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For Healthier Mothers and Babies in California, Start with Safety: Strategies to Address and Prevent Intimate Partner Violence

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List of Abbreviations

ACOG	American College of Obstetricians and Gynecologists
AAIMM	African American Infant and Maternal Mortality
AIM CCI	Alliance for Innovation on Maternal Health – Community Care Initiative
BCP	Birthing Care Pathway
BIH	Black Infant Health
CBO	community-based organization
CBP	Community Birth Plan
CDPH	California Department of Public Health
CHR	community health representative
CHW	community health worker
CMQCC	California Maternal Quality Care Collaborative
CUES	confidentiality, universal education, empowerment, and support
DHCS	California Department of Health Care Services
ECM	Enhanced Care Management
HRSA	Health Resources and Services Administration
IPV	intimate partner violence
MCAS	Managed Care Accountability Sets
MCP	managed care plan
PATH	Providing Access and Transforming Health
PEI	Perinatal Equity Initiative
PHM	Population Health Management Program
TA	technical assistance

Executive Summary

Intimate partner violence (IPV) and maternal morbidity and mortality are public health crises in California that intersect to disproportionately affect people of color. Experiences of IPV can increase the risk of maternal and infant morbidity and mortality; in fact, IPV during pregnancy or immediately postpartum is a leading cause of maternal mortality. IPV during pregnancy is also linked to higher rates of depression; fewer prenatal care visits; and increased likelihood of stillbirth, preterm delivery, and fetal injury. California policymakers and programs have implemented many recent initiatives to address maternal mortality, decrease disparities, and improve birth outcomes in the state. However, integrating IPV prevention and intervention services into these initiatives is essential to fully address the root causes of high maternal mortality rates.

This policy brief highlights evidence-informed strategies and opportunities to integrate IPV services into maternal health care and capitalize on the opportunities presented by recent maternal health initiatives. This brief presents recommendations for preventing and addressing IPV (1) during pregnancy, (2) through postpartum care, and (3) through perinatal care delivered by doulas. The Department of Health Care Services (DHCS), managed care plans (MCPs), California Department of Public Health (CDPH), California Maternal Quality Care Collaborative (CMQCC), health care providers, local health jurisdictions, care coordinators, hospitals, and policymakers should pursue the recommendations listed in Table 1 through the strategies summarized in the brief.

Table 1. High-level recommendations

Recommendation		Actor
Strategies to prevent and address IPV during pregnancy		
1.	Partner with IPV experts to raise awareness among health care providers, care coordinators, and local health jurisdictions administering maternal health programs about the prevalence and impacts of IPV among pregnant people.	DHCS, CMQCC, CDPH, MCPs
2.	Ensure health care providers receive training to prevent and address IPV among pregnant and postpartum people.	MCPs, DHCS
3.	Equip providers with tools and strategies to offer patients culturally responsive, nonjudgmental, and supportive prenatal education about adverse developmental outcomes associated with prenatal IPV experiences.	MCPs
4.	Partner with IPV advocates to safeguard survivor privacy within the Medi-Cal Connect system.	DHCS, MCPs, health care providers
5.	Encourage MCPs to build partnerships with IPV CBOs to serve as Enhanced Care Management (ECM) and Community Supports providers for pregnant and postpartum members who are at risk of or experiencing IPV.	DHCS, MCPs
6.	Partner with IPV advocacy organizations to design and tailor culturally responsive community education programs.	MCPs, health care providers
7.	Identify, support, and fund existing multi-sectoral collaboratives working on social drivers of health, improved maternal health outcomes, and birth equity, particularly among communities of color, to infuse an IPV lens into these efforts.	DHCS, CDPH, MCPs
8.	Continue to expand and incorporate the nonmedical workforce, including community health workers, community health representatives, *promotores*, and IPV advocates, into maternal health programs, and require training on best practices for addressing IPV.	DHCS, MCPs
9.	Screen all patients for mental health conditions consistently throughout the perinatal period, given that previous experience of IPV is a significant risk factor.	Health care providers

Recommendation	Actor
Strategies for incorporating interventions for the postpartum period	
10. Ensure comprehensive postpartum visits address IPV through universal education and referrals.	MCPs
11. Disrupt the cycle of violence by working with IPV advocacy organizations to train pediatric providers on a two-generation IPV intervention approach using a standard curriculum and covering IPV services during home visits.	DHCS, MCPs, pediatricians
12. Link pregnant and postpartum people experiencing or at risk for IPV to parenting and family relationship programs to strengthen connections to community supports and IPV services.	Health care providers, people working in public health programs
13. Promote economic stability for pregnant and postpartum people experiencing or at risk for IPV.	Policymakers
Strategies to engage doulas to address IPV	
14. Provide economic guidance and support to help doulas become billable providers, receive appropriate billable rates, and explore alternative payment options and compensation.	DHCS, MCPs
15. Train doulas to address IPV through prenatal and postpartum care.	DHCS

Introduction

Intimate partner violence (IPV) has a substantial negative effect on maternal health.[i] Recent and emerging California policies have spurred widespread momentum to address long-standing disparities in maternal health. It is essential to act now to imbed IPV prevention and intervention services in maternal health initiatives. The purpose of this policy brief is to highlight evidence-informed strategies and opportunities to integrate IPV services into maternal health care in California to improve maternal health and birth outcomes and reduce disparities.

IPV is a pervasive issue in California and across the United States. Two in five women in the United States (41 percent) and more than one-third (35 percent) of women in California have experienced IPV in their lifetimes.[1,2] From 8 to 37 percent of women have experienced reproductive coercion in their lifetimes,[3] which is a specific form of IPV that involves exerting power and control over reproduction through interference with contraception and pregnancy coercion.[4,5,6,7] People of color are at increased risk of experiencing IPV.[8] In the United States, 44 percent of Black women, 46 percent of American Indian or Alaska Native women, and 54 percent of multiracial women have experienced IPV in their lifetimes.[9]

Maternal mortality is a parallel public health crisis and has a similarly disproportionate effect on people of color and parents with low incomes. From 2018 to 2020, the pregnancy-related mortality ratio in California was three to four times higher for Black pregnant people than the ratio for Hispanic/Latinx, Asian/Pacific Islander, and White pregnant people. The pregnancy-related mortality ratio for people covered by Medi-Cal, California's Medicaid program, was more than double the ratio for those covered by private insurance.[10]

IPV during pregnancy has significant negative consequences on the physical and mental health of pregnant people.[11] IPV can worsen during pregnancy[12] and IPV during pregnancy or immediately postpartum is a leading cause of maternal mortality.[13,14] ***Pregnant people are more likely to be murdered during pregnancy or immediately postpartum than they are to die from hypertensive disorders, hemorrhage, or sepsis, the three leading obstetric causes of maternal mortality.***[15] People experiencing IPV during pregnancy are more than twice as likely to experience depression than those not affected by IPV.[11] IPV during pregnancy is associated with many negative health impacts for both the pregnant person and the fetus. Pregnant people experiencing IPV are less likely to receive adequate prenatal care[16] and violence during pregnancy can result in stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, or low birth weight.[11,12] People who require hospitalization for physical violence while they are pregnant are at eight times the risk of fetal death and nearly six times the risk of neonatal death.[11]

Amid high levels of maternal morbidity and mortality in the state, particularly among people of color, California has implemented several initiatives to improve maternal health and reduce health disparities. (Appendix A summarizes some of these initiatives.) For example, in January 2023 the state implemented new Medi-Cal benefits, such as expanding Medi-Cal coverage to 12 months postpartum and covering doula services.[17,18] California is also funding additional education and training for midwives who support people with low- to moderate-risk pregnancies with a whole-person approach throughout pregnancy and postpartum.[19] The California Department of Public Health (CDPH) is currently addressing Black maternal and infant morbidity and mortality through three initiatives: the Perinatal Equity Initiative (PEI), Black Infant Health (BIH), and Community Birth Plan (CBP).[20]

[i] We acknowledge and respect that pregnant, postpartum, and parenting people have a range of gender identities and do not always identify as women or mothers; therefore, this brief uses nongendered language when possible.

