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The DELTA PREP Initiative: Accelerating Coalition Capacity for Intimate Partner Violence Prevention

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Abstract

Background—The DELTA PREP Project aimed to build the prevention capacity of 19 state domestic violence coalitions by offering eight supports designed to promote prevention integration over a 3-year period: modest grant awards, training events, technical assistance, action planning, coaching hubs, the Coalition Prevention Capacity Assessment, an online workstation, and the online documentation support system.

Objectives—Using quantitative and qualitative data, we sought to explain how coalitions integrated prevention within their structures and functions and document how DELTA PREP supports contributed to coalitions' integration process.

Results—We found that coalitions followed a common pathway to integrate prevention. First, coalitions exhibited precursors of organizational readiness, especially having prevention champions. Second, coalitions engaged in five critical actions: engaging in dialogue, learning about prevention, forming teams, soliciting input from the coalition, and action planning. Last, by engaging in these critical actions, coalitions enhanced two key organizational readiness factors—developing a common understanding of prevention and an organizational commitment to prevention. We also found that DELTA PREP supports contributed to coalitions' abilities to integrate prevention by supporting learning about prevention, fostering a prevention team, and engaging in action planning by leveraging existing opportunities. Two DELTA PREP supports—coaching hubs and the workstation—did not work as initially intended. From the DELTA PREP experience, we offer several lessons to consider when designing future prevention capacity-building initiatives.

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Intimate partner violence (IPV) affects an estimated 12 million Americans annually, most of whom are women (Black et al., 2011; Breiding et al., 2014). IPV refers to physical, sexual, or emotional abuse or threats by a current or former partner or spouse of opposite or same sex (bCenters for Disease Control and Prevention [CDC], 2013b). Early grassroots efforts to address IPV began with the battered women's movement in the 1960s when advocates offered services to survivors, raised awareness, and called for accountability and resources to address the problem. During the 1970s, local agencies that provided victim services began to organize into state domestic violence (DV) coalitions (National Coalition Against Domestic Violence, 2008). Today, all 50 U.S. states and 6 territories have a DV coalition that provides training, technical assistance (TA), and funding to local agencies, as well as advocating for state and national policies. Collectively, these coalitions have influenced how systems and policies at the national, state, and local levels respond to both IPV victims and perpetrators (National Network Against Domestic Violence, n.d.).

In addition to *responding* to IPV, state DV coalitions hold great promise for *preventing* the onset of IPV (i.e., primary prevention) by leveraging their community organizing expertise and building on their successful victim response efforts. In this article, we use the term *prevention* to refer specifically to primary prevention, defined as preventing the onset or first occurrences of IPV perpetration and victimization.

During 2002–2012, the CDC funded 14 state DV coalitions to engage in IPV prevention work through the Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) Program (CDC, 2009, 2013a; Graffunder, Noonan, Cox, & Wheaton, 2004). Building on DELTA experiences, DELTA PREP (Preparing and Raising Expectations for Prevention) was implemented in 2008 as a 4-year initiative designed to build the prevention capacity of additional state DV coalitions. DELTA PREP was a collaborative effort among the CDC, the CDC Foundation, and the Robert Wood Johnson Foundation, which provided $3.2 million dollars for the project. DELTA PREP included the project team's 1-year planning phase, after which 19 state DV coalitions received funding to participate in DELTA PREP's 3-year implementation phase.

This article seeks to explain how coalitions integrated prevention of IPV into their organizations and how DELTA PREP supports accelerated coalitions' integration process.

Project Overview

The Interactive Systems Framework illustrates how both general and innovation-specific capacities are necessary to successfully support and deliver public health interventions (Flaspohler, Duffy, Wandersman, Stillman, & Maras, 2008; Flaspohler, Meehan, Maras, & Keller, 2012; Wandersman et al., 2008). The Interactive Systems Framework has mostly been applied to implementing specific interventions or programs, but it can also be applied

to broader innovations that require organizations to develop new capabilities (Freire et al., in press). Innovation-specific capacities may include new knowledge, skills, and organizational practices needed to implement prevention activities. DELTA PREP aimed to select coalitions that already had high general capacity to support their existing operations in IPV response efforts, as well as motivation and willingness (i.e., prevention readiness) to build their IPV prevention capacity.

Participant Selection

Because DELTA PREP's main goal was to increase coalition's prevention capacity, the project team selected coalitions with high *general capacity* to support their existing operations. Criteria included having organizing documents, a strategic plan, an executive board that meets regularly, an executive director, a budget, and paid staff. In addition, selection criteria included coalitions' organizational *prevention readiness* defined as openness to a public health approach, organizational flexibility to integrate prevention, and leaders' willingness to participate in project activities and engage staff in a change process. Prevention readiness was assessed through open-ended questions in the application that asked coalitions to describe how leaders would engage staff in planning and making organizational changes and who in the coalition would participate in project activities. Coalitions had to commit to having at least one coalition leader attend project trainings and coaching calls to be selected. A review committee of IPV and prevention experts (CDC and non-CDC partners) scored applications and selected coalitions.

