Building Bridges between Healthcare Systems and Community-Based Organizations to Address Health Disparities

February 1, 2024

National Webinar Series: Part 3 of 4

Brought to you by the National Training and Technical Assistance Partners (NTTAPs) of the SDOH Academy

The Social Determinants of Health Academy

Agenda

1. Introduction & Housekeeping
2. Speaker Presentations
3. Q&A and SDOH Resources

SDOH ACADEMY

Housekeeping

- All participants are muted on entry to limit background noise
- Use the Q&A or chat box to ask a question during the session
- This webinar is being recorded and materials will be emailed to participants
- We would love to hear your feedback – please fill out our brief evaluation at the end of this session!

SDOH ACADEMY

The Social Determinants of Health (SDOH) Academy

The SDOH Academy is a HRSA-funded virtual training series designed to help staff from health centers, health center controlled networks, and primary care associations develop, implement, and sustain SDOH interventions in their clinics and communities.

The power of The SDOH Academy is that it does not focus on a single intervention. Instead, multiple HRSA-funded national training and technical assistance partners work together to offer a coordinated curriculum on multiple community-based SDOH interventions.

To learn more, visit: https://sdohacademy.com/

SDOH ACADEMY

National Training and Technical Assistance Partners (NTTAPs)

- Maximize impact of Health Center Programs
- Increase access to high-quality comprehensive primary health care for underserved populations
- Support HRSA awareness of issues impacting health centers and special populations
- Support HC to identify and implement evidence based and promising practices
- Leverage HC shared experience and data to improve health outcomes for patients

To learn more, visit:
https://bphc.hrsa.gov/technical-assistance/strategic-partnerships/national-training-technical-assistance-partners

SDOH ACADEMY

National Training and Technical Assistance Partners (NTTAPs)

SDOH ACADEMY

AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

CAPITAL LINK

CSH

HEALTH PARTNERS ON IPV + EXPLOITATION

HEALTH INFORMATION TECHNOLOGY, EVALUATION, AND QUALITY CENTER
HITEQ

ACU
ASSOCIATION OF CLINICIANS FOR THE UNDERSERVED

STAR²CENTER
SOLUTIONS TRAINING AND ASSISTANCE FOR RECRUITMENT & RETENTION

FARMWORKER JUSTICE

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

MHP Salud

NATIONAL ASSOCIATION OF Community Health Centers®

NCHPH
National Center for Health in Public Housing

National Center for Medical Legal Partnership
AT THE GEORGE WASHINGTON UNIVERSITY

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

NATIONAL CENTER FOR EQUITABLE CARE FOR ELDERS

SCHOOL-BASED HEALTH ALLIANCE
The National Voice for School-Based Health Care

NATIONAL LGBT HEALTH EDUCATION CENTER
A PROGRAM OF THE FENWAY INSTITUTE

MIGRANT HEALTH
NCFH
National Center for Farmworker Health, Inc.

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

MIGRANT CLINICIANS NETWORK
MCN

Let’s do a Poll!

Tell us what type of organization you represent.

SDOH ACADEMY

Learning Outcomes

1. Recognize how SDOH impacts health equity and access to care

2. Explain the importance of building and sustaining successful community SDOH partnerships between health centers and community-based organizations

3. Identify innovative strategies and resources for SDOH screening and best practices to build effective SDOH partnerships.

SDOH ACADEMY

Overview of Social Determinants of Health (SDOH)

What are Social Determinants of Health?

- **SDOH** are conditions in the environments in which people are **born, live, learn, work, play, worship, and age** that affect a wide range of health, functioning, and life outcomes and risks.
- Resources that could enhance or diminish quality of life and can have a significant influence on population health outcomes.

SDOH ACADEMY

Why do Social Determinants of Health Matter?

- Addressing SDOH is a primary approach to achieving health equity.
- SDOH such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying, contributing factors of health inequities.

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SDOH ACADEMY

Role of Community Partnerships in Addressing Social Determinants of Health

Collaborative relationships provide an opportunity for organizations to work together towards a common goal or purpose.

When we think about SDOH:

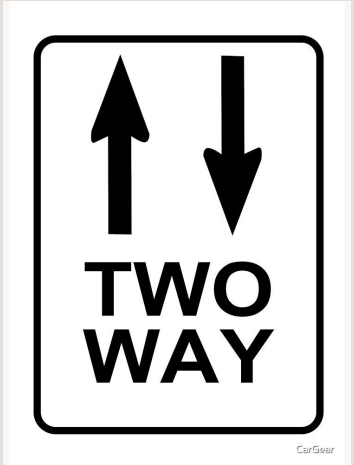
- Partnerships broaden opportunities to access services for special and vulnerable populations
- Allows for a more integrated approach to identifying and tackling SDOH barriers
- Partnerships help us accomplish goals/objectives we would not be able to do on our own.

SDOH ACADEMY

Role of Community Partnerships in Addressing Social Determinants of Health

Partnerships help to accomplish goals/objectives we would not be able to do on our own, partnerships can help us:

- Expand our knowledge/skills/expertise
- Increase resources ($, time, staff, etc.)
- Improve visibility of a cause/goal
- Expand our reach (reaching a broader audience)



SDOH ACADEMY

Role of Community Partnerships in Addressing Social Determinants of Health

Access to Healthcare Services

- Collaborations with CBOs or other health facilities to improve access to healthcare services (mobile health clinics, provide interpretation services, transportation vouchers, etc.)

Education and Training Programs

- Collaboration with educational institutions and CBOs to design and deliver educational programs that address health challenges

Community Empowerment/Advocacy

- Collaboration with local leaders/stakeholders to facilitate community engagement, education, and capacity-building initiatives that support the wellbeing of patients

SDOH ACADEMY

Today's Presenters

Lina Guerrero
Community Partnership Manager
La Clínica del Pueblo

Yasmin Tarver
Director of Workforce Development
Jenesse Center

SDOH ACADEMY

LA CLÍNICA DEL PUEBLO

Lina Guerrero

Community Partnerships Manager

Fostering Intersectoral Partnerships to Address Social Determinants of Health

The Social Determinants of Health Academy

LA CLÍNICA DEL PUEBLO

1983

Volunteer-run clinic launched in response to first Salvadorian immigrant wave (war, natural disasters, violence) to the DMV area

1995

Incorporated as an independent, non-profit 501(c)(3) agency

2007

Federally Qualified Health Center (FQHC) status

Locations

Columbia Heights, DC
Clinical Site

La Casa
Health & Action Center

School-Based MH Program

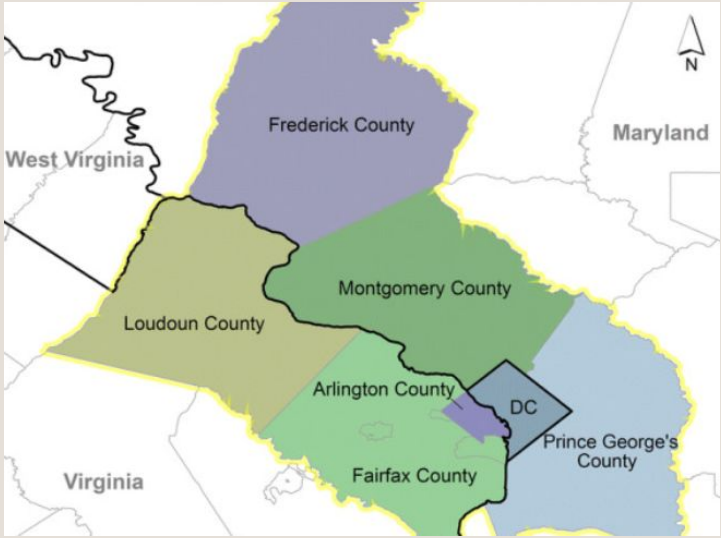
Northwestern High School

Hyattsville, MD
Clinical Site

The Communities We Serve

- 4,500 patients each year
- 92% are Latinx
- 80% are immigrants (predominantly from Central America)
- 35% are uninsured
- 83% feel more comfortable communicating in a language other than English
- 84% have an income at or below 200% of the federal poverty line
- 20,000 through community programming

* LCDP Data 2020



Where they live:

- 54% in DC
- 44% in MD
- 2% in VA

Community Of Care: Integrated Approach

Rooted in the cultural understanding of the community we serve, our work blends health care and social justice