California's Department of Health Care Services (DHCS) is implementing efforts to improve maternal health and reduce disparities. The DHCS 2022 Comprehensive Quality Strategy's 50x25 Bold Goals aim to reduce maternity care disparities for Black and Native American people by 50 percent and improve maternal depression screening by 50 percent by 2025.[21] In addition, DHCS began requiring Medi-Cal managed care plans to report on maternal health and health equity measures through the Managed Care Accountability Sets (MCAS) for reporting year 2024.[22] In 2023, DHCS began developing its Birthing Care Pathway (BCP), a comprehensive policy and care roadmap that aims to reduce maternal morbidity and mortality and address significant racial and ethnic disparities in maternal health outcomes among Black, American Indian/Alaska Native, and Pacific Islander individuals. The BCP outlines new and ongoing Medi-Cal care delivery, policy, and program initiatives for pregnant and postpartum people from conception through 12 months postpartum and aligns them with related Medi-Cal benefit and payment strategies. BCP policies focus on improving access to providers, strengthening clinical care and care coordination, providing whole-person care, and modernizing how Medi-Cal pays for maternity care. The BCP includes opportunities to address and prevent IPV by (1) requiring that Medi-Cal risk assessments include IPV screening, (2) addressing health-related social needs of pregnant and postpartum members, and (3) emphasizing the importance of trauma-informed care.[23]

In October 2023, the Health Resources and Services Administration (HRSA) awarded California $10 million through the State Maternal Health Innovation grant, which the California Maternal Quality Care Collaborative (CMQCC) will administer. The CMQCC will work with the Office of the Surgeon General, CDPH, and DHCS to convene a Maternal Health Steering Committee and Task Force to issue a baseline assessment, develop and implement a strategic plan, and fund community-centered interventions to improve perinatal outcomes.[24] In January 2025, California received $17 million in federal funding to implement the 10-year Centers for Medicare & Medicaid Services (CMS) Transforming Maternal Health (TMaH) Model. In synergy with its BCP, DHCS will work with managed care plans (MCPs), providers, and community partners to implement this value-based payment and care delivery model that aims to improve maternal health outcomes and reduce health care expenditures through a whole-person approach to pregnancy, childbirth, and postpartum care.[25]

On a national level, in summer 2023 the federal government released the landmark U.S. National Plan to End Gender-Based Violence, presenting a comprehensive approach to prevent and respond to sexual violence, IPV, stalking, and other forms of gender-based violence.[26] Maternal–infant health and efforts to confront structural racism that contributes to health disparities in maternal morbidity and mortality are also high priorities on national and state policy agendas (see Appendix A).[27,28,29]

Given the significant impact of IPV on maternal health, the current California and federal policy momentum to address long-standing disparities in maternal health offers a synergistic opportunity to integrate IPV within the maternal health initiatives mentioned earlier and others and thereby advance health equity. Mathematica conducted a targeted evidence review and key informant interviews to identify evidence-informed strategies to address and prevent IPV that promote maternal and infant health, advance equity, and improve quality of care. (Appendix B describes our approach).

This brief presents recommendations for preventing and addressing IPV (1) during pregnancy, (2) through postpartum care, and (3) through perinatal care delivered by doulas. We explain the evidence supporting each approach and highlight the actors (such as MCPs, DHCS, and CDPH) that can implement each recommendation.

Evidence-Informed Recommendations and Implementation Strategies

I. Strategies to prevent and address IPV during pregnancy

Pregnancy can often be an especially risky period for IPV; many pregnant people report their experience of abuse started or intensified when they became pregnant.[12] IPV during pregnancy can jeopardize both maternal and infant health. We offer the following recommendations to support a coordinated, trauma-informed,[ii] and survivor-centered[iii] response to IPV.

Recommendation 1. Partner with IPV experts to raise awareness among health care providers,[iv] care coordinators,[v] and local health jurisdictions administering maternal health programs about the prevalence and impacts of IPV among pregnant people. [DHCS, CMQCC, CDPH, and MCPs]

DHCS, CDPH, and MCPs should partner with IPV advocates and organizations that can provide the expertise to craft trauma-informed, survivor-centered, and culturally and linguistically sensitive educational campaigns and messages.

- **Strategy 1.1. Continue and expand opportunities for maternal health services and programs to connect with IPV advocates and organizations through the BCP work. [DHCS]** Throughout the BCP's implementation and ongoing development, DHCS must continue and expand collaborations with IPV advocates to incorporate survivor-centered perspectives. While the policies DHCS is pursuing and exploring through the BCP have potential to address IPV, strong representation from the survivor community is essential to ensure sensitivity and safety as efforts progress.
- **Strategy 1.2. Include IPV experts, such as Futures Without Violence, the California Partnership to End Domestic Violence, and other IPV service organizations, as part of the CMQCC Maternal Health Steering Committee and Maternal Health Task Force. [CMQCC, DHCS, and CDPH]** The Maternal Health Task Force will be multidisciplinary and diverse (see Introduction).[24] Futures Without Violence,[vi] the California Partnership to End Domestic Violence,[vii] and other IPV organizations can provide essential expertise on how to address the impacts of IPV in maternal health to achieve the Task Forces' goals of improving perinatal outcomes.

[ii] Trauma-informed approaches deliver care with an understanding of the vulnerabilities and experiences of trauma survivors, including the prevalence and physical, social, and emotional impacts of trauma. Elements of trauma-informed care include awareness of the effects of trauma on survivors; physical and emotional safety for survivors; trustworthiness in processes and relationships; empowerment in decision-making processes; and inclusiveness for all, including people from historically marginalized groups and people with disabilities. Adapted from the Office for Victims of Crime and the National Network to End Domestic Violence.

[iii] A survivor-centered approach creates a supportive environment, ensures safety and dignity to promote a survivor's recovery, and reinforces the survivor's capacity to make decisions. Adapted from USAID.

[iv] In this brief, health care provider refers to physicians, obstetricians, nurses or midwives.

[v] In this brief, care coordinators include community health workers, *promotores*, community health representatives, social workers, and patient navigators.

[vi] Futures Without Violence trains medical professionals to respond to IPV and works with advocates and policymakers to educate and build sustainable community leadership around violence prevention.

[vii] The California Partnership to End Domestic Violence is California's recognized domestic violence coalition and represents more than 1,000 survivors, advocates, and organizations across the state.

- **Strategy 1.3. Help health care providers understand the impacts of IPV and the opportunity to improve key outcomes and advance health equity by addressing IPV. [MCPs]** IPV increases the risk for pregnancy complications and poor maternal health outcomes. Health care providers can fill a critical role in reducing violence and the adverse health burdens associated with IPV with early detection and treatment of IPV. DHCS incentivizes MCPs to narrow health disparities and improve maternal and birth outcomes, including through specific quality and performance measures that are linked to compensation in value-based care in MCP contracts. As Table 2 illustrates, IPV impacts many risks and health conditions that MCPs and health care providers report on through the MCAS. MCPs should engage IPV experts and consult evidence-informed resources to provide this education and support to their providers. MCPs can use the California Partnership to End Domestic Violence's resource list as a starting place to identify IPV experts and resources in their communities.[30]

Table 2. Crosswalk of Managed Care Accountability Set measures with IPV-associated risks

Relevant MCAS measures[22]	IPV-associated risks
Prenatal and Postpartum Care: Postpartum Care*	IPV during pregnancy or immediately postpartum is a leading cause of maternal mortality. Black pregnant people are three to seven times more likely than White pregnant people to die from pregnancy-associated homicide.[13,14]
Prenatal and Postpartum Care: Timeliness of Prenatal Care*	People experiencing IPV before and during pregnancy are more likely to receive inadequate prenatal care.[16] Those experiencing IPV during pregnancy are two times more likely to miss prenatal care visits or initiate prenatal care later than recommended compared to people not experiencing IPV.[11]
Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate	One recent study found IPV was not associated with an increased risk of cesarean delivery, but IPV was associated with increased risk of other adverse obstetric outcomes, such as preterm birth and neonatal intensive care unit admission.[31] However, older studies found people who experienced IPV had a higher rate of cesarean delivery.[32]
Prenatal Depression Screening and Follow Up/Postpartum Depression Screening and Follow-Up	Experiencing IPV during pregnancy is associated with high depression rates during pregnancy and postpartum; people experiencing IPV during pregnancy are 2.5 times more likely to experience depression.[11]
Well-Child Visits for the First 30 Months of Life—0 to 15 months	Children of people experiencing IPV are less likely to receive the recommended number of well-child visits within their first year of life. In addition, children of people experiencing IPV are less likely to have a regular site for well-child care or primary pediatric provider.[33]

Note: DHCS identified the measures indicated with an asterisk (*) for stratification by race and ethnicity.

