stakeholders for the purpose of building expertise and proficiency in providing advocacy services in health care settings. The Train the Trainer session will also look at ways the local project sites can plan for sustainability. In the second year of the project, FWV will be featured as a primary speaker at OCADSV's annual conference, along with offering a two-part workshop on advocacy in health care settings. In the last two years of the project, FWV will provide trainings for local health care providers in each of the four project site areas on assessment, identification and response to IPV. Through these four trainings, FWV will promote collaborations between health care provider networks (CCOs) and local non-profit victim advocacy organizations.

In addition to the trainings, FWV will provide ongoing technical assistance to the identified project sites via email and phone. This technical assistance will be enhanced by the quarterly 90-minute troubleshooting and skills-building webinars that FWV develops and implements for the four project sites. Lastly, FWV will make available medically accurate clinical tools for health care providers, including clinical guidelines, sample protocols, patient safety cards, posters, and other materials to support the provider's role in IPV prevention, assessment, and response.

CVSD's third partner for training and technical assistance in support of the Health Care Cohort is the state domestic violence/sexual assault coalition, OCADSV. The partnership with OCADSV is important for Oregon to sustain the efforts and accomplishments of the Health Care Cohort and to pass along the lessons learned onto other non-profit victim advocacy organizations. OCADSV is also interested in building their capacity to become the leading training and technical assistance provider on advocacy in Oregon health care settings.

CVSD will contract with OCADSV to launch and maintain a blog site where topics are discussed, articles are provided, podcasts are distributed and archived, audio/video clips are housed, and where informational postings, such as links to webinars are posted. OCADSV will facilitate distance learning opportunities that promote peer sharing and problem solving among project sites and conduct workshops at CVSD's annual project summits on topics which are timely to the project sites as they develop their practice. Such topics may include advocate confidentiality in the context of health care, policies that govern local CCO provider networks, and state health care mandatory reporting laws.

OCADSV will produce two products by the end of the federal project period. These include 1) a video about on-site advocacy in Oregon health care settings to use in training new

advocates, and 2) a resource manual for Oregon health care professionals on health and IPV. OCADSV has permission from FWV to use their national materials as guides for developing these Oregon-specific products. Lastly, CVSD also plans for OCADSV staff to attend two of the OAH annual grantee conferences the National Conference on Health and Domestic Violence in the spring of 2015.

Performance Measurement and Evaluation

CVSD will contract with the PSU Regional Research Institute (PSU RRI) for the performance measurement and evaluation of the proposed project. PSU RRI will conduct a local evaluation to identify changes in practices and policies that enhance the safety of pregnant and parenting women and their children, and collect evidence of the impact of the project for use in securing future funding. Measurable process and outcome objectives and their benchmarks are included in the logic model, and these will guide the selection of particular data collection strategies as well as the development of specific items and measures. PSU RRI evaluation staff will partner with CVSD to ensure coordination of the evaluation efforts.

PSU RRI will consult with OAH in finalizing the evaluation design. PSU RRI will also collaborate with staff at selected sites during the first year of the project to identify additional performance measures and to develop data collection procedures to ensure the evaluation reflects the array of services and the particulars of the community.

The local evaluation will consist of three components: 1) an implementation study to ensure services are being delivered as intended; 2) an in-depth process evaluation to identify the key mechanisms as well as opportunities for improving the ability of the system to meet the needs of survivors; and 3) an outcome evaluation to document changes in knowledge, attitudes and beliefs as well as the impact on pregnant and parenting women and their children. In

addition, PSU RRI will partner with CVSD and staff at the project sites to disseminate evaluation results in an accessible and timely manner in an effort to promote the effective utilization of this information, and produce conference presentations and scholarly articles as appropriate.

PSU RRI will use certain research questions to guide the evaluation. In the implementation evaluation, PSU RRI will ask 1) how did the program as implemented differ from the original plan and why, 2) what factors facilitated implementation, 3) what factors facilitated systems and practice change, and 4) what barriers and challenges did sites encounter and how were they overcome? In the process evaluation, PSU RRI will ask 1) how does the project support the provision of needed services to pregnant and parenting women, 2) what policies, practices, manuals, and other texts support women and children's safety and perpetrator accountability, 3) what policies and practices should be changed to further support women and children's safety and perpetrator accountability, and 4) what barriers exist to improving the system? In the outcome evaluation, PSU RRI will ask 1) did the project meet its goals and objectives as outlined in the logic model, 2) what is the impact of the project on providers, programs, and survivors, 3) what changes in knowledge, self-efficacy or skills are reported by program staff to have resulted from this project, and 4) what difference did the project make from the perspective of pregnant and parenting survivors?

The implementation component will take place during years one and two of the project. PSU will utilize semi-annual interviews/focus groups with key project staff as well as a review of quarterly reports (containing both narrative and quantitative data) submitted to the CVSD Fund Coordinator to assess the degree to which the projects are being implemented as intended. Interviews will ask about activities, outputs and process objectives as outlined in the logic model, as well as any facilitators of and barriers to implementation.