Project Supports

The project provided eight supports intended to accelerate coalitions building their IPV prevention capacity as they integrated prevention in their structures and functions (Table 1). Supports included the following: funding, training, TA, action planning resources, the Coalition Prevention Capacity Assessment (CPCA), coaching hubs, an online workstation, and the online documentation support system. The project team designed supports using principles known to promote organizational leaders facilitating organizational change and to help practitioners adapt new practices into their organizational settings (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Marquardt, 1999; Orton et al., 2006; Robertson, Umble, & Cervero, 2003; Umble & Cervero, 1996; Umble et al., 2006). Funding ranged from $15,000 in Year 1 to $27,000 in Year 3. Funds supported staff and leaders time to participate in project activities and travel to onsite trainings. In Years 2 and 3, coalitions could apply for supplemental funds up to $5,000 in order to implement specific action plan items.

DELTA PREP's summative evaluation demonstrated that most coalitions significantly improved their prevention capacity by integrating prevention within their existing structures and functions by the end of the project, measured by a 10-item prevention capacity index. Coalitions also served as catalysts for prevention activities in their states by the end of the project period, measured as initiation or expansion of six types of activities: state-level prevention training, state capacity building, work with media outlets, programs, policies, and media campaigns (Freire et al., 2015).

Study Aims

In this article, we describe: (1) How coalitions integrated prevention into their structures and functions, and (2) How DELTA PREP supports accelerated coalitions' integration process.

Method and Data Sources

Table 2 summarizes study data sources and collection methods.

Aim 1: How Coalitions Integrated Prevention Into Their Organizational Structures and Functions

To examine how coalitions began to integrate prevention into their structures and functions, we conducted a multisite case study of five DELTA PREP coalitions that (1) had improved their prevention capacity by the end of their second grant year, (2) had made substantial progress on action plans to implement prevention activities, and (3) had staff and leaders who were actively involved with the project (Brinkerhoff, 2002). The project's interview team (one external consultant and one project staff member) conducted 1-day site visits at each coalition that included multiple in-depth interviews with staff, leaders, and partners. Sometimes the team conducted group interviews to gain the perspectives of multiple partners at once. The team audio recorded all interviews and both team members recorded notes. Prior to site visits, the first author reviewed coalitions' grant applications, progress reports, information entered into the online documentation support system, and documents coalitions sent about their current prevention work to develop coalition profiles that the team used to prepare for interviews and tailor interview protocols.

Aim 2: How DELTA PREP Supports Accelerated Coalitions' Integration Process

To examine how DELTA PREP supports accelerated coalitions' integration process, we systematically reviewed data collected from all 19 coalitions as part of DELTA PREP's rapid-cycle program improvement evaluation (Zakocs, Hill, Brown, Wheaton, & Freire, 2015). The program improvement evaluation assessed participants' satisfaction with and use of project supports, as well as how useful supports were to coalitions' prevention capacity building. Project staff initially used data to make midcourse adjustments during the project. Qualitative data included 33 interviews and 9 focus groups with representatives from all DELTA (i.e., coaches; $N = 14$) and DELTA PREP coalitions ($N = 19$). The first author used semistructured guides to conduct all interviews and focus groups to solicit their experiences with the supports offered. Specifically, coalitions were asked about their experiences with supports, how useful supports were for building their prevention capacity, and the challenges coalitions experienced with each support. Interviews and focus groups were audio recorded when possible, and written notes were always taken.

The final online survey included questions about participants' perceptions of the project overall and its eight supports. Participants reported on how valuable DELTA PREP was for building their coalition's prevention capacity and the extent to which participating in DELTA PREP accelerated their coalition's prevention capacity. Both questions were measured on a 5-point Likert-type scale, with 1= *very valuable* or very useful and 5 = *not at all valuable* and *not at all useful*, respectively. Additionally, coalitions were asked to rate how useful each of

the eight supports were for building coalition prevention capacity on a 4-point Likert-type scale, with 1= *very useful* and 4 = *not at all useful*. The evaluation team conducted phone interviews with all 19 coalitions within 6 months after the project ended. Coalitions reported on whether or not they continued to use action plans, administer the CPCA, or participate in coaching hubs. To assess coalitions' use of the online workstation and documentation support system 6 months after the project, we reviewed online data. We used registration records to verify coalitions' attendance at a national training offered after grantees' funding ended.

Analytic Approach

Aim 1: How Coalitions Integrated Prevention Into Their Structures and Functions

For the case studies, our qualitative approach focused on data reduction, data display, conclusion drawing, and verification (Miles & Huberman, 1994). First, a narrative summary that synthesized interview findings and coalition profile information was drafted and sent to each coalition's interview participants for their feedback on the accuracy and completeness of the narrative. Participants were asked to comment on factual information as well as the perspective rendered from the interviews. From the written narrative summaries, preliminary codes were identified across coalitions, and then a matrix for each coalition was drafted to synthesize evidence around codes. Cross-site matrices were then developed to analyze key themes across the five coalitions. Quotes from notes and audio recordings were used to illustrate themes.