Recommendation 2. Ensure health care providers receive training to prevent and address IPV among pregnant and postpartum people. [MCPs, DHCS]

People affected by IPV are likely to interact with health care providers (for example, nurses, physicians, or midwives), making this a critical opportunity to offer universal education, assessment, and response to IPV, even for those who do not disclose violence (see the following CUES description). Training health care providers on how to offer prevention education and response to IPV is an important intervention to improve providers' knowledge and self-perceived readiness to respond to IPV, and subsequently the care and health outcomes for IPV survivors. IPV advocacy organizations are well positioned to help health providers respond to IPV. MCPs should partner with IPV experts to offer trainings and continuing education. Universal education can prevent and assess for IPV and offer harm-reduction strategies and tailored care plans, including support getting to health care appointments or managing care if an abusive partner is interfering. Making warm referrals to local IPV programs can help mitigate

the impact of these poor outcomes. Universal education is a best practice and, if combined with screening, can encompass a range of IPV experiences. The universal education approach centers equity and focuses on treating patients with respect by giving them key information about healthy and unhealthy relationships and where to get supports without requiring disclosure first.[34,viii]

- **Strategy 2.1. Adopt and provide training to health care providers on confidentiality, universal education, empowerment, and support (CUES). [MCPs]** Despite implementation of the 2012 American College of Obstetricians and Gynecologists (ACOG) recommendation to screen for IPV during pregnancy and postpartum and the United States Preventive Services Task Force recommendation to screen women of reproductive age for IPV and provide or refer individuals who screen positive to support services,[35,36] screening rates remain low, with slightly more than one-quarter of pregnant people being screened during pregnancy.[37] Many survivors do not disclose their experiences of IPV or delay disclosure; some survivors are more likely to disclose their experiences of IPV with friends or family members than formally report to health care providers. Fear of judgment, shame, worries about data privacy issues, and concerns about child welfare involvement make disclosure challenging, and the disclosure itself can amplify a survivor's immediate risk of harm; thus, rates of disclosure in health care settings are much lower than the known prevalence of IPV.[38,39] Therefore, screening in isolation is not a sufficient method to address or respond to IPV; universal education is essential, whether in combination with or in place of screening. In addition to universal education, MCPs can support health care providers to follow professional association guidelines for IPV screening during and after pregnancy by adopting and integrating a validated IPV screening tool, endorsed by IPV advocates, into the electronic health record. The US Preventive Services Task Force provides a detailed discussion of IPV screening tools.[40]

> *"CUES flips the problem with screening; low percentages screen positive for IPV. In CUES, 100 percent of people know that other people are in complicated relationships besides me."*
>
> *— Key informant*

- **Strategy 2.2. Augment opportunities for maternal health service providers and programs to partner with IPV advocates and organizations. [DHCS, MCPs]** Staff and providers will need specialized training to implement BCP policies to include IPV screening as part of Medi-Cal risk assessments and to enhance trauma-informed care. Throughout the BCP's implementation, DHCS must continue and expand collaborations with IPV advocates to implement survivor-centered policies and further integrate IPV service organizations into the Medi-Cal care delivery landscape. Although DHCS BCP workgroups have incorporated diverse perspectives, including pregnant and postpartum Medi-Cal members,[23] DHCS can expand representation from and encourage MCP and provider partnerships with IPV survivors and advocates. As DHCS continues to explore strategic opportunities to increase universal education and provider IPV training to improve maternal health through the BCP, partnerships with IPV experts will be critical. Connecting clinical services with IPV advocates will strengthen linkages and make these connections part of the continuum of care.

[viii] Advocates are working to reform California's mandatory reporting law, which requires health care providers to report to local law enforcement if they provide medical services to a patient who they suspect may be suffering from a physical injury caused by a firearm or assaultive or abusive conduct.

- **Strategy 2.3. Support effective trauma-informed care with organizational- and clinical-level policies and practices. [MCPs]** An effective response to IPV requires a trauma-informed approach, meaning providers and staff recognize the impact of current and past trauma on patients' health and well-being and promote healing in a safe and supportive environment. Adopting a trauma-informed approach to care can improve patients' engagement and health outcomes and prevent staff burnout. Organizational practices shift the health care setting's culture to address the potential for trauma in both patients and staff, and trauma-informed clinical practices address the impact of trauma on individual patients.

  - **Strategy 2.3.1. Adopt trauma-informed organizational practices that support health and public health workforces and enable them to access the services they need to heal from their own experiences of IPV or trauma. [MCPs and local health jurisdictions]** Health care staff and social workers working with survivors often experience their own secondary traumatic stress.[41,42,43] A key informant highlighted the urgent need for better strategies to support health and social service providers, stating inadequate support for these workforces is "… destroying the people that help the people." The key informant explained, "Thinking about how we build in workforce sustainability relative to people being able to hold trauma, how can we build a workforce that takes care of its people?" Three evidence-informed strategies to support staff working with patients and families in health care and public health include strengths-based attitudes and practices, reflective practice, and reflective supervision. For a more in-depth exploration and descriptions of these strategies, see:

    "It's hard to hear hard stories… how can we build a workforce that takes care of its people?"

    — Key informant

    - Strengthening Trauma-Informed Staff Practices[44]
    - Key Ingredients for Trauma-Informed Care Implementation[45]
    - Adopting a Trauma-Informed Approach to Improve Patient Care: Foundational Organizational-Level Steps[46]

  - **Strategy 2.3.2. Strengthen trauma-informed clinical practices by training health providers and nonclinical staff to recognize trauma and healing as universal experiences and create a safe, supportive, and nonjudgmental setting for patients, including pregnant people with experiences of IPV. [MCP]** Incorporating an IPV and trauma-informed approach recognizes the ways in which IPV can influence survivors' symptoms and presentations, their experience of clinical interactions, and their responses to treatment. Clinical survivor-centered approaches prioritize survivors' voices and autonomy to disclose IPV in their own time and access resources through a variety of channels to match their readiness and self-defined needs.[47] Trainings should equip providers to guide discussions that help shape birthing plans to maximize the patient's agency and comfort, consider partner interference, avoid retraumatization, and enhance the likelihood the patient will engage in preventive care during and after pregnancy.[48,49]

- **Strategy 2.4. Ensure health care providers and care coordinators receive training and partner with IPV advocates to provide adaptable and culturally, linguistically, and contextually specific safety planning. [MCPs]** Safety plans can include strategies to help patients to be safer if leaving the abusive partner is not feasible. Health care providers should offer supportive care regardless of a survivor's readiness to leave an abusive relationship. Health care

"When you are in a violent relationship your needs are not about the health care but about your safety."

— Key informant

providers do not have to navigate safety planning on their own; they can partner with IPV organizations to offer safety planning to help survivors prepare to navigate dangerous situations in the safest way possible. Table 3 lists key components of safety planning.[50] Safety planning must also address culturally specific needs and histories: for example, recognize the violence inherent in threatening to remove children from their homes, especially in Native communities, and that fear might prevent a survivor from disclosing they need help. For some, focusing on staying in the relationship more safely might be more appropriate than leaving a tight-knit community that provides support and healing in other ways.

Table 3. Effective safety planning components

Effective safety planning components	
• Center empowerment and advocacy	• Identify threats
• Address individual strengths and needs	• Link to resources
• Educate individuals about IPV	• Provide behavioral health support as needed
• Elevate parenting strategies that support child well-being postpartum	• Include follow-up safety and wellness checks

Recommendation 3. Equip providers with tools and strategies to offer patients culturally responsive, nonjudgmental, and supportive prenatal education about adverse developmental outcomes associated with prenatal IPV experiences. [MCPs]

MCPs can work with IPV experts to identify and share empowering educational resources appropriate for their patient populations, such as those related to adverse developmental outcomes associated with prenatal IPV exposure. MCPs can share these resources directly with their subscribers and serve as primary prevention for high-risk patients (for example, those with lower prenatal care visits and/or prenatal substance use). See Words Matter for best practices for empowering and humanizing strategies for providers.[54]

- **Strategy 3.1. Orient providers to existing tools to support maternal and infant health and safety. [MCPs]** Examples of evidence-based educational resources include Connected Parents, Connected Kids and Text4baby. See Exhibit 1 for details.

Recommendation 4. Partner with IPV Advocates to Safeguard Survivor Privacy within the Medi-Cal Connect System. [DHCS, MCPs, health care providers]

In 2024, DHCS began rolling out Medi-Cal Connect, a statewide data sharing software where Medi-Cal members, DHCS, health plans, state partners and agencies, health care delivery partners, local

Exhibit 1. Tools that can help protect pregnant people and their children.