Primary Medical Care

Mental Health & Substance Use

Community Health Action

Health Equity and Community Partnerships

VOLVIENDO A VIVIR
SUBSTANCE USE PROGRAM

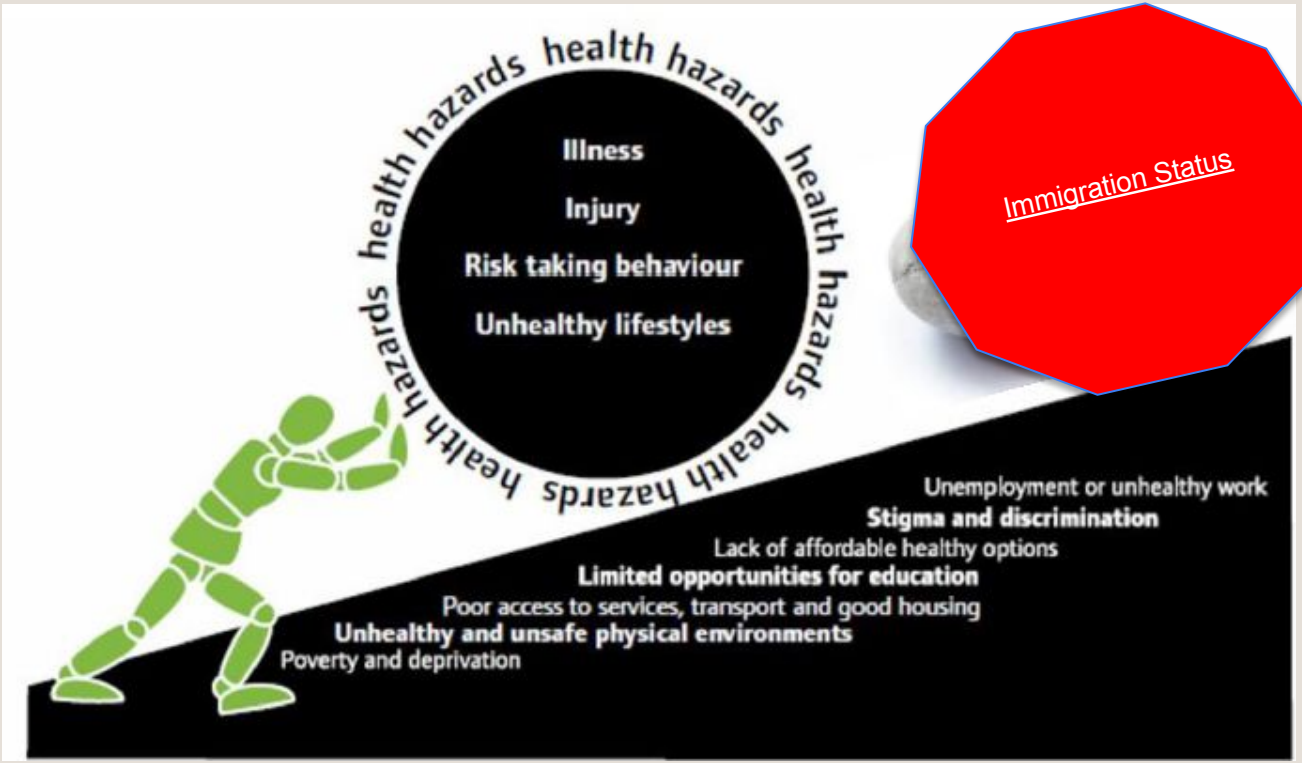
MI REFÚGIO
SCHOOL BASED PROGRAM

ENTRE AMIGAS
HEALTH AND GENDER PROGRAM

EMPODÉRATE
LA CLÍNICA DEL PUEBLO

PROMOCIÓN DE SALUD
LA CLÍNICA DEL PUEBLO

Immigration Status: Social Determinant of Health



Exclusion from Services due to immigration status

MEDICAID

SOCIAL BENEFITS

JOBS

Health Equity and Community Partnerships

Direct service through medical interpreter and health system navigation and simultaneous interpretation programs

Centralizes information on cross-sectoral network of agencies supporting social needs (Health Equity Hub) and organizes medical-legal partnerships for the organization.

Increase access to health care coverage in Washington DC and Maryland through policy change and coalition work.

Identify urgent social needs affecting Latino Immigrants in the region.

Community Partnerships to address Social Determinants of Health

SDOH Screening

- The **P**rotocol for **R**esponding to and **A**ssessing **P**atients' **A**ssets, **R**isks, and **E**xperiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better **understand** and **act** on their patient's social determinants of health
- Electronic Health Record
- Personal characteristics; Family and Home: Housing Status and Stability, Neighborhood. Money and Resources: Education, Employment, Insurance Status, Income, Material Security, Incarceration History, Refugee Status, Safety and Domestic Violence

LCDP Patient example: PRAPARE + Health Record

- Hispanic
- Female
- 78 years old
- Diabetic
- Unable to read and write
- Unemployed
- Green card holder patient
- Limited English Proficiency
- Experiencing domestic violence

How can community partnerships and wrap-around services help this patient?

Addressing Social Conditions through Medical-Legal Partnerships

Lawyers are as important as Doctor

Lawyers help with eviction, utilities, divorce, access to SSS, SNAP, immigration status

Positive impact on patient’s health and well-being

Example of Medical-Legal Partnerships

Addressing Food Insecurity through Partnerships with Farmers Market

Food distribution and tokens

Health Promotion

Health educators and navigators

Promotores de Salud

Partnership Assessment Tool for Health

Welcome to the Partnership Assessment Tool for Health (PATH). This resource is intended for community-based organizations (CBOs) that provide human services and healthcare organizations currently engaged in a partnership. For the purposes of this tool, we define partnership as **a structured arrangement between a healthcare organization** (e.g. health system, hospital, provider, insurer, state or local public health department) **and nonprofit or for-profit community-based organization** (e.g. housing organization, workforce development agency, food bank, early childhood education provider) **to provide services to low-income and/or vulnerable populations**.

The objective of the PATH is to help partnering organizations **work together more effectively to maximize the impact of the partnership**. As your partnership continues serving the community, open and honest dialogue around strengths, gaps, challenges, and opportunities is essential for partners to stay aligned, focus communications, prioritize changes, leverage opportunities, identify needs, and more. These types of conversations require dedicated time and can be challenging. The tool provides an approachable format to understand progress toward benchmarks characteristic of effective partnerships, to identify areas for further development, and guide strategic conversation between partners.

Developed by **Partnership for Healthy Outcomes**

Bridging Community-Based Human Services and Healthcare

A collaboration of

Nonprofit Finance Fund
Where Money Meets Mission

CHCS
Center for Health Care Strategies, Inc.

Alliance for Strong Families and Communities

Support for this project was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

Robert Wood Johnson Foundation

Factors to consider for a successful partnership

Accountability: Are both Partners invested in solving the patient's issue?

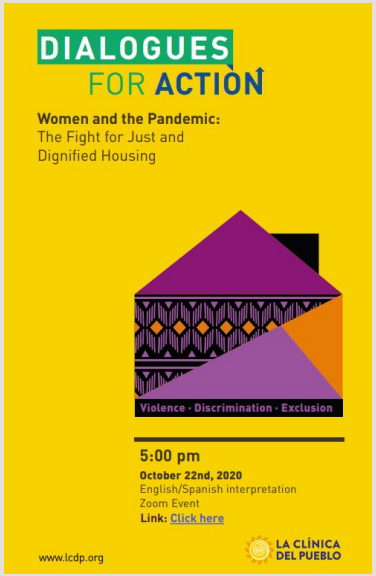
Language and cultural barriers: Are both Partners committed to provide interpretation services and provide navigation Support?

Time: Are both organizations aware of the time restrictions that low-income immigrants have? Ex: filling out unnecessary forms; location and transportation expenses

Evaluation: Satisfaction surveys and using tools such as PATH help to assess your partnership

Health in All Policies

Advocacy and Dialogues



LCDP Patient example: Community Partnerships

How did Community partnerships and wraparound services help this patient?

- Hispanic
- Female
- 78 years old
- Diabetic
- Unable to read and write
- Unemployed
- Green card holder patient
- Limited English Proficiency
- Experiencing domestic violence

- **Diabetes** support: physical activity; fresh produce through farmers market partnership ; healthy eating classes
- Culturally appropriate services in Spanish
- Referred to **Legal** Provider for US Citizenship and Domestic Violence
- **Mental Health Services**: belongs to the Gender Violence Program “Entre Amigas
- **Advocacy**: Housing for DV survivors; More legal service; Citizenship (do not read and write) elderly

Reflection


Migrants and refugees are not pawns on the chessboard of humanity. They are children, women and men who leave or who are forced to leave their homes for various reasons, who share a legitimate desire for knowing and having, but above all for being more.
Pope Francis

Questions?

Use the chat box or Q&A feature!

The Social Determinants of Health Academy

Jenesse Center, Inc.
DOMESTIC VIOLENCE INTERVENTION PROGRAM

Yasmin Tarver

Director of Workforce Development

The Social Determinants of Health Academy

Jenesse Center, Inc.
DOMESTIC VIOLENCE INTERVENTION PROGRAM

- Jenesse was founded in 1980 by and for women of color, drawing clients from communities where poverty is rampant, unemployment is high, educational attainment is low, and the housing market is the least affordable in the nation
- These– factors make women more vulnerable to abuse and make it even more difficult for victims to leave
- Jenesse Center is one of the few DV shelters that welcome large families, families with adolescent males and persons with one or more disabilities
- In addition, Jenesse houses those who identify as LGBTQ+, Gender Neutral
- All Jenesse services are provided in both English and Spanish and are free of charge.
- Survivors of DV often have a history of chronic generational poverty
- Among Jenesse clients, 95% live below the Federal Poverty Guidelines and a staggering 92% report having experienced severe physical or sexual violence

Jenesse Center

Offering 43 years of life-saving services, Jenesse Center Inc. is a nationally recognized non-profit domestic violence prevention and intervention organization. Jenesse works locally, nationally and globally to shine a light on violence against women, girls, men and boys and advocates the basic human right for all people to have peace in their homes and relationships. Jenesse's culturally sensitive programs and services not only transition families from crisis to self-sufficiency, but transforms the lives of its clients and the community at large by offering education, referrals and resources that go beyond shelter.