The process evaluation at the Public Health cohort will consist of annual interviews and/or focus groups with advocates, direct service staff and supervisors as well as a review of any protocols or other written materials created as a result of the project. Questions will focus on outputs, process and short-term outcome objectives as outlined in the logic model. The work of the TPD Coordinator will receive extra emphasis given that this is a new position and the process evaluation will inform efforts best to shape this work.

The process evaluation of the Child Welfare cohort will be more intensive than that provided to Public Health because of their participation in the institutional analysis. A description of the analysis is provided under the section "Proposed Intervention." The analysis will take place during years two and three of the project at one site at a time. Each analysis is expected to take between four and six months. PSU RRI evaluation staff will do most of the data collection. However, interpretation will be done by each of the local project leadership teams.

The outcome evaluation will be multilayered in order to account for effects at the provider and policy level as well as the impact on individual women and children as represented by the list of outcomes in the logic model. Beginning in year one, participants who have had at least three contacts (either in person or over the phone) with an advocate will be invited to complete a written survey asking about their experience with the project. During years three and four, interviews will be conducted with a minimum of two participants from each site. Questions will focus on the relationship between the participant and the advocates, the types of assistance provided, and participants' understanding of the impact of the partnership. Surveys will be administered to Child Welfare, Public Health and non-profit victim advocacy organization staff during the first half of year four of the project. Surveys will be distributed on-line and will

include questions about the ways in which advocates have partnered with staff as well as changes in knowledge, beliefs and practices that have resulted from the partnership.

Dissemination: The timely dissemination of evaluation findings to project partners is essential to the implementation and program development process and will facilitate the active engagement of program staff in the evaluation. The PSU RRI evaluation team and CVSD will partner in facilitating the active and on-going utilization of evaluation findings by project staff by providing frequent and accessible reports and opportunities for dialogue. Dissemination activities will provide for annual reviews of data related to both OAH performance measures and the goals and objectives outlined in the logic model and serve as an important compliment to the monitoring efforts of the CVSD Fund Coordinator. The sharing of annual results will also allow for consideration of the adequacy of the benchmarks with an eye towards establishing appropriate standards for program success.

Written reports detailing evaluation activities, findings and dissemination efforts will be produced annually and shared with CVSD and its advisory committee. In addition, evaluators will meet annually with CVSD and its advisory committee to review these reports and evaluation plans for the coming year(s). The evaluators will partner with the CVSD Fund Coordinator to produce annual "newsletters" containing key evaluation findings, success stories and lessons learned, as well as practice tips, useful resources, etc. The newsletters will be distributed to project partners including non-profit victim advocacy organizations, and Child Welfare and Public Health offices. Copies will also be made available to clients and other community partners such as juvenile court, TANF, and other non-profits.

Mid-year evaluation findings will be shared with project staff via conference calls, blog sites, or in communication provided to CVSD. The evaluation team will present at annual

summits for both the Health Care and Child Welfare cohorts. These presentations will provide ample opportunities for questions and dialogue about the meaning of evaluation results and brainstorming about recommendations for further systems' improvements. Evaluation results may also be written up in scholarly journals and/or presented at conferences. If possible and appropriate, project staff and participants themselves will be invited to participate in writing articles and conference presentations.

Capacity to participate in federal evaluation efforts: The PSU RRI evaluation team will cooperate fully in any data collection of cross site performance measures as determined by the OAH and attend any training and/or other meetings as required. PSU RRI will work with all of the project sites to develop appropriate intake and tracking processes that will facilitate reliable collection of the performance measures related to individual program participants as well as mechanisms for documenting the delivery of relevant services. These data will be reported to the OAH annually or as required. CVSD is confident that PSU RRI has the capacity to collect and report on the relevant process and outcomes data as needed for OAH required performance measures and those identified as relevant to the local evaluation. It is likely that some of the project sites will already have processes in place for collecting and reporting most of the performance measures that will be required by this effort.

We are not able to meet the criteria for federal cross site evaluation for the following reasons: Though over 1000 participants will receive services within the four year period, the "intervention" that pregnant and parenting women receive will vary markedly. This is because services are individualized to the needs of the women and their families. Many women will need on-going, intensive advocacy as well as direct services such as emotional support and accompaniment to court hearings, while others will need only short term/one time services such

as a referral to safe housing. The number of women receiving brief, crisis-oriented services is likely to be quite high, which raises significant concerns regarding whether the "dosage" is sufficient to warrant including them in a rigorous outcomes study. In addition, randomly assigning women to a control or treatment group within the child welfare or public health setting is not feasible primarily because entry into the program can occur at a variety of locations during the women's system involvement which makes managing a random assignment process very challenging. It is also the case that random assignment is historically a very tough sell in child welfare settings and staff cooperation would be critical to any such effort. Finally, creating an adequate comparison group would be very difficult as the variables allowing for a sufficient match are not available in the administrative data and would be very costly (and beyond the budget of this grant) to collect from potential comparison group members.

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