- Connected Parents, Connected Kids is a tool that home visitors, perinatal health care providers, and other child-serving professionals can distribute to patients during universal education. The safety card outlines questions survivors can ask themselves about their relationships, birth control use, and parenting, while offering supportive messages and referrals to national support services for help. This tool also prompts providers with quick phrases to improve discussions with survivors about the impact of IPV on their parenting and children and offers strategies to support their children and other parents who might be experiencing IPV.[51]
- Text4baby is a free mobile application and information service designed to promote maternal and infant health through text messaging, from pregnancy until a baby's first birthday. Messages from health care professionals address topics such as prenatal care, signs and symptoms of labor, urgent alerts, breastfeeding, nutrition, exercise, oral health, immunizations, developmental milestones, safe sleep, family violence, injury prevention, mental health, and substance abuse.[52] Text4baby's ongoing evaluation efforts indicate the service supports increased knowledge and increases the likelihood participants will access health care services and speak with their providers about specific topics.[53]

business partners, and Tribal/Urban Indian Organizations can access aggregated Medi-Cal member data on health care utilization, social services, public health, behavioral health, and demographic and socioeconomic variables.[55] Authorized agencies and providers can use Medi-Cal Connect to evaluate the full scope of what services members are receiving, identify gaps in care, and connect members to necessary supports, including services provided by connected community-based organizations (CBOs).[56] In late 2026, Medi-Cal members will be able to access Medi-Cal Connect to review their benefits and enrollment status and review eligibility for additional Medi-Cal programs. While this has great potential to link survivors with the services they need, there are also strong concerns over the confidentiality of the data, who has access to the data, and how survivors can control their data. Before implementation, DHCS must partner with IPV advocacy organizations to implement strong privacy and security measures unique to ensuring IPV survivor safety.

- **Strategy 4.1. Safeguard survivor privacy and safety when documenting and sharing IPV risk data and when making referrals through Medi-Cal Connect. [DHCS, MCPs, health care providers]** For IPV survivors, there is a serious concern about how information is shared and with whom, and there can be serious negative consequences, such as harmful retaliation from their partner if they discover abuse has been disclosed. As Medi-Cal Connect allows for greater data interoperability, DHCS must account for the increased likelihood of entities inadvertently sharing private IPV data or that unauthorized users can access confidential health data. Prior to Medi-Cal Connect's implementation, DHCS should collaborate with survivors and IPV advocacy organizations to determine the precautions and design protocols necessary to ensure survivors' confidentiality, privacy needs and protect safety. An important part of this is ensuring that patients provide informed consent that they know how and when their information would be accessed. Survivors and IPV advocacy organizations are intimately familiar with survivors' complex privacy and confidentiality needs and can offer state agencies invaluable insight to ensure that referral processes are survivor centered and information is kept confidential. DHCS should also require entities with Medi-Cal Connect access to receive training on IPV-specific confidentiality procedures, to protect IPV and other sensitive data behind a firewall, and to limit access to IPV data. For IPV organizations that receive Medi-Cal Connect access, MCPs should provide technical assistance resources and additional funding to change IPV service organizations' preferred practices for receiving referrals. IPV organizations typically accept referrals by phone call, which does not require submitting patient details electronically.

Recommendation 5. Encourage MCPs to build partnerships with IPV CBOs to serve as Enhanced Care Management (ECM) and Community Supports providers for pregnant and postpartum members who are at risk of or experiencing IPV. [DHCS, MCPs] ECM is a statewide Medi-Cal benefit where members with complex needs receive comprehensive care management, including connections to medical and social services. To receive ECM services, members must fall into one of nine Populations of Focus, such as the Birth Equity Population of Focus, which includes pregnant or postpartum beneficiaries who are subject to racial or ethnic disparities. MCPs are required to contract with providers specializing in care for the Birth Equity Population of Focus such as doulas, midwives, substance-use disorder specialists, housing navigators, and others who provide Community Supports to members.[57] MCPs should contract with IPV CBOs to provide ECM services and Community Supports to pregnant and postpartum members who are at risk of or experiencing IPV, as these organizations have valuable expertise in how to care for these members.[23] To encourage partnerships between MCPs and IPV CBOs, DHCS should establish enforceable network adequacy parameters for MCP service provision, perform outreach to potential ECM providers, and provide technical assistance (TA) as providers navigate the MCP contracting space.

- **Strategy 5.1. Provide TA to IPV CBOs becoming ECM providers. [DHCS]** Many CBOs becoming ECM providers have never contracted with MCPs or provided Medi-Cal services before, presenting challenges with billing, contracting, and ECM implementation. As IPV CBOs build partnerships with MCPs, DHCS should perform outreach to connect new providers to TA resources through the Providing Access and Transforming Health (PATH) TA Marketplace, an online resource of trainings and best practice models for ECM. Training modules on the PATH TA Marketplace are developed by successful ECM providers, showcasing successful implementation strategies and information.[58] As MCPs contract with IPV CBOs, DHCS should identify example partnerships and reach out to providers to develop additional trainings specific to IPV services.

Recommendation 6. Partner with IPV advocacy organizations to design and tailor culturally responsive community education programs. [MCPs and health care providers]

MCPs and health care providers should recognize the role extended families and communities play in birthing plans in various cultures, and partner with IPV advocacy organizations to offer culturally responsive supportive resources to pregnant peoples' chosen extended networks. MCPs and health providers could make educational resources available in the following ways: in-person trainings or community presentations, free webinars, information on the MCP website, print or electronic newsletters, hard-copy resource packets, or resource cards displayed throughout health care settings. It is important that information is culturally appropriate and available in a variety of languages. One key informant explained, "Often in a western worldview, it's just the pregnant person and their provider; but within American Indian communities it can be a person supported by a whole network, and that whole network needs to be supported with the same kind of education because they are so critical (especially in after-birth care)." The key informant concluded, "Responsibility and burden cannot be held exclusively on the pregnant person; they are already experiencing so much burden and stress that we should be surrounding them in a community that is equipped with all the information they need." This education could better position extended family and community networks with the resources they need to be strong supports for maternal and infant health and safety.

- **Strategy 6.1. Refer patients to culturally responsive community-centered supports. [MCPs and health care providers]** One key informant underscored the importance of providing services in nonmedical settings, explaining "We're really interested in community-centered, family-centered supports that are out of the medical model, because of the harm associated with it," referencing the harm caused by centuries of racist structural designs, implicit bias, and discriminatory behaviors that have permeated the health care system and lifting up the role health care providers and programs can play in connecting survivors to community-centered supports. MCPs could support these efforts by joining work groups or steering committees, sponsoring local education and outreach activities, or spotlighting these efforts in provider and member newsletters.

Recommendation 7. Identify, support, and fund existing multi-sectoral collaboratives working on social drivers of health, improved maternal health outcomes, and birth equity, particularly among communities of color, to infuse an IPV lens into these efforts. [DHCS, CDPH, and MCPs]

With the growing recognition of the interplay of social conditions as risks or protective factors, multisectoral collaboratives are working to address root causes and provide community-based solutions to confront health inequities. Social drivers of health are often linked to risk and impacts of IPV, including poor nutrition, housing instability, and lack of transportation as a barrier to accessing health care. Experiencing IPV is associated with an increased likelihood that an individual does not have food security, transportation, child care, or time off work.[16,59,60] One key informant from DHCS said, "I think that there is so much to be learned from the good work that is done on the public health side and we are trying to be better partners and collaborators in looking at the total needs." Another key informant highlighted the need to coordinate and co-locate services to minimize barriers to access, explaining, "If you are trying to get all of the perinatal support services, even in Oakland you will be driving around all day long and what about people with limited transportation. Being pregnant or with a newborn getting around is hard; it is a time of restricted mobility and yet we ask people to do all this running around."

"We are trying to be better partners and collaborators in looking at the total needs."

— *Public health informant*

To minimize silos and address these social drivers of health, DHCS, CDPH, and MCPs must first identify linkages and encourage collaboration and referral between maternal health programs and IPV services. Drawing on cross-cutting taskforces could also present an opportunity to coordinate funding for shared goals across agencies and organizations.