Jenesse Center

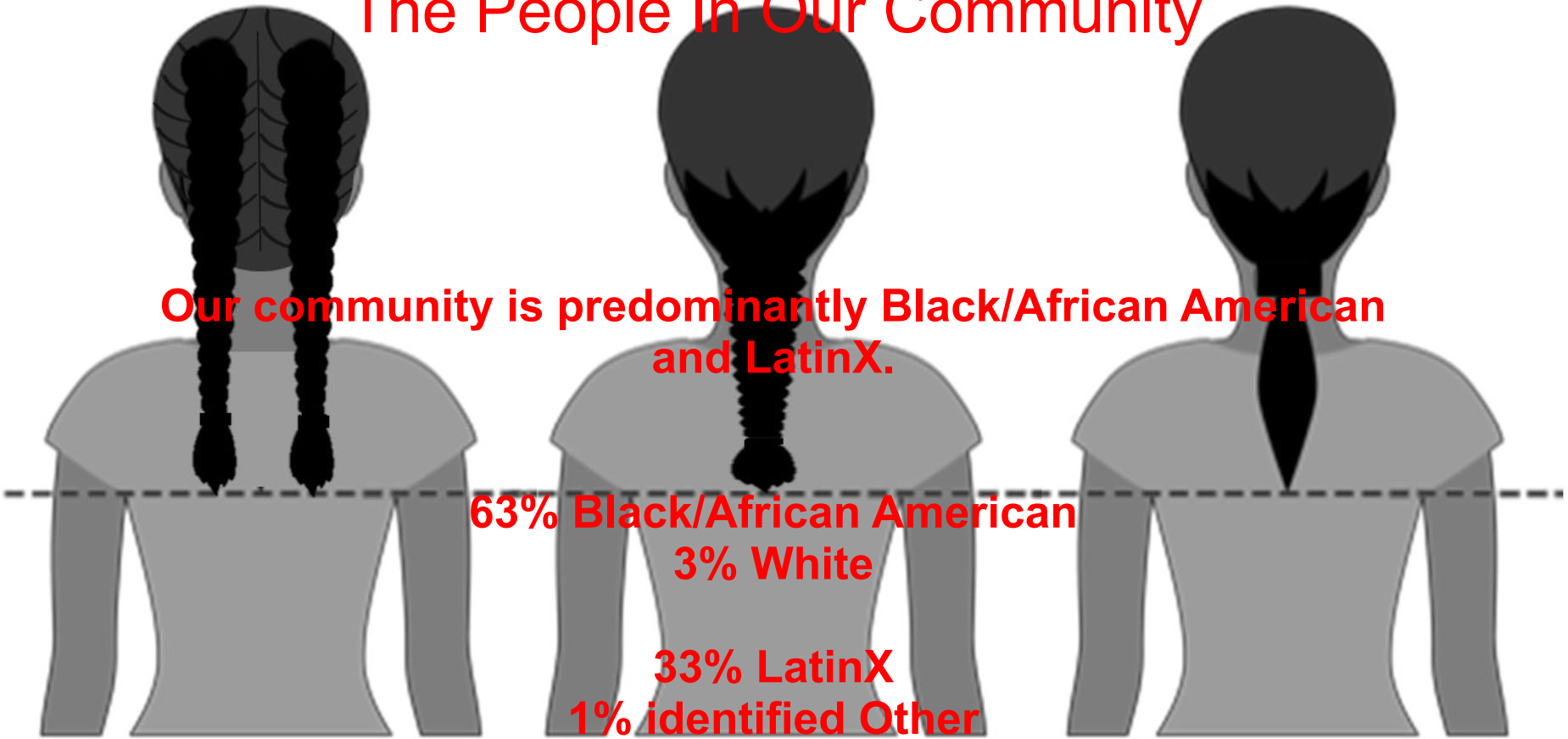
Housing women, men and children from 30 days up to two years through our emergency and transitional shelters, Jenesse provides a variety of support services, including mental health counseling, independent life skills classes, computer training, job referrals, after school programs for children, field trips, tutoring and comprehensive, direct legal services. Jenesse takes a proactive stance in educating young people to learn what healthy relationships look like and works to break the generational cycle of violence.

Who We Serve

THE COMMUNITY:
Located in South Los Angeles, Jenesse serves Service Planning Area (SPA) 6, one of the most diverse and densely populated areas in the city of Los Angeles. SPA 6 is home to six federally subsidized housing projects.

COMMUNITIES: Baldwin Hills, Compton, Crenshaw, Exposition Park,Florence, Gramercy Park, Hyde Park, Jefferson Park, Ladera Heights,Leimert Park, Lynwood, Paramount, Rosewood, South Los Angeles, SouthCentral, South Park, University Park, Vermont, Watts, West Adams,Willowbrook, Windsor Hills.

The People In Our Community



Our community is predominantly Black/African American and LatinX.

63% Black/African American
3% White

33% LatinX
1% identified Other

Jenesse's program philosophy is based on the following values:

- Domestic Violence is a societal issue; it affects the lives of all people in society
- Women and children are our primary clients
- Children are equal victims of domestic violence
- Clients should receive culturally sensitive and culturally competent services
- Shelter is only the beginning of intervention
- Clients must receive more than shelter – they must receive life skills
- Services must transform victims into survivors
- Men have to be a part of the conversation
- Services must be provided to populations that are generally turned away elsewhere
- Public opinion and public policy must be impacted to combat domestic violence

FAMILY WELLNESS

- Case Management
- Assist Clients n accessing their needs and goals
- Coordinate the receipt of all services and participation in all programmatic classes
- Advocacy for financial resources
- Client domestic violence certificate program
- Behavioral services including: individual, group and peer counseling
- Empowerment and enrichment classes
- Substance abuse and anger management

JENERATION J YOUTH PROGRAM

- Elevate awareness about domestic violence in schools
- Healthy relationship presentations to adolescents
- Tutoring and educational activities
- Manage the M. Sue Frazier Children's Program and Summer Camp
- Raise Your Voice 4 Peace Youth Competition

LEGAL SERVICES

- Domestic Violence Restraining Orders
- Family Law (Divorce, Paternity, Custody, Visitation, Child Support Orders)
- Immigration (VAWA/U-Visa/T-Visa Applications)
- Sexual Assault/Stalking Issues
- Legal Education and Empowerment
- Court Accompaniment
- Safety Planning
- Dependency Court and DCFS Advocacy
- Limited Scope Representation
- Pro Bono Clinics
- D.A.R.T. Service Provider for the Southeast, Southwest and 77th Division Police Stations

PERMANENT HOUSING

- Identify Barriers to Permanent Housing (Credit, Evictions, Income, Work History)
- Landlord Education and Advocacy
- Move-In Assistance - Funding available to clients that qualify: survivor of domestic violence, slept in LA County as least one day, make at or below the Average Median Income for LA County, produce last 8 weeks of pay stubs,
- Eviction protection/assistance
- Policy Changes

WORKFORCE DEVELOPMENT PROGRAMS

- Pre-employment services
- Post-employment services
- Career and skills exploration services
- Job training (hotel, hospitality, tech, green, health and child care)
- Education services (GED, HS diploma, continuing education, ESL)
- PAID Work Experience program **FORWARD™** (six week -hybrid program)
- Entrepreneurship program (eight-week online program)
- Financial Literacy Program (Allstate and Capital One)
- Social Enterprise (online retail store, **FORWARD™** merchandise

FORWARD
BY JENESSE WORKS

California statistics reveal:

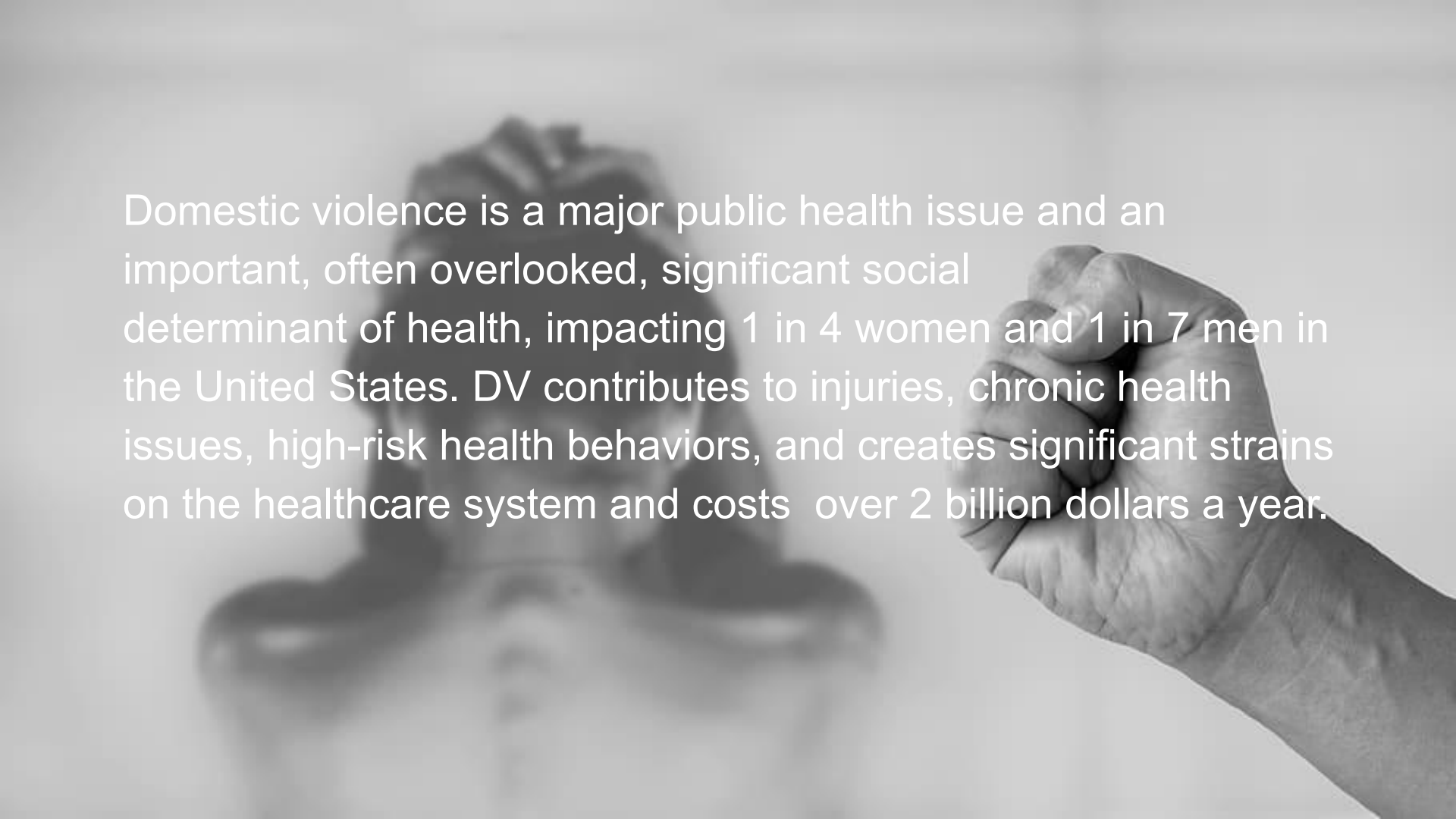
40% of women have experienced DV in their lifetime