Aim 2: How DELTA PREP Supports Accelerated Coalitions' Integration Process

We triangulated survey, interview, and focus group data to examine how project supports accelerated coalitions' capacity-building and prevention activities. We used survey summary reports to examine survey response frequencies. As part of the rapid-feedback program improvement evaluation, focus group and interviews had been summarized and reported back to participants during the project period. Participants provided feedback on the original narratives that were usually formatted in short reports and presented on conference calls. To address Aim 2, interview and focus group narratives were initially coded for any mention of how a DELTA PREP support benefited the coalition and how grantees were challenged while using the supports. These codes were then reviewed, categorized by support type, and summarized into a matrix. From this matrix, themes were identified across seven of eight supports (i.e., not funding) to identify common ways that the supports fostered coalition prevention capacity building. Quotes made by DELTA PREP or DELTA coalition members were used to represent key themes.

Results

Aim 1: How Did Coalitions Begin to Integrate Prevention Into Their Structures and Functions?

We found a common pathway by which the five coalitions began to integrate prevention into their structures and functions (Figure 1). First, as a prerequisite for participating in the project, coalitions demonstrated two characteristics: *general organizational capacity* to

support their existing operations, and initial *prevention readiness* including the following: (1) openness to a public health approach, (2) organizational flexibility to integrate prevention, and (3) leaders' willingness to participate in project activities and engage staff in a change process. Key leaders were expected to serve as *prevention champions*, as they engaged coalition staff in integrating prevention within the organization. Second, during DELTA PREP, coalitions engaged in five *critical actions* around prevention: engage in dialogue, resolve concerns, offer opportunities to learn about prevention, form a prevention team, solicit input from the coalition, and develop an action plan that leverages existing resources. Through these critical actions, coalitions *enhanced two key prevention readiness factors* that were not part of the project selection criteria: (1) developing a common understanding of prevention and (2) having an organizational commitment to prevention.

Prevention Champions—A few coalition leaders emerged as champions for prevention and ignited the entire integration process. Case study coalitions had at least two leaders (i.e., executive staff, managers, and board members) who worked collaboratively with coalition staff to rally the prevention cause. Coalition staff and board members consistently pointed to these champions as those who led the charge. One coalition manager recounted that having the board chair "involved from the beginning has made all the difference. Having your board chair stand up at a board meeting and say, 'Prevention is where we are going,' makes it easier to move forward."

Critical Actions—Although the timing and execution varied, all five coalitions engaged in four critical actions that enabled them to move forward with integrating prevention. These actions, illustrated in Figure 1 and described herein included engaging in dialogue to resolve concerns, offering learning opportunities to develop a common prevention understanding, action planning as a tool to leverage existing opportunities, and soliciting input to foster a mind-set that "prevention is everyone's job." Four out of the five coalitions engaged in a fifth critical action by forming a prevention team. The prevention champions played a large role in fostering these five critical actions, in concert with other coalition members.

Engage in dialogue to resolve concerns—Coalitions questioned whether their organization's traditional response approach actually would end violence, and the staff and leaders needed to discuss their concerns about a prevention approach. For example, a spike in the state DV death rate spurred leaders of one coalition to begin questioning:

> What's happening in our state that we are not able to bring those numbers [of victims] down? How are we ever going to end this? When our local agency started seeing the adult children coming back who were in the same situation as their moms, that's when we knew we had to do something. We can't continue to put a band aid on it. We have to stop it.

Initial questioning sometimes had started before DELTA PREP, and became more focused board and staff dialogues during the project around two key issues: (1) the coalition's mission to serve victims and (2) a gendered approach to framing violence. There were concerns that integrating prevention would divert the coalition from its original mission of providing victim services. Some coalition board and staff members were fearful that

"prevention will take away from victim services. How are we going to fit this in with what we are already doing?" During initial dialogues about prevention, one coalition decided to close a clinic, due to lack of resources. One assistant director remembered, "This was really hard because we had 900 [DV] cases that still needed assistance and people were losing their jobs." Another coalition was awarded a relatively large prevention grant. The associate director recalled staff questioning, "Why are we going to put all this money into a social marketing campaign when our local programs are struggling to keep their doors open?"

Another concern raised by coalitions was moving toward a gender-neutral approach to framing IPV, which conflicted with what coalitions viewed as the founding principles of violence against women movement: IPV is about power and control, which manifests in gender inequality. In contrast, public health language is often gender-neutral when the emphasis is on modifiable risk and protective factors, and when terms such as *universal strategies* and *population-level outcomes* are used to describe a public health approach. Although the CDC uses the term *intimate partner violence* to refer to violence committed by a partner or spouse of either sex, some DV coalitions have deliberately used the term *violence against women* to emphasize the disparity in women's versus men's experience as victims of partner abuse. As they began to discuss prevention, coalition staff differed on whether to maintain their current gender analysis frame or move to a more gender-neutral frame. One staff member explained her concerns: "Gender analysis is a [necessary] political element; it's standing with and for victims." A longtime coalition executive director was concerned about gender-neutral language when revising the coalition's mission statement:

> Are we going to talk about intimate partner violence or violence against women? When violence against women is neutralized, it removes our historical roots, our connection to the social change movement. It moves the discussion away from power and control and gender inequality.