- **Strategy 7.1. Identify, fund, and link to promising, culturally responsive local multisectoral collaboratives and community-based programs addressing risks and promoting protective factors to address social drivers of health, including IPV. [MCPs and local health jurisdictions]** Culturally responsive community-based programs that address maternal and infant health through social drivers of health are important intervention opportunities for IPV. Table 4 highlights select maternal health programs that address SDOH and could incorporate IPV.

MCPs and local health jurisdictions can identify and fund existing SDOH multisectoral collaboratives using a newly released toolkit from the Institute for Medicaid Innovation.

Table 4. Maternal health programs that address SDOH and could incorporate IPV

Program	Details
African American Infant and Maternal Mortality Prevention Initiative	The African American Infant and Maternal Mortality (AAIMM) Prevention Initiative in Los Angeles County addresses root causes of birth disparities. One of AAIMM's evidence-based programs is group prenatal care that provides culturally specific care. Other programs provide direct services to pregnant people to support whole-person care and social support.[61]

Program	Details
Black Infant Health	The Black Infant Health (BIH) Program is a group-based intervention focused on improving maternal and infant health outcomes by helping Black women and birthing people build resilience, gain social support, and improve skills for reducing stress—proven strategies for addressing IPV.[62,63] BIH is a group-based intervention that provides prenatal and postpartum sessions as well as healthy meals, transportation, and other supportive services. The program demonstrated improvements in health outcomes among Black pregnant people. An evaluation of this program showed significant positive changes, including a 60 percent decrease in participants reporting no practical or emotional support and a 35 percent decrease in depressive symptoms.[64]
Black Mothers United	Black Mothers United offers Black pregnant and postpartum people support and services, including doulas, lactation support, health and wellness services such as yoga and mindfulness, and opportunities to socialize with other expecting people to share experience in a judgment-free space.[64]
Humboldt County Better Birthing	In Humboldt County, Tribal leaders and a local hospital engaged in a community codesign process to establish their "Better Birthing" work for Native pregnant people. The community designed solutions to address health disparities and implemented culturally responsive birthing care initiatives, such as building a more diverse and reflective workforce, increasing the agency of pregnant people, expanding the role of Native support systems in birthing environments, and accommodating traditional practices, such as waiting to register births until after the blessing and naming ceremony.[65]

Partnerships between MCPs and CBOs improve health outcomes, improve quality-of-care metrics, and advance MCPs' economic justice and business enterprise requirements.[66]

- **Strategy 7.2. Map maternal and public health services offered at the local level to help the broader maternal health workforce link pregnant people to whole-person care. [CDPH]** Absent a comprehensive understanding of maternal health services at the local level, health providers cannot consistently or effectively make connections between and across providers. CDPH's Maternal, Child and Adolescent Health Division and Injury and Violence Prevention Branch represent important opportunities for alignment and braiding with health systems to prevent IPV and effectively support pregnant survivors with culturally responsive services to meet their physical, social, and emotional needs. CDPH should develop and disseminate a comprehensive list of maternal public health services sortable by local counties or regions and identify whether or how CDPH violence prevention initiatives integrate with local maternal health programs and services. CDPH could then share this information with MCPs to enable health care providers, care coordinators, and others involved in maternal health care to link to all available services to support maternal health and safety. CDPH should also help ensure that this list is kept up to date.
- **Strategy 7.3. Encourage providers to establish a referral process to survivor-centered, culturally and linguistically appropriate services. [MCPs]** MCPs should make connections with care coordinators, including community health workers (CHWs), to support referrals. MCPs can consult available mapped lists of maternal health and IPV services from DHCS or CDPH (Strategy 5.2), in combination with 2-1-1,[67] to support health care providers in establishing strong formalized partnerships with IPV organizations and facilitating a warm referral: a supported referral to an IPV organization from a health provider. Ideally, warm referrals involve the provider offering a patient access to an onsite IPV advocate. If an advocate is not co-located, the provider should offer use of the clinic's phone to call a local resource. Providers need to understand the scope of the services provided by their local IPV organization, such as languages spoken, child care offerings, group sessions, safety planning, and other services. If the patient is not ready or comfortable reaching out, the provider should offer the contact information for IPV services so the patient can reach out independently.[68]

Recommendation 8. Continue to expand and incorporate the nonmedical workforce, including CHWs, community health representatives (CHRs), *promotores,* and IPV advocates, into maternal health programs and require training on best practices for addressing IPV. [DHCS and MCPs]

CHWs, CHRs, and *promotores*, are embedded in communities and are trusted health authorities who can serve as an additional intervention point for addressing IPV. CHRs are Indian Health Service–funded CHWs who provide culturally specific health care services, promotion, and outreach to tribal communities.[69] *Promotores* provide health education and system navigation to their communities. People in these nonmedical roles are uniquely positioned to meet the needs of community members experiencing IPV. In 2022, California became the only state to specifically extend Medicaid coverage to include CHW services related to IPV and violence prevention,[70] providing additional opportunities to engage CHWs in addressing IPV in maternal health care.

- **Strategy 8.1. Incorporate IPV-trained CHWs, CHRs, and *promotores* directly into maternal health programs. [DHCS and CDPH]** CHWs, CHRs, and *promotores* are trusted community members who leverage their community connections and lived experience to improve health care access and outcomes. CHW services address perinatal health conditions, sexual and reproductive health, IPV, and violence prevention, among other issues.[72] Mathematica's companion brief, Using California's Community Health Worker Initiatives to Address Intimate Partner Violence, provides recommendations and strategies for leveraging CHWs and *promotores* to address and prevent IPV.[71] CHWs can provide important services to people during pregnancy and postpartum, including maternal and infant health education and care coordination. CHW support during pregnancy and postpartum is linked with decreased stress levels, decreased depressive symptoms, increased emotional support, increased referral follow-through, and increased parental confidence.[72] IPV-trained CHWs can provide this support to pregnant and postpartum people while simultaneously offering resources on IPV services.
- **Strategy 8.2. Directly hire CHWs or contract with smaller CBOs that employ CHWs. [MCPs]** CHWs and *promotores* are currently reimbursable through Medi-Cal.[73] Directly employing CHWs, CHRs, and *promotores* through MCPs or contracts with smaller CBOs could increase their professional stability. It would also build trust between pregnant people and the health system by incorporating this culturally responsive workforce in health institutions.[74] This is particularly important when supporting people who have experienced trauma and violence and those who have been traumatized by the traditional medical system, such as populations of color.
- **Strategy 8.3. Include information on addressing IPV in required CHW trainings. [DHCS]** CHWs must demonstrate minimum qualifications through a (1) certificate pathway, (2) work experience pathway, or (3) violence-prevention-only pathway. CHWs must also complete six hours of continuing education training annually.[75] CHW violence prevention services are evidence based, trauma informed, and culturally responsive to reduce further violence and promote recovery and improved health outcomes.[72] CHWs qualified through the violence-prevention pathway are well equipped to address IPV, but DHCS should include training on IPV in the certificate pathway and the continuing education requirements to reach all CHWs.
- **Strategy 8.4. Cover IPV advocates as billable providers. [DHCS]** IPV advocates can integrate maternal health and IPV services to better support pregnant and postpartum people with experiences of IPV. As part of the shift to expand the nonmedical workforce to better serve communities and address health disparities, DHCS should consider IPV advocates as billable providers as an extension of this workforce. For example, North Carolina's Healthy Opportunity Pilots covers IPV advocates as billable providers for IPV case management services.[76]

Recommendation 9. Screen all patients for mental health conditions consistently throughout the perinatal period, given that previous experience of IPV is a significant risk factor. [Health care providers]

Consistent depression screening is essential because the onset of perinatal depression occurs nearly equally preconception, during pregnancy, and postpartum.[77,78,79] People experiencing IPV during pregnancy are three times more likely to report symptoms of depression in the postnatal period than pregnant people who do not experience IPV.[80] Depression screening is especially crucial for parents and pregnant people experiencing IPV, as IPV can exacerbate mental health challenges and create additional barriers to seeking help.[81,82] Untreated postpartum depression can hinder maternal–infant bonding, potentially affecting the child's emotional and cognitive development.[83] For parents and pregnant people experiencing IPV, screening for mental health conditions can be a gateway to safety planning, revealing effective parenting strategies to promote positive childhood experiences, and connecting them with appropriate resources.

For parents and pregnant people experiencing IPV, screening for mental health conditions can be a gateway to safety planning.