10% of homicides are linked to intimate partner violence

58% of residents have been touched by DV, either as a victim, abuser, or through a close friend or relative

40% of female homicide victims were killed by their current or former male intimate partner

- **In Los Angeles county, 1 in every 28 households makes 911 calls related to DV, approximately 48,000 calls a year**



Domestic violence is a major public health issue and an important, often overlooked, significant social determinant of health, impacting 1 in 4 women and 1 in 7 men in the United States. DV contributes to injuries, chronic health issues, high-risk health behaviors, and creates significant strains on the healthcare system and costs over 2 billion dollars a year.

In 2014, in response to the high prevalence of domestic/sexual violence and the profound health impacts of violence, Blue Shield of California Foundation pioneered the Domestic Violence and Health Care Partnership (DVHCP) project. Nineteen partnerships across the state were funded with the intent of improving DV response through practice, policy and systems change in both health care and advocacy program settings. Through intentional partnerships, sites advanced integrated systems of care and innovations to promote prevention, and better address and respond to DV and the health impacts of violence.

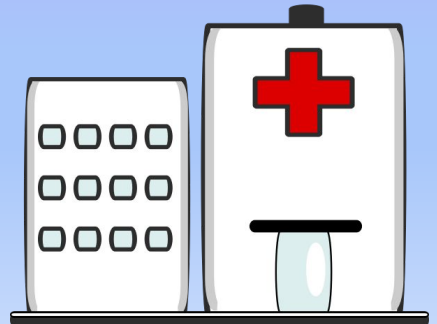
Of the sites, four in particular based in Los Angeles County (LAC), committed to changing systems within their own organizations and then leveraging those lessons learned to promote systems change across their region. This cohort self-organized in 2017 to continue this work, disseminate best practices, and promote DV and health care integration across the County, developing the DV and Health Care Leadership Council.

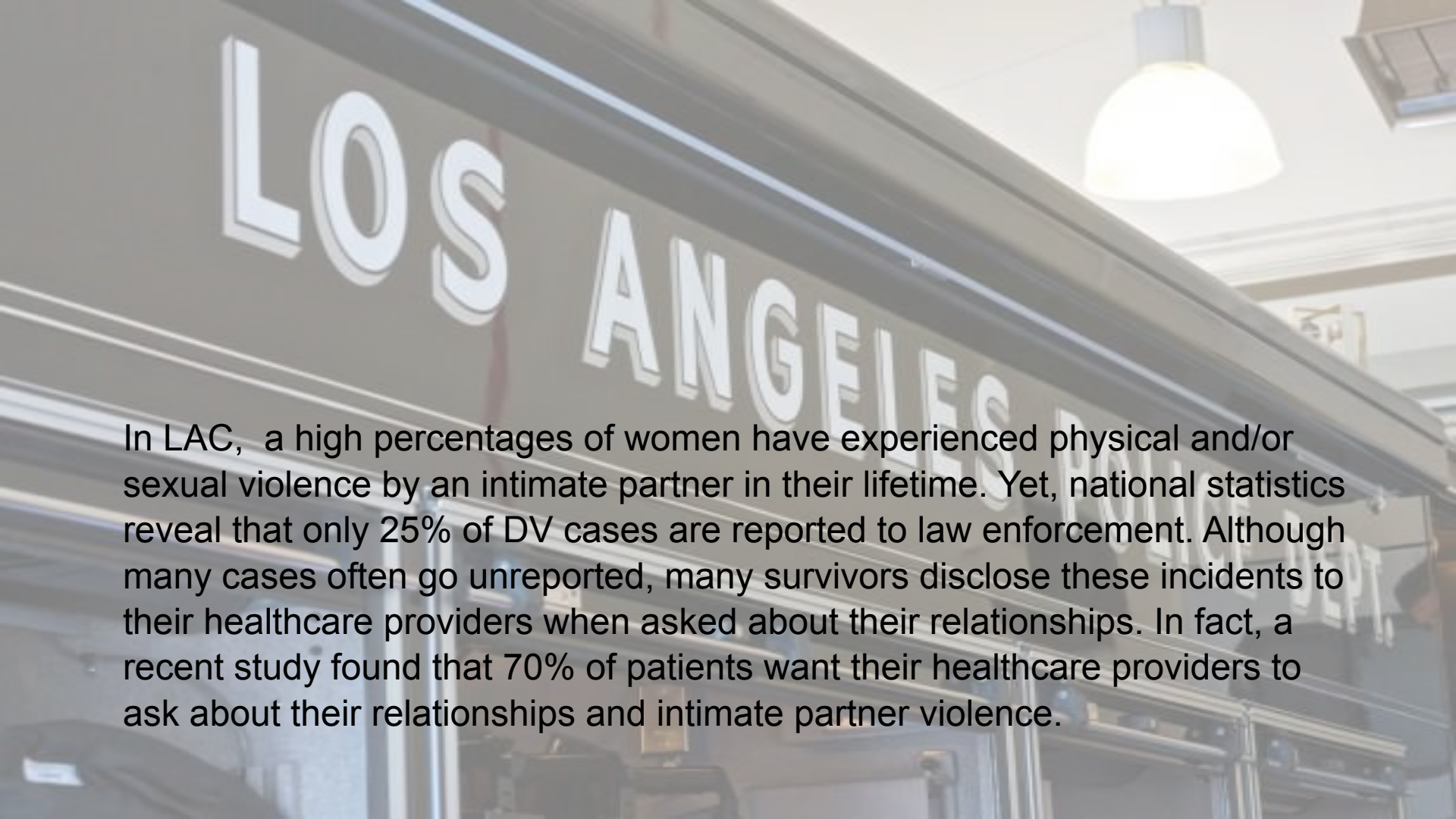
DV HC

Leadership Council for
Domestic Violence & Health Care

In 2019, the Leadership Council partnered with the LAC Department of Public Health to build upon and scale best practices and learnings in order to improve sustainable systems addressing the intersections of DV and health care across Los Angeles.This partnership positioned the County to move beyond silos toward a collaborative framework for service provision specifically addressing vulnerable communities.

Working through new and existing public health models, this work is advancing integrated care for DV survivors, sharing policy-change recommendations,fostering opportunities for capacity building and cultural responsiveness, and promoting transformational systemic change in intersectional approaches to marginalized communities impacted by violence within LAC.





In LAC, a high percentages of women have experienced physical and/or sexual violence by an intimate partner in their lifetime. Yet, national statistics reveal that only 25% of DV cases are reported to law enforcement. Although many cases often go unreported, many survivors disclose these incidents to their healthcare providers when asked about their relationships. In fact, a recent study found that 70% of patients want their healthcare providers to ask about their relationships and intimate partner violence.

Jenesse and Watts Healthcare Corporation

Jenesse Center, Inc. leveraged and strengthened an existing and long-standing partnership with ***Watts Health Care Corporation (WHCC)*** to close the gap between DV and health care in South Los Angeles. Together we implemented an innovative community initiative focused on improving the health care response to violence and strengthening the way health and DV service providers interface to address the health impacts of violence in support of survivor health.

Through this partnership, we were able to make lasting changes in their practice, policies and systems to improve the provision of quality care; streamlined cross-referrals that expedites access to needed medical and advocacy services; enhanced confidentiality policies that supports a feedback loop to track referral outcomes; and an overall strengthened organizational approach to meeting the unique health and safety needs of survivors in their community.

Mission Statement:

- The mission of the Watts Healthcare Corporation is to improve the health and well-being of the people and communities that we serve by ensuring access to compassionate, quality, culturally-sensitive preventive and primary health care services.

Vision Statement:

- Watts Healthcare Corporation will remain relevant by leading forward within a culture of strategic thinking to resolve community health care issues.