Influenced by their concerns about diversion from historical mission and gender-neutral framing, coalitions, early on, created opportunities for honest dialogue about whether the coalition should address prevention, the trade-offs for changing how the coalition operates, and visioning about how this change process may happen. During DELTA PREP, coalitions scheduled time for dialogues during off-site retreats, lunch-time "prevention potlucks," and regular weekly staff and board meetings. As one executive director recounted, "We dedicated time, space, and resources to have conversations." Another executive director explained that during an off-site retreat, she was able to let go of some of her concerns about shifting away from the coalition's traditional mission: "[Because] people listened to me and let me cry a little bit . . . I felt like I was heard and people trusted me, so I was able to let it go pretty quickly." Another executive director explained, "Sometimes there needs to be a storming stage before moving on. It's important to be able to voice concerns without feeling you're against the whole thing."

Offer opportunities to learn about prevention—Coalition staff and board members struggled to understand what prevention is, how it differs from intervention (i.e., what they are currently doing), and how prevention work is done. Central to this challenge was learning a new language—terms like *public health models; socioecological framework;*

primary, secondary, and tertiary prevention; and *risk and protective factors*—then translating this prevention language into their service language. One staff member, who had worked at a local shelter on federally funded prevention work, recalled that before DELTA PREP, "I still didn't get [prevention]. I hadn't fully actualized the paradigm shift. I understood the values, but I was still largely at the awareness raising level."

Coalitions underscored the importance of developing a common understanding of prevention for everyone—the board members, managers, and staff members. These coalitions provided several types of learning opportunities such as offering Prevention 101 trainings during off-site retreats or standing meetings, holding one-on-one meetings with staff, bringing in charismatic prevention experts, and conducting literature reviews to examine prevention work. One coalition board member recounted, "We didn't know even how to begin. We just knew that we wanted to end [violence]. We just started learning."

Form a prevention team—Integrating prevention into the coalition's structures and functions was viewed as a major change that required a few individuals to spearhead the change process. Four of the case study coalitions formed prevention teams that brought together individuals from different organizational functions, including staff members, managers, and sometimes board members. These teams served as a core group of prevention champions that carried out the action planning process and solicited input from the larger coalition body. As one coalition staff member reported, "The [prevention team] provided wisdom of more and different eyes." After the initial action planning was complete and coalitions had started to make organizational changes to integrate prevention, prevention teams tended to disband, as they were no longer needed. Coalitions had started to view prevention as part of the organization's work, rather than the work of a separate team.

Develop an action plan that leverages existing resources—Per the project's design, coalitions engaged in an action planning process (see Schober & Fawcett, 2015). Coalitions embraced a "don't start from scratch" mind-set when developing their action plans. Coalitions already had relationships and projects with a wide network of organizations, and they decided to spring their prevention efforts from these past successes. For example, one coalition had already collaborated with its statewide Girl Scouts organization to the implement the Girl Scouts Bars Beyond program before DELTA PREP. During the project, the coalition expanded its existing partnership with the Girl Scouts to cosponsor a bystander prevention curriculum for young girls.

Solicit input from coalition staff and leaders to foster a mind-set that "prevention is everyone's job"—After dialoguing to address concerns about integrating prevention, coalitions continued to solicit input from staff and leaders to inform organizational changes and prevention activities. For over 20 years, these coalitions had worked to change complex criminal justice systems with a mind-set that everyone must be involved in the work. Coalitions embraced a similar mind-set that prevention is too big and complex for one person to do it all. Hence, all five coalitions solicited input from the entire coalition body—even staff working on victim services—about how everyone could contribute to addressing prevention. One coalition leader explained, "It's important for

[staff] to own it and [prevention] not be forced upon them . . . to see this as a movement and where they fit within it." Another coalition manager explained,

> The whole point of this was to do a cultural change in the organization, so we didn't know how to do that without involving the organization. There was no way we could have done an action plan and tell everyone this is what you were doing.

Another leader described her approach, "You can't turn the Titanic around in the middle of the Mississippi in 2 minutes. It takes time and space. It's about bringing people with you."

Coalitions used various mechanisms for soliciting input from board members, managers, and staff members about proposed ideas for integrating prevention including holding one-on-one meetings, circulating drafts of action plans, facilitating staff or board meetings, collectively reviewing job descriptions, and hiring a consultant to facilitate a prevention 'dreaming session.'

Enhanced Organizational Readiness—Taken together, the five critical actions of engaging in dialogue, learning about prevention, forming a team, action planning, and soliciting input from the entire coalition further enhanced two key prevention readiness factors: (1) a common understanding of prevention and (2) organizational commitment to prevention.

A common understanding of prevention—According to the five case study coalitions, developing a common understanding of prevention was a key factor for moving forward because many coalition members and staff did not have a clear understanding of prevention. Discussing concerns related to adding prevention to coalition work and offering learning opportunities were identified as key critical actions that facilitated a common understanding of prevention. One coalition manager recounted,

> [When] I was a prosecutor; I thought I was doing prevention. I've now learned intervention is NOT prevention, but it was hard to grasp. It's like doing mental gymnastics. Now when I give talks around the state to prosecutors and police officers about our coalition and domestic violence, I always include prevention by talking about protective and risk factors.

One coalition executive described herself as a prevention skeptic, but after learning more about prevention she now has become a prevention champion:

> I [was] the resident skeptic when it came to prevention. I spent years watching failed prevention programs like DARE. I was leery, but I believed in social change. I now understand that social change and prevention fit together. I'm on board.