- **Strategy 9.1. Leverage available referral platforms and resources to address patients' needs, including social drivers of mental and physical health. [MCPs and health care providers]** Linkages and open communication channels between health and mental health providers, substance abuse providers, IPV advocacy and legal organizations, and public health programs can enhance services and supports for pregnant and postpartum families at higher risk for adverse outcomes due to health-related social needs, including IPV. Referrals to individual or group therapy and counseling can help address perinatal or postpartum depression and trauma resulting from IPV.[84,85] Trained counselors can support the survivor with prenatal cognitive-behavioral interventions, including education about abuse and safety behaviors. These approaches can improve health outcomes for mothers and infants and interrupt intergenerational cycles of family violence.[86]

MCPs and health care providers can build linkages with prevention strategies outlined in Comprehensive Prevention Plans developed for county child welfare agencies and/or probation department. These plans will include evidence-based programs for providing behavioral health services to pregnant and postpartum individuals at risk of child welfare involvement.

II. Strategies for incorporating interventions for the postpartum period

Data show that more than half of pregnancy-related deaths occur during the first postpartum year. ACOG recommends care coordination during this critical period to provide tailored support, based on the patient's risk factors, and to facilitate the transition to primary and, if needed, specialist care.[87,88] Postpartum interventions also present an important opportunity to address IPV.

We offer recommendations for collective coordination, response, and referral for the extended Medi-Cal postpartum coverage period with the potential to improve maternal health, promote parental bonding, and interrupt intergenerational cycles of violence.

Recommendation 10. Ensure comprehensive postpartum visits address IPV through universal education and referrals. [MCPs]

A comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being and safety.[90] Employing a standard postpartum visit template has been shown to significantly increase adherence with recommended counseling and documentation guidelines for postpartum visits.[89] For example, ACOG provides standard IPV questions and language to use in postpartum visits[36] and the Alliance for Innovation on Maternal Health Community Care Initiative (AIM CCI) provides maternal safety bundles—a small set of evidence-based, equity-focused, community-informed, and community-tested interventions. AIM CCI offers bundles related to postpartum safety and wellness and IPV during and after pregnancy.[90]

- **Strategy 10.1. Before hospital discharge, assess and address potential safety and access barriers to ensure comprehensive postpartum visit attendance and develop a detailed, personalized postpartum care plan. [MCPs, hospitals, health care providers, and care coordinators]** Health care providers and care coordinators should work with patients, and their chosen support person, before postpartum hospital discharge to prioritize the patient's autonomy and needs. They should also support access to a comprehensive postpartum check-up within 12 weeks of giving birth,[90] by addressing and surmounting potential obstacles that might prevent the visit. In the case of IPV, this support could include addressing any partner interference with coming to postpartum checkups and facilitating home visits when appropriate. MCPs should cover needed services identified through the postpartum visit. They should also collaborate with postpartum people to develop a detailed and personalized postpartum care plan to span the period between birth and one year postpartum and account for medical and behavioral health, social, and IPV-related safety needs. Postpartum visits and care plans are an important intervention point for assessing IPV and safety.

- **Strategy 10.2. Equip programs supporting new parents with educational materials on IPV and resilience-building strategies to support parents and children. [MCPs and local health jurisdictions]** MCPs and local health jurisdictions should connect postpartum people to local programs supporting new parents and work with IPV advocates to equip programs with educational material and resources related to IPV to share with participants. For example, crisis nurseries, such as the Bay Area Crisis Nursery, offer emergency child care, shelter, respite care, food, and diapers. For new mothers with experiences of IPV, these settings could provide a safe space for them to rest and make personal phone calls or safety plan arrangements.[91] Family resource centers are local community centers that support parents and families. Their supports and services vary by area, but can include parent groups, resource libraries, classes, and play groups. They also can provide referral information for home visitation services and food and clothing banks; therefore, they could be an ideal community resource to display IPV educational materials and facilitate referrals to IPV organizations and services. Training tools are available for programs serving new parents, including Futures Without Violence's Connected Parents, Connected Kids training resources and tools for providers and educational materials for clients.

Crisis nurseries provide a safe space for new mothers experiencing IPV to rest and make safety plans.

Recommendation 11. Disrupt the cycle of violence by working with IPV advocacy organizations to train pediatric providers on a two-generation IPV intervention approach using a standard curriculum and covering IPV services during home visits. [DHCS, MCPs, and pediatricians]

The American Academy of Pediatrics recommends universal education for caregivers using trauma-informed, healing-centered engagement as an approach to support IPV survivors (Strategy 2.1).[92] Most caregivers experiencing IPV will seek care for their children but not for themselves. Thus, the pediatric setting presents an important opportunity to identify postpartum depression (see Recommendation 7), address IPV, and support healing with referrals to mental health and IPV services.[93]

- **Strategy 11.1. Train pediatricians on recognizing subtle signs of possible IPV and tactics partners can use during pediatric encounters to control, manipulate, or discredit IPV survivors. [MCPs]** Examples of these behaviors include limiting health care access, monopolizing conversations during health care visits, controlling medical decision making, and manipulating the health care team's perceptions.[94]
- **Strategy 11.2. Fund IPV services through home visiting and encourage pediatricians to make referrals to home visiting programs. [MCPs]** In addition to pediatric visits with universal education, IPV screenings, and referrals, home visiting services present an important opportunity for intervention. Home visitation programs can effectively disrupt intergenerational cycles of violence with the following activities:[95]
  - / Educating pregnant and postpartum people about IPV and resources
  - / Offering universal education
  - / Connecting people with IPV experiences or risk of IPV and their children to community resources and behavioral health services
  - / Speaking with empathy with parents about the potentially harmful health effects related to their own experiences of IPV and their children's exposure to IPV
  - / Providing these services during a child's first two years reduces the risk of subsequent episodes of violence against the mother[96]

  The BCP report indicates that DHCS is collaborating with CDPH and CDSS to identify opportunities to further promote home visiting programs to pregnant and postpartum Medi-Cal members. Concrete planning efforts and establishing metrics for success can aid progress.[23]

Mathematica's companion brief, Recommendations for Medi-Cal Managed Care to Prevent and Address Intimate Partner Violence, provides more information on proactive and responsive services to support the intergenerational impact of IPV.[97]

Recommendation 12. Link pregnant and postpartum people experiencing or at risk for IPV to parenting and family relationship programs to strengthen connections to community supports and IPV services. [health care providers and people working in public health programs]

The National Plan to End Gender-Based Violence and the Centers for Disease Control and Prevention's IPV Technical Package endorse connecting new parents to parenting and family relationship programs as an effective intervention to disrupt intergenerational cycles of violence and improve infant developmental outcomes.[26,65]

"If you are a new parent with experience of IPV, how can we support you to be the most present, best parent you can be?"

— Key informant

- **Strategy 12.1. Fund and work to expand availability of and access to parenting programs that support postpartum people with experiences of IPV, while ensuring health care providers and people working in public health make referrals to these programs. [DHCS, CDPH, and MCPs]** Evidence suggests challenges with emotional regulation, conflict management, and communication increase risk of both perpetration and victimization of IPV. Parenting programs offer intervention opportunities to build key skills and address IPV through a primary prevention approach.[65] Table 5 provides examples of evidence-based parenting programs that address IPV.

Table 5. Evidence-based parenting programs that address IPV

Program	Details
Nurturing Parenting Program	The Nurturing Parenting Program is an evidence-based, family-centered, and trauma-informed initiative customized to cultivate nurturing parenting skills as an alternative to abusive and neglectful parenting and child-rearing practices.[98] The Substance Abuse and Mental Health Services Administration and the National Registry of Evidence-based Programs and Practices recognize the Nurturing Parenting Program as an effective program,[99] and evaluations have found the program improved parenting knowledge and increased child welfare.[100,101]
Mothers in Mind	Mothers in Mind is a community-based group parenting program designed for parents with experiences of IPV and their children. The dyadic model, which addresses the relationship between two people, is built to resemble a parent–child play group and provide trauma-informed parenting support. The program seeks to strengthen the parent–child connection and provide tools for coping with trauma and violence.[102,103] A program evaluation indicated Mothers in Mind effectively supported key parenting outcomes, including parent–child connections and parenting self-efficacy, and promoting maternal health and well-being.[105]
North Carolina's Healthy Opportunities Pilots	North Carolina's Healthy Opportunities Pilots address social drivers of health needs for Medicaid beneficiaries, including those with experiences of IPV, and offers an evidence-based parenting curriculum to people experiencing IPV. The trauma-informed curriculum provides group and one-on-one instruction on parental stress, coping with parental challenges, and children's behavioral or health issues. The state Medicaid agency covers up to 20 sessions in either classroom settings or beneficiaries' homes.[104]

- **Strategy 12.2. Fund and promote fatherhood programs, especially for men with histories of violence, to prevent IPV and interrupt intragenerational cycles of violence. [DHCS, CDPH, and MCPs]** Fatherhood programs are intervention opportunities to prevent IPV.[105,106] Futures Without Violence created the Fathering After Violence framework and established the National Institute on Fatherhood and Domestic Violence to offer technical assistance to professionals working with fathers who have used violence, operating under the belief that they can be held responsible and be encouraged to change their behavior through fatherhood.[107,108] Examples of culturally congruent fatherhood programs include Black Daddy Dialogue and the Good Road of Life, detailed in Exhibit 2.