Our Values:

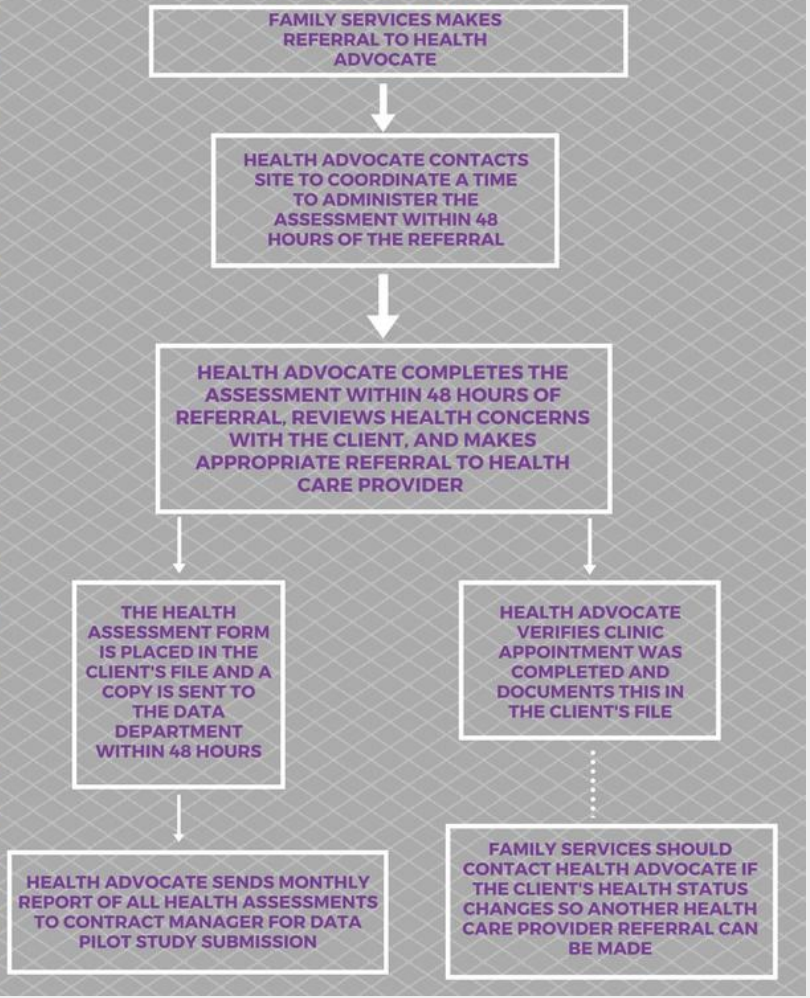
- We value high quality comprehensive health care services
- We value high ethical standards
- We value promotion of healthy living and behaviors
- We value our employees in the support of our mission

We’re proud of our history that spans over five decades as a leader in the community health center movement. From a volunteer-driven clinic that was birthed out of the Watts riots in 1965 to serving those most in need in Los Angeles county, we’ve grown to become a federally recognized and award winning, health care institution.

Jenesse, Inc.

Health Advocate Health Assessment Flow Chart

This is a diagram representation of the health advocate role in conducting health assessments for each of the clients.



Jenesse Center, Inc.
Health and Wellness Services

Transportation Options to Crenshaw Community Health Center (CCHC), California Hospital, and Children's Hospital

CCHC
3756 Santa Rosalia Drive, Suite #400
Los Angeles, California 90008

In the case of an emergency please call 911

It is the client's responsibility to arrange transportation to the clinic for non-emergency appointments.

For urgent care needs please go directly to California Hospital or Children's Hospital. Travel options listed here

Walking/ Public Bus	CCHC/WHC Transportation	Taxi	Driving
0.9 MILES FROM SITE B TO CCHC. EST. 20 MIN WALK DASH BUS STOP AT SANTO TOMASO & NICOLET STREETS TAKE "DASH CRENSHAW" BUS TOWARDS MLK. ESTIMATED 6 MINUTE BUS RIDE	AFTER THE FIRST VISIT, CLIENTS CAN CALL WHC (323) 564-4331 TO SCHEDULE A FREE PICK UP CLIENTS MUST CALL A DAY BEFORE & BEFORE 4PM. EARLIEST PICK UP IS 8AM AND LAST PICK UP IS 2:30PM.	USE YOUR TAXI VOUCHER OR PAY FOR A TAXI ESTIMATED $7.00 TAXI FARE	ESTIMATED 4-6 MINUTE DRIVE ENTER CCHC PARKING LOT ON SANTA ROSALIA, 2 HOUR FREE WITH VALIDATION

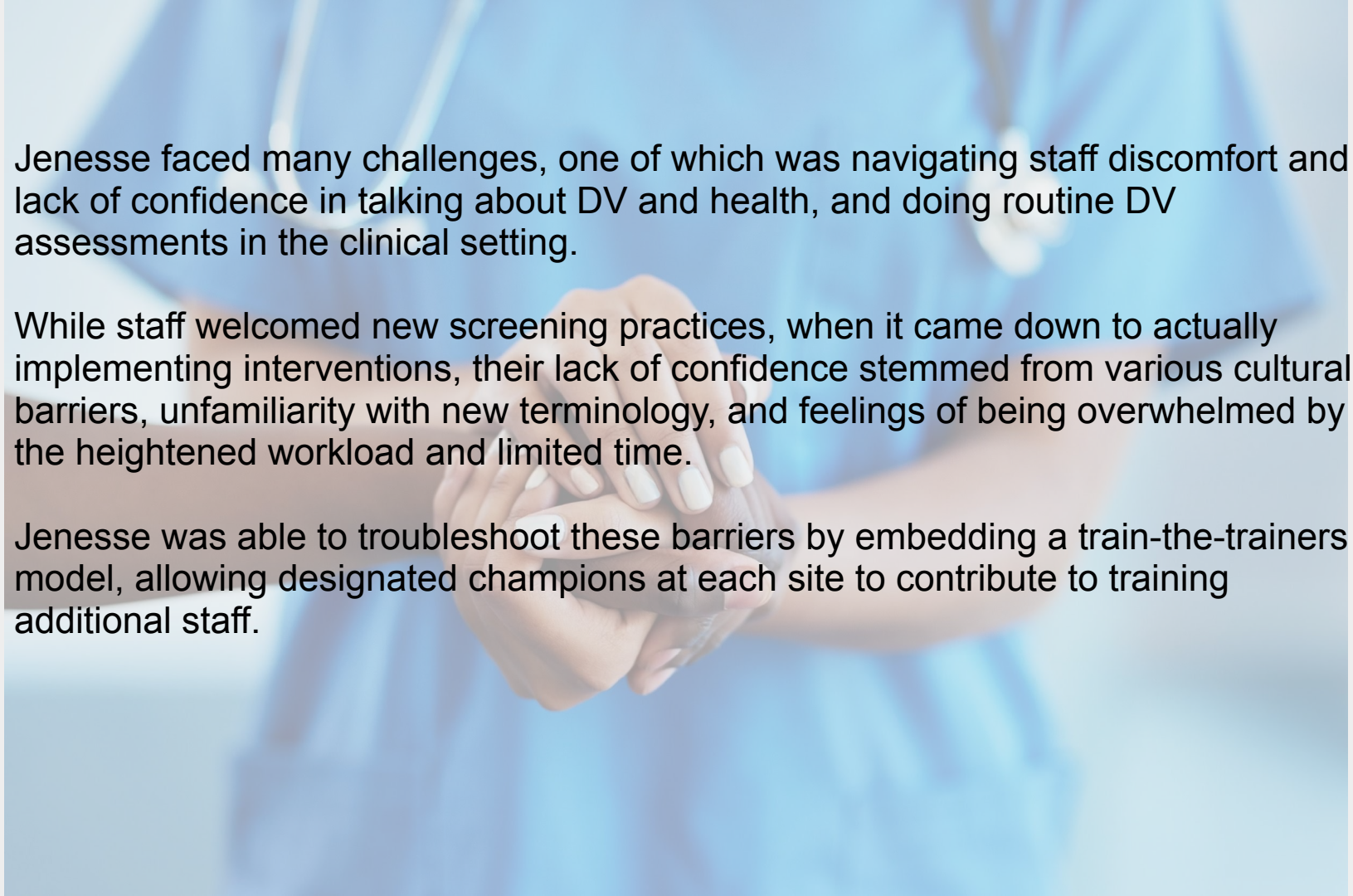
24 hour Urgent Care

CALIFORNIA HOSPITAL 1401 S. GRAND BLVD.,LOS ANGELES, CA 90015	CHILDREN'S HOSPITAL LOS ANGELES 4650 SUNSET BLVD., LOS ANGELES, CA 90027
ESTIMATED 7.2 MILES DISTANCE, 19 MIN APPROX. $35.00 TAXI CAB FARE	ESTIMATED 9.6 MILES DISTANCE, 32 MIN APPROX. $45.00 TAXI CAB FARE
ASK STAFF FOR TAXI SCRIPT	ASK STAFF FOR TAXI SCRIPT

Any questions please contact your Case Manager or Client Services Specialist on duty

Towards the beginning of the study, the Jenesse Health Advocates provided a referral form to the clients to take with them to their health care appointment to inform the health care site front desk staff that they were Jenesse clients. Within our first month of collecting the data, we noted that this was not practical. After a meeting with the Jenesse and WHCC staff, we decided to create a purple Jenesse referral card that the clients would take with them to the appointment that had no identifying information on it.