Commitment to prevention—Coalitions described how organizational commitment was a key ingredient in moving toward integrating prevention. Commitment developed over time as staff and coalition members resolved their concerns through dialogue, learned more about what prevention really is, and began to provide input into the process of integrating prevention. As the whole organization increased its commitment to prevention, prevention champions served an essential role in maintaining enthusiasm and leading specific changes.

As one associate director stated, “Everyone has to buy into something different . . . to see that prevention can make the problem better. [Prevention] then just becomes a piece of what you do.” One executive director summarized her commitment this way: “It’s a ‘Yes *and*’ approach. Yes, we will work to prevent domestic violence *and* we will continue to provide services.”

Aim 2: How Did DELTA PREP Supports Accelerate Coalitions’ Integration Process?

Twenty-four representatives from 17 of 19 (89%) coalitions completed the final training evaluation survey. Seven coalitions had one staff member and one leader complete the survey, and 10 coalitions had a leader or staff member respond. A majority of coalition representatives (71%) reported that participating in the DELTA PREP was “very valuable” and that DELTA PREP accelerated their coalitions’ prevention capacities “a lot” (71%; Table 3). However, representatives varied in their ratings for the eight supports (Table 4). More representatives rated funding, training, TA, and action planning as “very useful,” compared to coaching hubs, the CPCA, workstation, and online documentation. Six months after the project period, over half of coalitions continued to use action planning, while none continued to use or participate in the online workstation, the online documentation support system, the CPCA, or coaching hubs. Training, TA, and funding were not available 6 months after the project ended, except for one training event offered to all project participants.

From focus groups and interviews conducted with all 19 DELTA PREP coalitions, we found that project supports contributed greatest to coalition’s abilities to integrate prevention through three of the five identified critical actions—offering learning opportunities to develop a common prevention understanding, forming a prevention team, and undertaking action planning as a tool to leverage existing opportunities.

In-Person Training Coupled With Peer-to-Peer Sharing Facilitated Learning About Prevention—Many DELTA PREP coalition members struggled to understand the nuances of prevention from a public health perspective, how it differed from what the coalition was already doing, and how prevention happens. Coalition representatives identified in-person training events as a valuable venue for learning prevention concepts through formal instruction, as well as hearing from other coalitions. Discussion with peers helped coalitions apply abstract prevention concepts to concrete actions and provided coalitions with new ideas for approaching prevention work. Coalitions could share detailed examples with each other, such as strategies for educating coalition members about prevention, engaging men in prevention work, working with media outlets on framing IPV prevention lens, and implementing statewide teen dating violence prevention policies. As one coalition staff member stated, learning from peers “expanded my thinking about what is possible. [I thought] I can do that!” Training participants also found they gained new insights that strengthened their ability to educate the larger coalition body about prevention.

Coalition members also learned about prevention ideas by reviewing the organizational changes and prevention activities that all coalitions recorded in the online documentation system. By the end of the project, coalitions had recorded over 900 entries, which collectively described a wide variety of approaches and actions coalitions used to integrate

prevention and work with external partners on prevention activities. Some coalitions also found TA calls with project staff and coaching hub calls useful venues for learning about other coalitions' prevention work, although most coalitions did not view conference calls as the best venue for discussion with peers. During TA calls, project staff sometimes served as a matchmaker, connecting coalitions that were working on similar prevention strategies. Coaching hubs offered opportunities for coalitions to test out ideas with peers as a sounding board.

Time and Space to Foster Prevention Teams—For coalitions that formed teams to spearhead their prevention integration process, the in-person training events provided opportunities for these teams to coalesce and become change agents for prevention. Training events created dedicated "time and space" for teams to "get on the same page" about prevention before making the prevention case to the larger coalition body. Because coalitions often must prioritize emergent crises, coalition representatives valued having physical and mental space outside their organization to plan for prevention. "We are very action oriented. DELTA PREP has made us stop and think. When we stop, we're able to check and make sure that we're on the same page."

Action Planning Resources Offered a Process to Begin Prevention Integration —The DELTA PREP action planning tools—guidebook, templates, inventory list, and the CPCA[1]—provided a process for the prevention team to brainstorm concrete steps for their coalition to integrate prevention (see Schober & Fawcett, 2015). Reviewing the CPCA provided an opportunity for coalitions to dialogue about their current prevention capacity and to identify focus areas for action planning. The action plan was a springboard for reaching out to the larger coalition. "It got us starting to talk. Just talking about the action plan facilitated our whole process."

Coalitions Experienced Challenges With Coaching Hubs and the Workstation —Although some DELTA PREP coalitions reported that coaching hub calls offered a venue for exploring new ideas with peers, many DELTA and DELTA PREP coalitions reported that coaching hubs did not facilitate peer discussion as they were intended. Coaching hubs were expected to build small communities of practice, where more experienced DELTA coalitions would facilitate an action learning process among less experienced DELTA PREP coalitions (Marquardt, 1999; Marquardt & Waddill, 2004; Parker, Hall, & Kram, 2008; Wegner, McDermott, & Snyder, 2012). In practice, however, most coalitions experienced challenges that impeded their sharing on coaching calls, especially at the beginning of the project.