Exhibit 2. Examples of culturally congruent fatherhood programs

Black Daddy Dialogue	Good Road of Life
• Engages Black fathers • Led by and for Black dads[109] • Discussion topics include:[110] – Parenting skills – Communication skills – Mental health – Healthy relationships – Boundaries – Discipline practices – Self-care – Cultural stressors	• A culture-based program that uses sources of strength such as **spirituality, humor, and healing** to assist **Native men** and their family members in addressing the impact of colonization, trauma, racism and other challenges that threaten the well-being of children and families.[111] • Designed to help Native men reclaim their roles as brave warriors, fathers, and husbands who provide for and protect their families and communities. • Program evaluation found that the program increased participants' willingness to ask for help, supported healthy coping strategies, and fostered self-esteem and communication.[112]

Recommendation 13. Promote economic stability for pregnant and postpartum people experiencing or at risk for IPV. [Policymakers]

"The economics of this situation [IPV] is a huge problem."

— Key informant

Economic levers are essential intervention points for pregnant and postpartum people experiencing IPV. One key informant explained, "99 percent of IPV victims do not have economic freedom. Where are they going to go? Everything is so expensive these days."

- **Strategy 13.1. Address IPV through guaranteed basic income program pilots. [Policymakers]** For many people, a significant reason for staying in or returning to an abusive relationship is fear about their ability to financially provide for themselves and their children. Almost three-fourths (73 percent) of survivors indicated they stayed with their abusive partners longer due to financial barriers.[113] When IPV survivors have access to resources to build economic stability, they are more likely to stay safe and secure. Therefore, guaranteed basic income programs for pregnant people could aim to assist people experiencing IPV as well. In a community–academic partnership, Expecting Justice piloted the first pregnancy income supplement program in the United States called the Abundant Birth Project. The project provides unconditional cash supplements to communities experiencing disproportionately high rates of adverse outcomes as a strategy to reduce preterm births and improve economic outcomes.[114,115,116]
- **Strategy 13.2. Provide care coordination to ensure postpartum people experiencing IPV can connect with all available financial supports. [Policymakers, MCPs, CDPH, local health jurisdictions, and multi-sectoral partnerships]** CHWs, IPV organizations, and other care coordinators can connect postpartum people experiencing IPV with financial supports. For example, the California Young Child Tax Credit provides a credit up to $1,083 per tax return for individuals who qualify for the Earned Income Tax Credit and have a child younger than 6,[117] providing additional financial support that could reduce relationship conflicts.[118] Additionally, providers can refer to the resource guide DHCS developed with the Employment Development Department and Legal Aid at Work, which outlines opportunities for providers to connect pregnant and postpartum beneficiaries to financial supports.[119] In July 2025, DHCS will begin rolling out the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) program, which will provide coverage of rent or temporary housing for up to six months for specific populations who are at risk of or experiencing homelessness (including pregnant and postpartum members).[120] [121]

- **Strategy 13.3. Continue to press for equitable access to existing programs, such as paid parental leave and affordable child care. [Policymakers]** Half of those experiencing IPV indicated that not being able to afford child care had a major impact on their decision to stay with an abusive partner.[115] Paid leave offers a range of benefits, including reducing financial stress and relationship conflicts, fostering egalitarian parenting practices, and enhancing breast-feeding and infant–parent bonding.[122,123,124] Though most California workers contribute to and are eligible for paid family leave for up to eight weeks to attend to a sick family member or bond with a newborn or adopted child, California workers with very low wages, who are disproportionately women, Black, and Latinx Californians, are less likely to have paid parental leave.[125] Additional child care supports, such as expanded publicly funded child care and universal prekindergarten, are also critical protective factors against IPV.

III. Strategies to engage doulas to address IPV

Doulas are professionals who offer emotional and physical support to individuals and families during the entire journey through pregnancy, childbirth, and the postpartum period. Doulas address questions, help create birth plans, provide support during birth, and advocate for the birthing person, contributing to more equitable and culturally responsive care and ultimately enhancing outcomes, especially within communities of color. A study of Medicaid beneficiaries in three states, including California, found people who received doula care during pregnancy had a 53 percent lower chance of cesarean delivery and a 58 percent lower chance of postpartum depression or postpartum anxiety.[126] People receiving doula care also have lower rates of preterm birth,[127] are four times less likely to have a low birth weight baby,[128] are two times less likely to have birth complications,[130] and are more successful with breastfeeding.[129] Doulas provide emotional support that effectively lowers stress and anxiety during the labor period.[131] Doula care increases the odds of respectful care, particularly for Black and Asian/Pacific Islander pregnant people and those on Medi-Cal.[130] Doulas improve birth outcomes and health equity, and through their close personal interactions with pregnant and postpartum people, are well positioned to support people experiencing IPV.

We offer the following recommendations to provide additional support for the doula workforce in California and increase doulas' capacity for addressing IPV among their patients.

Recommendation 14. Provide economic guidance and support to help doulas become billable providers, receive appropriate billable rates, and explore alternative payment options and compensation. [DHCS and MCPs]

Doula services became an approved Medi-Cal benefit in January 2023.[18] However, implementation of the benefit has been challenging. Doulas face many new barriers, including navigating the complicated process to enroll as a provider and learning how to bill, but technical assistance (TA) and support from DHCS is limited. One key informant said, "Applying to be a Medi-Cal provider is hard and painful, so we feel that for our doulas. That's the biggest barrier." While California's initial Medi-Cal billing rate for doulas was low, it was raised in January 2024 to appropriately compensate and incentivize the doula workforce and improve service availability.[131]

DHCS launched a Doula Implementation Stakeholder Workgroup in March 2023 comprised of doulas, providers, consumer and community advocates, county representatives, and health plans. This workgroup is developing a report identifying barriers to doula access and recommendations to increase access, which it expects to release in July 2025.

- **Strategy 14.1. Offer TA for doulas on how to enroll as Medi-Cal providers. [DHCS]** DHCS has provided instructions outlining how doula providers can enroll as Medi-Cal providers,[132] but DHCS should consider implementing a TA model similar to the PATH TA Marketplace to further support doula enrollment. This TA marketplace provides free capacity-building resources to CBOs, providers, local government agencies, federally qualified health centers, and Medi-Cal Indian Health Program designees implementing ECM and community supports services.[133] A central hub for doulas with additional enrollment and billing resources akin to this TA marketplace, including a DHCS enrollment specialist available for one-on-one assistance, would strengthen doulas' network and capacity in the state.
- **Strategy 14.2. Raise the billing rate for doulas with training on IPV to reflect the expertise that goes into the specialty. [DHCS]** Higher billing rates enable more people, particularly Black and Native American people who represent the communities emphasized in the 50x2025 Bold Goals, to view doula services as a viable career path, thereby increasing the availability of and access to doula services. On January 1, 2024, DHCS increased Medi-Cal fee-for-service doula rates. The rate for initial 90-minute visits increased from approximately $126 to $198 per visit; prenatal and postpartum visits increased from about $60 to $162 per visit; and the maximum total doula reimbursement for "all initial recommendation visits and support during vaginal delivery" increased from approximately $1,515 to $3,153, making California's reimbursement rate one of the highest in the country.[133, 134] Going forward, DHCS could also increase the billing rate for doulas who complete specific training on IPV, as they would provide more comprehensive services.
- **Strategy 14.3. Explore alternative payment models for doula services. [MCPs]** MCPs should consider equitable pricing models for doulas. For example, MCPs could provide doulas who specialize in IPV services higher rates than the Medi-Cal fee schedule. Another option is to employ doulas through community organizations, capitalizing on the trust and structure those organizations have already built. DHCS and CDPH could potentially use Title V funding to support community organizations' efforts to train, certify, and bill for doula services.[135]

Recommendation 15. Train doulas to address IPV through prenatal and postpartum care. [DHCS and MCPs]

Formal IPV screening is not part of most doula practices, but assessment and conversations around IPV often occur naturally as part of a doula's interactions with patients, making doulas an effective and trusted touch point for IPV prevention and intervention.