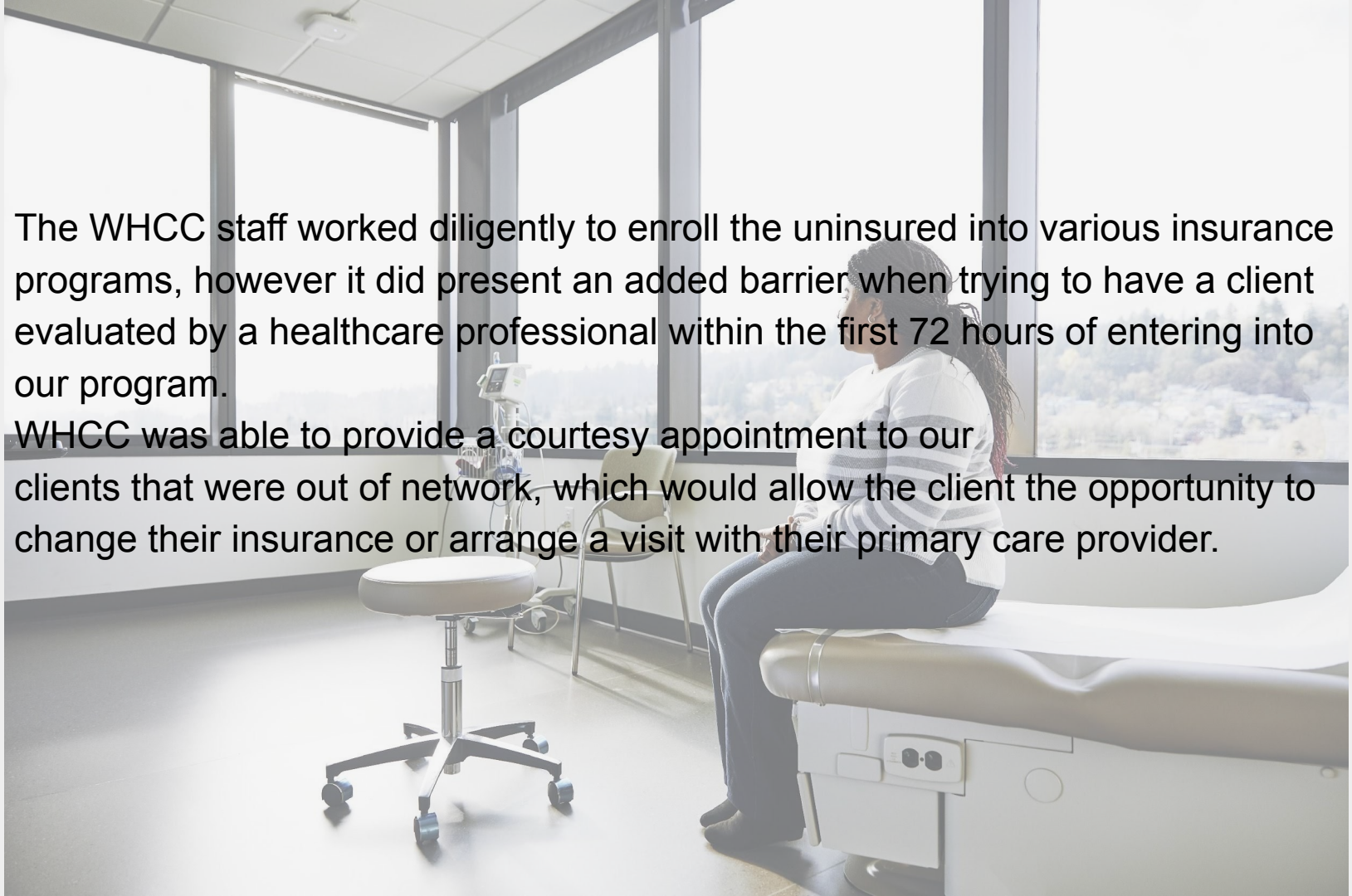
Additionally, the Jenesse Health Advocates would call the point of contact at the Crenshaw Community Health Center (WHCC site) to make the initial appointment with the hope that the staff will mark that the patient is also a Jenesse client. This amended protocol would allow both organizations to track the client/patient and collect their data. Another minor issue, many of the clients were uninsured or either had out of network.



Jenesse faced many challenges, one of which was navigating staff discomfort and lack of confidence in talking about DV and health, and doing routine DV assessments in the clinical setting.

While staff welcomed new screening practices, when it came down to actually implementing interventions, their lack of confidence stemmed from various cultural barriers, unfamiliarity with new terminology, and feelings of being overwhelmed by the heightened workload and limited time.

Jenesse was able to troubleshoot these barriers by embedding a train-the-trainers model, allowing designated champions at each site to contribute to training additional staff.



The WHCC staff worked diligently to enroll the uninsured into various insurance programs, however it did present an added barrier when trying to have a client evaluated by a healthcare professional within the first 72 hours of entering into our program.

WHCC was able to provide a courtesy appointment to our clients that were out of network, which would allow the client the opportunity to change their insurance or arrange a visit with their primary care provider.

Jenesse conducted ongoing trainings to over 300 health care and DV staff members, directly linked over 750 DV clients to medical services at WHCC, and promoted best practices in partnership development to over 200 people in the field.

Since, Jenesse has engaged several new partners to expand services and position themselves for new funding opportunities.

Impact + Key Data Findings

1. Health care providers are twice as likely to screen for DV. Health care providers doubled their rate of assessment of DV during clinical visits, and 2 out of 3 patients reported having their provider talk to them about healthy and unhealthy relationships (with some sites achieving 100%).

2. Patients are more likely to report DV. Among patients with prior exposure to unhealthy relationships, more than 1 in 3 reported that they shared this with their health care provider (compared with normal rates of fewer than 1 in 10).

3. DV survivors are more likely to focus on health needs. Clients receiving advocacy services were uniformly supportive of being asked about and receiving health related services within the shelter setting. In fact, 82% of clients reported an increased understanding of the effects of DV on personal health after receiving services.

Impact + Key Data Findings

4. DV advocates and health care providers are more likely to make referrals. Both advocates and health care providers reported significant increases in their confidence referring to each other's organizations, with over a 28% increase in confidence levels.

5. Access to care was significantly improved as a result of coordinated systems of care developed. 100% of survivors who tested positive for sexually transmitted infections were treated and completed their follow-up visit three months post screening.

What We Learned From Clients

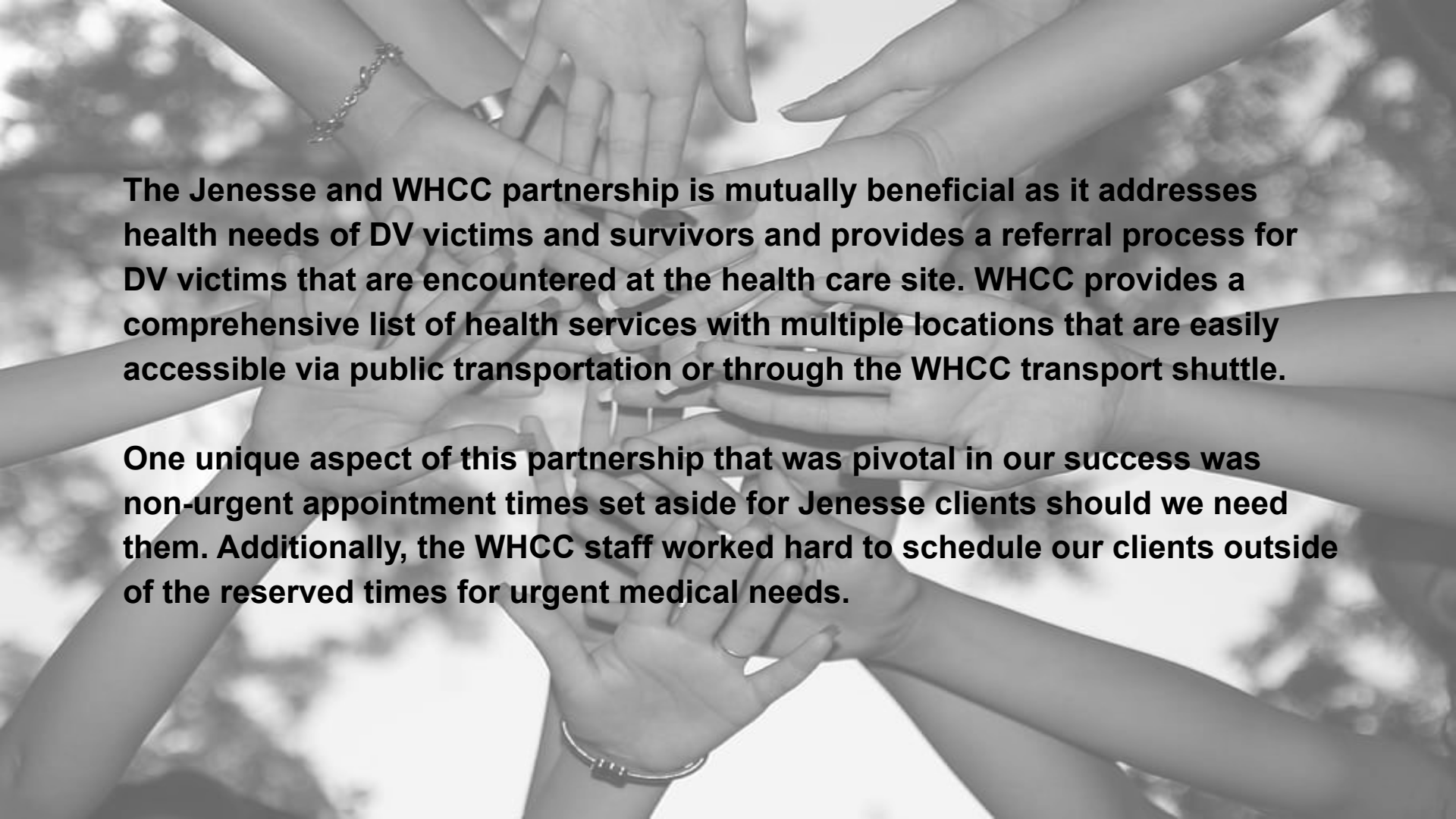
The true success of this partnership is the invaluable feedback received from the clients. A few clients were interviewed to receive an unbiased opinion on the referral process and the services received at WHCC. Among these clients, many reported on the ease of transportation from the shelter site to then Crenshaw Community Health Center site.