One factor that influenced group dynamics on coaching calls was that many DELTA coaches were uncomfortable being viewed as *experts* and desired a more co-learning model. As one coach stated, "This is as much as (sic) me learning from them as they are learning from me." In addition, DELTA staff had not previously served as prevention coaches and sometimes were unclear about their role and the appropriate structure for calls (e.g., open forum vs. specific agenda). Most DELTA PREP coalitions were just learning about prevention; staff

[1]DELTA PREP tool kit can be accessed at http://vawnet.org/DELTAPREPToolkit/.

and leaders often did not know enough about prevention work to identify specific questions to ask coaches. As one DELTA coach expressed, “[DELTA PREPS] haven’t done enough yet. They are unsure what they are doing is what they are supposed to be doing.”

Participating in coaching hubs was a new experience for everyone. Project staff had assumed that coaching hub participants had preexisting relationships though their victim service work, but most participants did not know each other well. In addition, coalitions reported that it was challenging to engage in discussion on a conference call. This contributed to an awkward atmosphere in the beginning. One coach explained, “It’s difficult to build community over the telephone.” Last, both DELTA and DELTA PREP representatives lacked clarity about the coaching goals, roles, and expectations. The general guidance provided to coaches by project staff on posing questions and problems for group discussion did not specify a formalized structure or steps for engaging in dialogue.

Project staff had envisioned that coalitions could build a community of practice using the online workstation. In practice, coalition representatives mostly used the workstation to find out about project activities and updates and reviewing other coalitions documented entries, rather than using it for dialoguing or sharing ideas among coalitions (Table 1). Coalitions reported barriers, including difficult navigation, competition with other social media frequently used by coalitions, and beliefs that documents produced by a coalition may not be worthy of sharing in a public venue. As one coalition staff member recalled, “I mostly poached. I didn’t share. Our materials weren’t that good. Who would want to look at them?” Although some coalitions reviewed their peers’ documented entries on the online documentation system, they did not communicate through the workstation about what they were learning from other coalitions’ work. Barriers dampened some coalitions’ initial use of the workstation, which eventually discouraged others from using the workstation for discussion threads and sharing prevention materials.

Discussion

We examined how coalitions integrated prevention in their structures and functions and how the project contributed to coalitions’ integration process. Our findings provide a context for DELTA PREP’s summative evaluation, which demonstrated that coalitions built their prevention capacity (i.e., integrated prevention) and in turn served as catalysts for prevention activities within their states during the project (Freire et al., 2015). We found that prevention integration began with basic organizational prevention readiness, where organizational leaders emerged as prevention champions. These champions ignited coalitions to engage in five critical actions that then enhanced two additional organizational readiness factors—a common understanding of prevention and organizational commitment to prevention. Critical actions reflect not only the specific organization changes coalitions made but also a process where coalitions began to view themselves as prevention organizations.

Funding, training, TA, and action planning resources in particular contributed to coalitions’ abilities to integrate prevention by supporting three critical actions—learning about prevention, fostering prevention teams, and engaging in action planning. In-person training events provided opportunities for coalitions to learn prevention concepts and to share

concrete examples of how they were integrating prevention within their organizations. Two DELTA PREP supports—coaching and the workstation—did not promote a community of practice among coalitions as expected but did provide opportunities for coalitions to review written examples of other coalitions' work. Despite challenges with coaching and connecting on the workstation, coalitions consistently expressed how essential networking with other coalitions was to advancing their prevention work.

The project selected coalitions that demonstrated three aspects of *prevention readiness*: openness to a public health approach to IPV prevention, flexibility to integrate prevention with traditional coalition work, and leadership willingness to engage staff in an integration process. In addition, participant coalitions had stable structures and functions (i.e., general capacities) where prevention could be integrated. Our findings support that initial prevention readiness contributed to coalitions cultivating prevention champions and engaging the whole organization in learning about prevention.

DELTA PREP was designed to facilitate leaders' essential role in creating organizational change (Boonstra, 2004; Butterfoss, Kegler, & Francisco, 2008; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Rogers, 2003; Williams, 2011). We found that leaders who served as prevention champions ignited the prevention integration process, helped the coalition reconcile concerns about a public health approach to IPV prevention, and identified points of convergence with public health, such as social change. Key coalition leaders also participated in project activities and joined prevention teams, which facilitated organizational learning and commitment to prevention. Initiatives that assess innovation readiness before engaging organizations can select highly ready participants or target supports to build leadership motivation and openness for an innovation.

One key driver known to promote organizational change efforts is establishing a "change facilitator team." Successful change teams tend to have a horizontal structure, where leaders and staff members share responsibilities for shepherding desired changes and teams engage in open planning, continual interaction, and collegiality (Hall & Hord, 2001). We found that some coalitions chose to form prevention teams comprising leaders and staff to drive their prevention integration process in the beginning. Three project conditions likely contributed to coalitions forming their prevention teams. First, DELTA PREP required at least one leader to participate in all activities (i.e., training, TA, and coaching), thus increasing leaders' exposure to prevention concepts and dialoguing opportunities. Second, coalitions used in-person training events as a dedicated "time and space" for a core group of staff and leaders to learn, dialogue, and visualize about prevention. In some cases, this core group transitioned into an ad hoc prevention team, and in some cases into a permanent work group charged with planning and implementing organizational prevention changes. Third, the project provided small amounts of funding that could only be used for staff time and resources needed for action planning, which allowed teams to work on prevention as part of their paid work. Initiatives focused on integrating new ideas or practices may benefit from designing supports to encourage team-led change processes that engage both program staff and organizational leaders.