There were positive comments on the short wait time to see a health care provider, the friendly health care staff, and most reported their expectations had been met. The common unfavorable opinion was the slight inconvenience to travel to the main WHCC facility for higher level of care.

What We Learned Through Collaboration

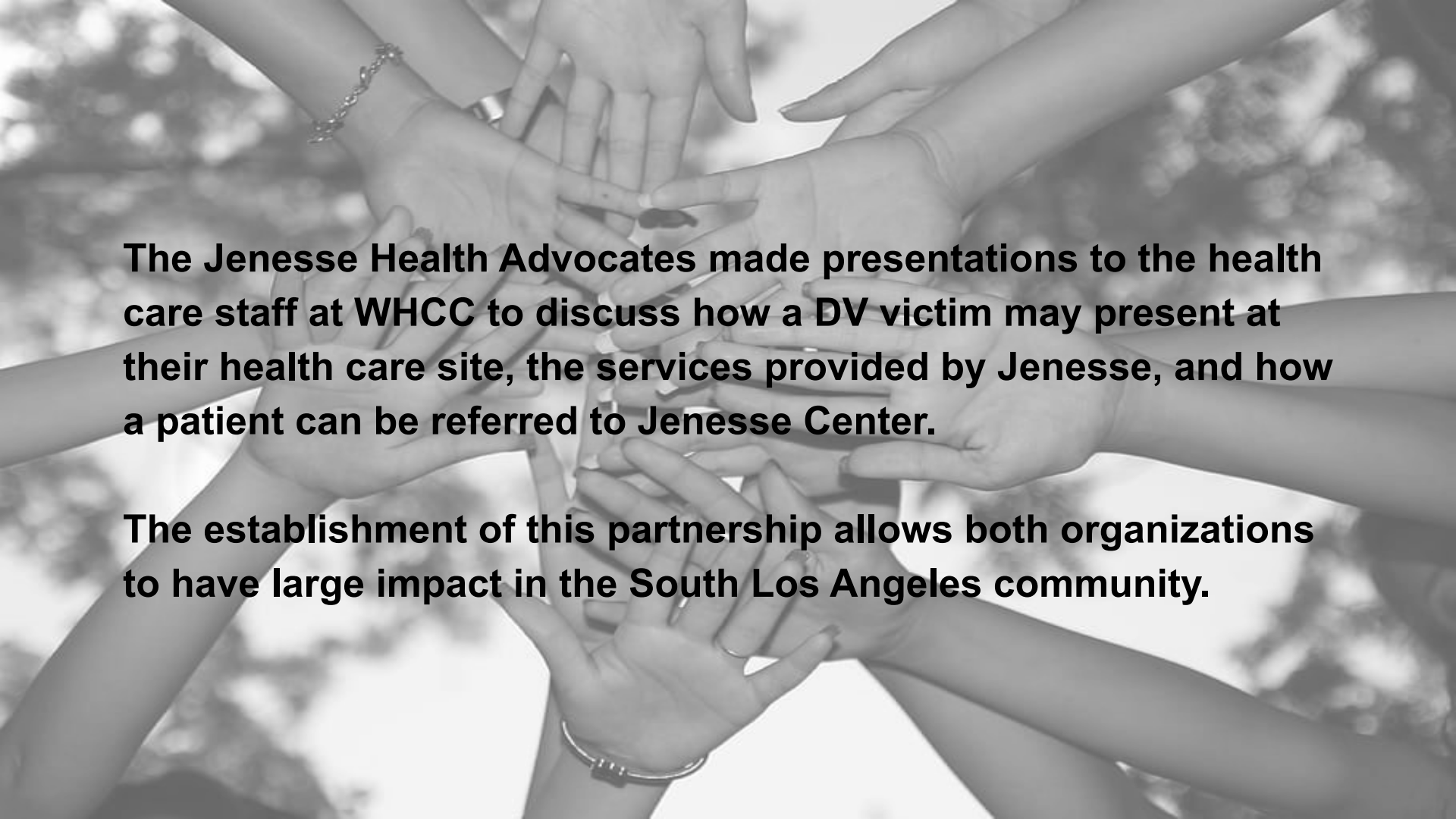
Partnerships take time to cultivate and champions ensure their growth. DV programs are well positioned to move the needle for change toward prevention, health advocacy and better survivor health outcomes.

This work takes time, and partners have learned that successful change over time is highly attributed to identifying organizational champions. Champions drive partnership development, promote buy in from leadership, support direct service staff and ensure that new practices and policies are implemented and embedded into ongoing programming. Without champions, partnership efforts are likely to stall or halt.



The Jenesse and WHCC partnership is mutually beneficial as it addresses health needs of DV victims and survivors and provides a referral process for DV victims that are encountered at the health care site. WHCC provides a comprehensive list of health services with multiple locations that are easily accessible via public transportation or through the WHCC transport shuttle.

One unique aspect of this partnership that was pivotal in our success was non-urgent appointment times set aside for Jenesse clients should we need them. Additionally, the WHCC staff worked hard to schedule our clients outside of the reserved times for urgent medical needs.



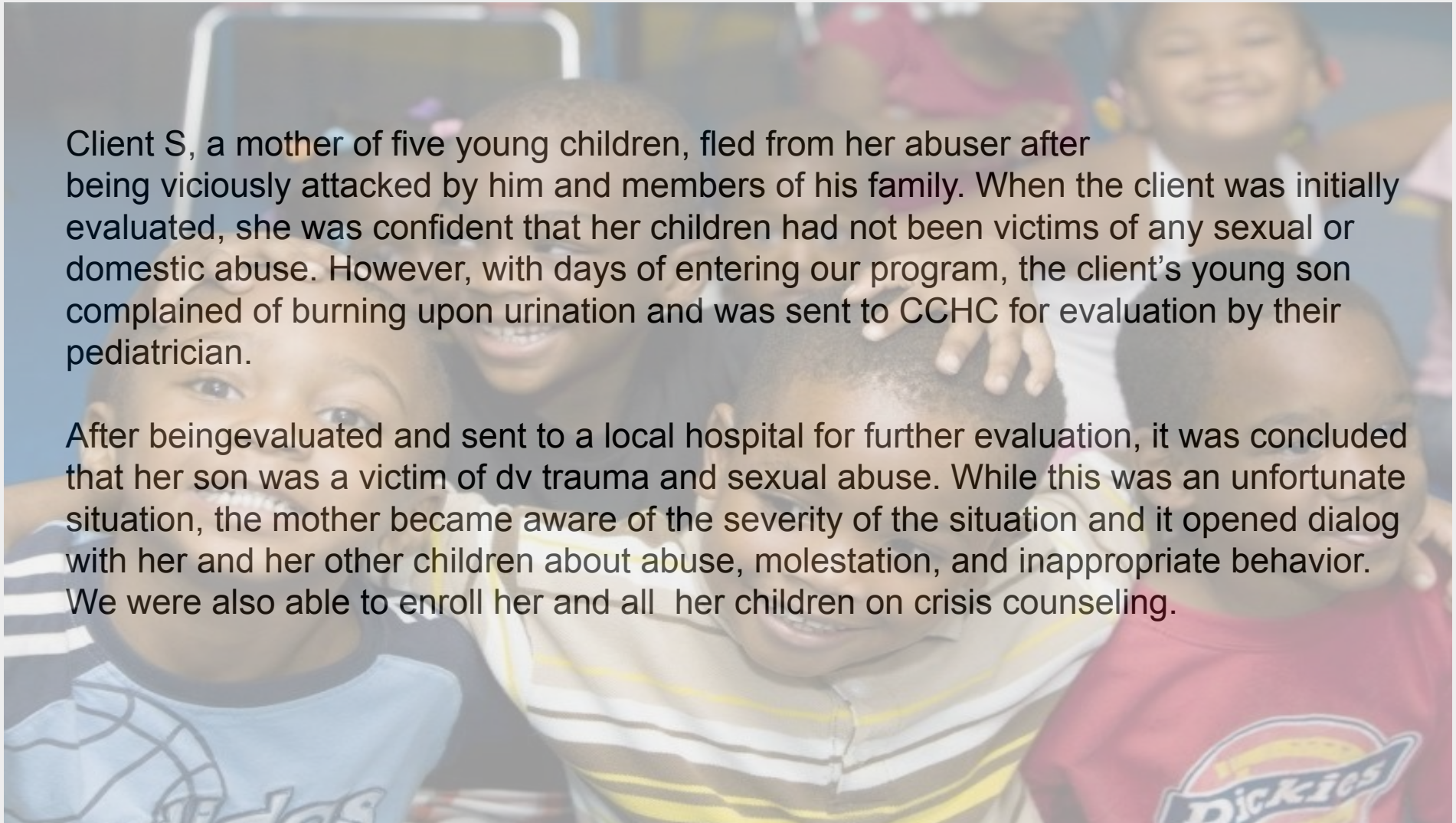
The Jenesse Health Advocates made presentations to the health care staff at WHCC to discuss how a DV victim may present at their health care site, the services provided by Jenesse, and how a patient can be referred to Jenesse Center.

The establishment of this partnership allows both organizations to have large impact in the South Los Angeles community.

Client Stories

- **Client H arrived at our emergency site after fleeing her abuser, her longtime boyfriend. As she was fleeing her abuser, he told her that he was HIV positive. She was so worried that she contracted the disease that she was having a hard time adjusting to being in the shelter. She explained that she is not knowledgeable about HIV transmission and she has been hesitant to interact with son until she knew her HIV status.**

- **We were able to gain an appointment at CCHC to have her HIV testing completed within 1 day of her explaining her situation. After receiving a negative result, the client expressed how grateful she was for our assistance in gaining a clinic appointment and the indescribable relief she felt of knowing her status. The countless success stories we have witnessed reinforce the significance of this partnership.**



Client S, a mother of five young children, fled from her abuser after being viciously attacked by him and members of his family. When the client was initially evaluated, she was confident that her children had not been victims of any sexual or domestic abuse. However, with days of entering our program, the client's young son complained of burning upon urination and was sent to CCHC for evaluation by their pediatrician.

After beingevaluated and sent to a local hospital for further evaluation, it was concluded that her son was a victim of dv trauma and sexual abuse. While this was an unfortunate situation, the mother became aware of the severity of the situation and it opened dialog with her and her other children about abuse, molestation, and inappropriate behavior. We were also able to enroll her and all her children on crisis counseling.

What We Learned About Sustainability

● Ongoing staff training on assessment, response and universal education must be prioritized. Change in practice, policy and systems is simply not possible if staff are not adequately trained, comfortable implementing new interventions, and confident in their abilities and referral procedures. One-time trainings are not sufficient.

●Training must be ongoing and accessible for all staff and integrated into the orientation process for new staff. As a result of training approaches taken, there was a two-fold increase in provider and DV advocate confidence in responding to DV and survivor health issues and making warm referrals to their partner organization.

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What We Learned About Patients

●Patients often do not disclose abuse out of fear of judgment and repercussions. A number of Advocates don’t ask survivors about their health because they are not aware of the health impacts of violence and don’t feel adequately educated to discuss the medical needs of clients. By understanding the barriers hindering progress, partners were able to strategize creative solutions, adjust staff training needs, and to help eliminate or reduce them.

Breaking Down Barriers And Fear Of The Unknown

● Exploring barriers is important to overcoming them. Take time to explore and understand the many barriers that will surface. For example, health care providers are commonly reluctant to talk about DV with patients because they lack confidence and knowledge on the subject, are uncertain in how to respond or where to refer, time constraints and cultural barriers.

Partners, Programs & Growth

●Partners were able to navigate this challenge by putting new systems in place—developing champions, scheduling staff training opportunities, embedding new practices into fluid staff roles, and writing new policies and procedures.

●Program capacity for adaptability is key and expands over time as new systems become institutionalized and staff is truly enrolled in the deep impact they are having.

The Health Care Staff Response To Domestic Violence

●The experience of violence is prevalent and impacts professionals in both the DV and health care sectors. One of the most unanticipated lessons was the incidence of staff seeking services as they were personally impacted by violence in their own lives. In fact, all partners reported that at least some staff from their health partner self-reported and accessed DV services.

●As a result, partners quickly learned how critical it was to develop a workplace response to violence within their new protocols; 72% of health partners implemented trauma-informed workplace policies for staff exposed to DV and procedures to link professionals to advocacy support, counseling and whole person care.

Partnerships Are Sustainable.. They Take Work!

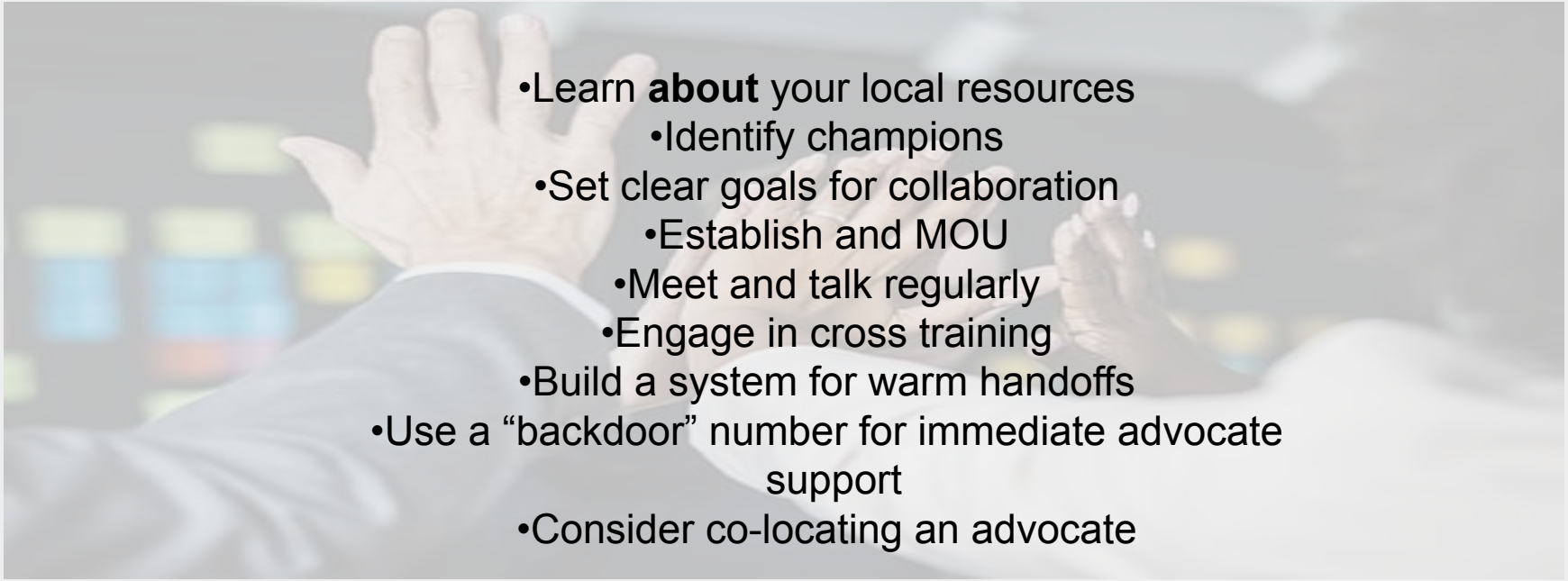
● Partnerships are viable and can be sustainable. Jenesse and WHCC learned that sustainability must always be at the forefront of their strategic planning. Having a long-term vision for integrated services and taking an innovative approach to leveraging new and existing resources have been imperative to changing systems that can withstand the test of time with minimal or decreasing funding streams.

●The initial costs of partnership development—both time and financial—tend to be highest at the start and over time as new systems and practices are embedded into organizational programming, financial demands become more manageable. By scaling learned best practices and demonstrating impact and outcomes, partners have identified sustainable funding streams to support their model programs, while expanding their partner network across sectors.

Community Partnerships Where To Start

- You don’t need to be an DV expert to provide support
- Build partnerships with family-serving, community-based organizations (CBOs)
- Lean on expert partners you know and trust when beyond your scope of practice
- DV support services are a critical part of our healthcare infrastructure
  - Wide range of trauma-sensitive services
  - Support to survivors and their children and health care providers

Strategies for Building Partnerships



- Learn **about** your local resources
- Identify champions
- Set clear goals for collaboration
- Establish and MOU
- Meet and talk regularly
- Engage in cross training
- Build a system for warm handoffs
- Use a “backdoor” number for immediate advocate support
- Consider co-locating an advocate

Domestic violence (DV) is a comprehensive issue that impacts a victim/survivor's life in every capacity. Often times seeking evaluation by a healthcare professional is delayed, unless there are visible signs of physical trauma. It is well understood that the stress of a domestic violence situation can lead to long term health effects such as hypertension (high blood pressure) and chronic stress. This collaborative, highlights the importance of building relationships between DV shelters/organizations and healthcare providers to address these health needs.

The data that was collected from our site and Watts Healthcare Corporation (WHCC) emphasized many trends seen among our client population and additionally revealed areas where both of our organizations could place more focus in prioritizing care.

The partnerships between DV organizations and Health Care providers is instrumental in addressing health concerns and allows for preventive medicine and family planning which improves the long term outcomes for DV victims, survivors and their families.

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Questions?

Use the chat box or Q&A feature!

The Social Determinants of Health Academy

NTTAP
SDOH & Community Partnership Resources

1. NCFH - SDOH Resource HUB
2. Farmworker Justice - Resources for Community Health Centers
3. NCHPH - Social Determinants of Health Resources
4. Health Center Medical-Legal Partnership Toolkit, "Bringing lawyers onto the health center care team to promote patient & community health"
5. Health Partners on IPV and Exploitation: A guide to increasing capacity to address health, justice and equity through partnerships
6. AAPCHO (with NACHC and OPCA): PRAPARE SDOH Screening Tool, Implementation and Action Toolkit

SDOH ACADEMY

Part 4

Empowering Change: Innovating and Scaling for a Healthier Tomorrow in the Face of Emerging Social Determinants of Health (SDOH)

March 14, 2024 | 3 - 4.30 PM ET

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