Peer-to-peer learning may be especially important in the IPV field where evidence-based interventions are relatively scarce, and practitioners are viewed as potential innovators for prevention strategies. A major source of innovation comes from building on ideas learned from others (Lehrer, 2012). Well-known models exist for fostering peer-to-peer learning such as coaching (Parker et al., 2008; Fixsen et al., 2005) and communities of practice (Wegner et al., 2012).

However, we found that peer learning needs to be carefully tailored to participants' cultural norms. Our model labeled DELTA coalitions as *coaches* and DELTA PREP coalitions as *participants*, which created a perceived hierarchical structure that was contrary to an egalitarian and co-learning approach valued by most participants and by the broader violence against women movement. In addition, peer-to-peer learning has developmental stages that may require guidance, structured activities, and relationship building in the beginning, rather than an open forum for participants to raise questions and ideas (Parker et al., 2008). Finally, having in-person time to complement any remote access communication seems to still be essential for building relationships and dialogue.

Limitations

Because the five case studies were coalitions that had made substantial progress in integrating prevention by Year 2, they do not necessarily illustrate the process or challenges for coalitions they had not advanced as far in their integration by this time. Other coalitions probably faced challenges that impeded or slowed their progress. Although we cannot generalize findings to the other 14 coalitions, per se, the common pathway found across the five case coalitions identifies places where initiatives could accelerate prevention integration by prompting critical actions. Case study coalitions may have emphasized more positive aspects of their process because they received funding from the CDC Foundation, which also supported case study data collection. However, by Year 2, the project team had already engaged coalitions in a rapid-cycle feedback evaluation where coalitions were encouraged to provide critical feedback and identify challenges. In addition, project staff encouraged coalitions to share challenges about their capacity building on TA calls to problem-solve. Finally, the case study coalitions were selected based on demonstrated actions, and their descriptions of their process were intended to elaborate on their demonstrated success. Because seven coalitions had two respondents who answered the survey, responses from these coalitions may not be independent and may overrepresent the views of these coalitions compared with coalitions that had one respondent.

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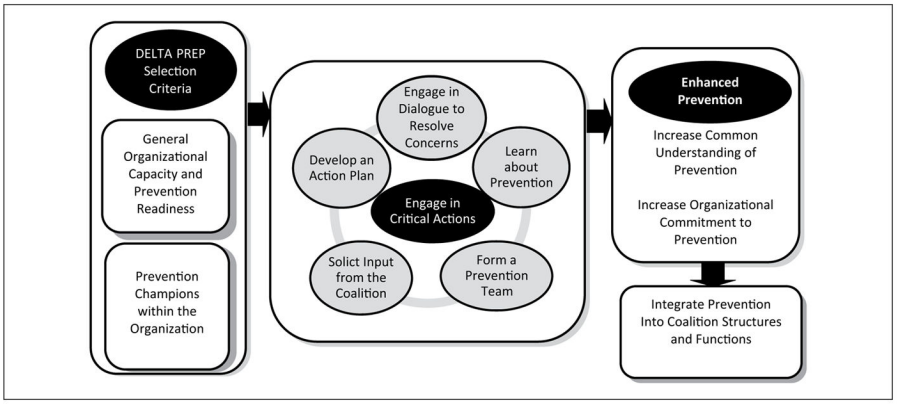

Figure 1.
Process by which coalitions integrate prevention into their structures and processes.

Table 1

DELTA PREP Project Supports.

Project support	Purpose	Implementation
1. Monetary awards	Promote coalition staff members' and leaders' project participation by funding individuals' time for training, technical assistance, and action planning activities, as well as travel to on-site training.	On average, coalitions received a total of $63,000 over the 3-year period. In Years 2 and 3, a total of 18 coalitions received supplemental awards that ranged from $3,000 to $7,000 in order to support implementation of one or more activities in their action plans.
2. Training events	Present key prevention and public health concepts and provide opportunities for coalitions to analyze and discuss how concepts could be integrated with their current IPV work.	The project team, consultants, and partners delivered 10 on-site training events and 5 webinars during Years 1–3. Year 1 training focused on prevention and public health concepts and action planning. Year 2 and 3 trainings were informed by the rapid-feedback evaluation and coalitions' action plans.
3. Technical assistance	Reinforce concepts presented in training, support online documentation data entry, and respond to coalitions' needs and interests as they integrated prevention within their organizations.	Project staff delivered over 320 technical assistance events across the 19 coalitions via national conference calls, individual telephone calls, and written feedback on action plans.
4. Coalition Prevention Capacity Assessment	Generate and use data to inform coalitions' action plans.	All 19 coalitions completed the Coalition Prevention Capacity Assessment in Years 1 and 3. All 19 received customized reports that were reviewed by coalitions at training events for their action and sustainability planning.
5. Action planning resources	Provide a structure and process for coalitions to specify organizational changes and prevention activities and to identify resources and a time line to complete activities.	All 19 coalitions drafted action plans that included organizational and prevention actions. The project provided workbooks, templates, inventories, training, technical assistance, and feedback to support action planning. Inventories listed organizational changes made by DELTA coalitions or supported by research on organizational change.
6. Coaching hubs	Establish a peer network with coalitions funded by CDC since 2002 to build IPV prevention capacity (DELTAs) and DELTA PREP coalitions to support DELTA PREPs as they developed and implemented their action plans.	Project staff divided coalitions into 5 coaching hubs that included 2–3 DELTA coalitions and 3–4 DELTA PREP coalitions. On average, coaching hubs convened by phone once a month throughout the project period, and as needed by e-mail or phone for individual consultations.
7. Online workstation	Facilitate communication among project staff and coalitions and build a community of practice among coalitions.	158 DELTA PREP representatives, DELTA coaches, project staff and consultants were registered to the workstation. The Workstation received an average of 430 visits each month.
8. Online documentation support system	Document organizational changes and prevention activities coalitions completed during the project period and feedback data to coalitions to facilitate their ongoing action planning.	984 entries were made by coalitions reporting their organizational changes and prevention activities to the online documentation system during the 3-year project period with an average of 52 entries per coalition.

Note. DELTA = Domestic Violence Prevention Enhancements and Leadership Through Alliances; PREP = Preparing and Raising Expectations for Prevention; IPV = intimate partner violence; CDC = Centers for Disease Control and Prevention.

Table 2

Data Collection and Analysis Methods by Study Aim.

Aim	Method	Data collection/sources	Participants	Data collection time frame	Analytic approach
1. Describe how coalitions integrated prevention into their structures and functions	Multiple case study	Document review In-person interviews	5 of 19 coalitions	During the project (Year 3)	Qualitative analysis of interviews
2. Describe how DELTA PREP supports accelerated coalitions' integration process	Triangulation of six data sources from the project's rapid feedback and 6-month follow-up	Final training participant survey	17 of 19 coalitions; 27 individuals	During the project (Year 3)	Report of frequencies by response
		Focus groups on project supports (i.e., action planning, CPCA, workstation, online documentation system, in-person training)	9 groups	During the project (Years 1 and 2)	Thematic analysis
		Workstation metrics on participant use	NA	During the project (Years 1 and 2) Within six months after the project	
		Interviews about coaching hubs with DELTA and DELTA PREP coalitions (N = 33)	All DELTA (n = 14) and DELTA PREP (n = 19) coalitions	During the project (Year 1)	
		Interviews with DELTA PREP coalitions	All DELTA PREP coalitions (n = 19)	Within 6 months after project end	
		Attendance records for a postproject training	NA	Within 6 months after the project	

Note. DELTA = Domestic Violence Prevention Enhancements and Leadership Through Alliances; PREP = Preparing and Raising Expectations for Prevention; CPCA = Coalition Prevention Capacity Assessment.

Table 3

Participants Reports of How Valuable and Useful the DELTA PREP Project Was for Building Their Coalition's IPV Prevention Capacity ($N = 24$).

	% (*N*)					
Survey question	***A lot***				***Not at all***	***Don't know***
	1	2	3	4	5	
How much has participating in DELTA PREP accelerated your coalition's capacity to work on primary prevention of IPV?	71 (17)	21 (5)	4 (1)	4 (1)	0	0
	Very valuable				*Not at all valuable*	*Don't know*
	1	2	3	4	5	
How valuable has participating in DELTA PREP been for building your coalition's capacity to work on primary prevention of IPV?	71 (17)	25 (6)	0	4 (1)	0	0

Note. DELTA = Domestic Violence Prevention Enhancements and Leadership Through Alliances; PREP = Preparing and Raising Expectations for Prevention; IPV = intimate partner violence. Percentages are rounded to the nearest whole number.

Table 4

DELTA PREP Participants Reports' of How Useful Project Supports were for Building Their Coalition's IPV Prevention Capacity ($N = 24$).

	% (*N*)				
	Very useful			***Not at all useful***	***Don't know***
Please rate the extent to which each project support was useful for building your coalition's capacity to work on primary prevention of IPV	**1**	**2**	**3**	**4**	
Monetary awards	92 (22)	4 (1)	4 (1)	0	0
Training events	71 (17)	21 (5)	8 (2)	0	0
Action planning resources	54 (13)	33 (8)	4 (1)	0	8 (2)
Technical assistance provided by project staff	50 (12)	33 (8)	8 (2)	4 (1)	4 (1)
Coaching hubs	29 (7)	29 (7)	25 (6)	8 (2)	8 (2)
Coalition Prevention Capacity Assessment	29 (7)	46 (11)	17 (4)	0	8 (2)
Online workstation	13 (3)	50 (12)	29 (7)	4 (1)	4 (1)
Online documentation support system	13 (3)	46 (11)	29 (7)	8 (2)	4 (1)

Note. DELTA = Domestic Violence Prevention Enhancements and Leadership Through Alliances; PREP = Preparing and Raising Expectations for Prevention; IPV = intimate partner violence. Percentages are rounded to the nearest whole number.