- **Strategy 15.1. Require IPV training for doulas. [DHCS]** Doulas can qualify as covered Medi-Cal providers through a training pathway or experience pathway.[136] All doulas must complete three hours of continuing education every three years. Although IPV training is included as a *recommended* training in the Medi-Cal provider manual for doula services,[18] DHCS should require IPV training for all doulas to better support their patients' health and safety needs. DHCS should partner with IPV advocates to develop and provide the training.
- **Strategy 15.2. Provide doulas with supplemental training and resources on IPV. [DHCS and MCPs]** Health Plan of San Mateo, for example, does not require doulas to complete formal IPV screenings for their patients. However, the MCP provides doulas with training and information about available community resources so doulas are prepared if a patient discloses IPV. Other MCPs should similarly partner with IPV advocates to develop resource lists and orient doulas to community resources that address the needs of IPV survivors to support their doula workforce in addressing IPV.

- **Strategy 15.3. Engage doula collectives directly on ways to address IPV among their patients. [MCPs and DHCS]** Doula collectives are collaborative professional networks in which individual doula practices come together to participate in continuing education, networking, and special events.[137] MCPs should work directly with doula collectives to solicit suggestions on needed trainings, resources, and workforce development so doulas can best support patients experiencing IPV. MCPs can establish doula advisory boards, hire doula consultants, facilitate evaluation mechanisms, or otherwise engage with doula collectives to receive continuous feedback and ensure doulas have the resources they need to address IPV in their work.

Conclusion and Next Steps

Acting now to integrate IPV services into maternal health care in California is vitally important for enhancing maternal health and safety and advancing birth equity. The recommendations and strategies in this policy brief provide action-oriented approaches for integrating IPV services during pregnancy and postpartum care and through care delivered by doulas, CHWs, and other partners and potential extensions of maternal health care. Working together, DHCS, CDPH, MCPs, IPV advocates and service organizations, and community partners can optimize opportunities to prevent and address IPV among pregnant and postpartum people and, in so doing, promote health equity, improve infant and child wellness, save lives, and create paths to healing for survivors and families.

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Appendix A. Recent California Maternal Health Initiatives

Table A.1. Recent initiatives

Initiative	Type	Details
Momnibus Act	Legislation	In 2021, Governor Gavin Newsom signed the California Momnibus Act, which seeks to improve maternal and infant outcomes, particularly for people of color. The law will improve research and data collection on racial and socioeconomic factors that contribute to higher rates of maternal and infant mortality in communities of color, strengthen the work of the Pregnancy-Associated Mortality Review Committee to investigate pregnancy-related deaths and make recommendations on best practices, support the midwifery workforce, establish a work group to support implementation of the new Medi-Cal doula benefit, and reduce CalWORKs paperwork requirements for pregnant people.[138]
Expanding Medi-Cal coverage to 12 months postpartum	Medi-Cal benefit	As of April 2022, pregnant people in California have 12 months of postpartum coverage for the full breadth of Medi-Cal services, regardless of income changes, citizenship, or immigration status.[139]
Medi-Cal coverage of doula services	Medi-Cal benefit	As of January 2023, doula services are an approved Medi-Cal benefit. Doula services are available through Medi-Cal managed care plans and fee-for-service Medi-Cal.[18]
Funding for midwife education and training	Budget	The 2022–2023 California budget included funding for midwives to receive additional education and training through the Song-Brown program.[19]
50x25 Bold Goals	Strategy	Under California's 2022 Comprehensive Quality Strategy, the state outlined "50x2025 Bold Goals" to close disparities in maternity care for Black and Native American people by 50 percent and improve maternal depression screening by 50 percent by 2025.[21]
Birthing Care Pathway	Medi-Cal care model	The Department of Health Care Services (DHCS) developed a Birthing Care Pathway that covers people from conception through 12 months postpartum to address racial disparities in maternal health outcomes and reduce maternal morbidity and mortality. DHCS convened work groups through fall 2023 on clinical care, social drivers of health, and member voice to inform their work. A report released in February 2025 details DHCS' new and updated approaches and outlines opportunities for further exploration, including universal IPV education and provider training.[23]
Population Health Management (PHM) Program	Program	The Population Health Management (PHM) Program, which California rolled out in 2023, requires managed care programs to address maternal health outcomes and racial disparities in maternity care. The program complements the new 2024 managed care contract requirements to develop a Health Equity and Quality Transformation Program and offer equity-focused interventions that address health-related social needs and incorporate community health workers and doulas.[140]
Medicaid Accountability Set Performance Measures	Standards	DHCS requires Medi-Cal managed care plans to report on the Managed Care Accountability Sets (MCAS). The 2024 MCAS includes multiple maternal health and health equity measures, including Prenatal and Postpartum Care: Postpartum Care; Prenatal and Postpartum Care: Timeliness of Prenatal Care; Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate; Postpartum Depression Screening and Follow-Up; Prenatal Depression Screening and Follow-Up; and Well-Child Visits for the First 30 Months of Life—0 to 15 months.[22]
Equity and Practice Transformation Provider Payments	Payment program	DHCS provides one-time Equity and Practice Transformation Provider Payments totaling $700 million to managed care plans or providers that advance equity and improve quality measures in maternity care in pursuit of the 50x2025 Bold Goals.[141]

Initiative	Type	Details
Perinatal Health Equity	Program	The Perinatal Health Equity program encompasses California Department of Public Health efforts to address Black maternal and infant morbidity and mortality through three initiatives: Perinatal Equity Initiative (PEI), Black Infant Health (BIH), and Community Birth Plan (CBP).[142] Through group prenatal care interventions; pregnancy intentionality, preconception, and interconception care interventions; fatherhood or partnership initiatives; home visitation programs; and other evidence-based strategies, the PEI aims to address root causes of disparities in infant mortality.[143] The Black Infant Health (BIH) Program is a voluntary, group-based intervention focused on improving maternal and infant health outcomes by helping Black women build resilience, gain social support, and improve skills for reducing stress.[144] The Community Birth Plan coordinates efforts to reduce preterm birth rates among the Black community, hospitals, perinatal health care providers, and other community organizations.[145]
State Maternal Health Innovation Award	Grant	In October 2023, the Health Resources and Services Administration awarded California $10 million as part of the State Maternal Health Innovation grant. The California Maternal Quality Care Collaborative (CMQCC) will administer the awards. CMQCC will work with the Office of the Surgeon General, CDPH, and DHCS to convene a Maternal Health Steering Committee and a Maternal Health Task Force to issue a baseline assessment, develop and implement a strategic plan, and fund community-centered interventions to improve perinatal outcomes.[24]
Transforming Maternal Health Model	Grant	In January 2025, the Centers for Medicare & Medicaid Services awarded DHCS $17 million to implement the Transforming Maternal Health (TMaH) Model, a value-based payment and care delivery model that aims to improve maternal health outcomes and reduce health care expenditures through a whole-person approach to pregnancy, childbirth, and postpartum care.[25] DHCS is working with MCPs, providers, CBOs, and other partners to implement the TMaH model in Fresno, Kern, Kings, Madera, and Tulare counties.[146]

Appendix B. Methods

Approach

Mathematica conducted a targeted evidence review of peer-reviewed and gray literature, consulted an advisory committee of experts for recommendations of key informants to engage and to share preliminary findings, and interviewed key informants. We conducted 11 interviews in summer 2023 with key informants from the Department of Health Care Services (DHCS), California Department of Public Health (CDPH), and managed care plans; home visiting experts; intimate partner violence (IPV) advocates; doulas; and experts in culturally responsive maternal health care. We used a semi structured interview protocol to guide our 60-minute interviews. We recorded our discussions and consulted transcripts to support coding of interview data. We then analyzed the data and abstracted high level themes.

Research questions

The following research questions informed our approach:

1. What strategies are effective to prevent and address IPV during pregnancy to promote maternal and infant health?
2. What postpartum interventions improve maternal mental health, promote parental bonding, and interrupt intergenerational cycles of violence?
3. How can Medi-Cal managed care plans integrate evidence-informed and promising IPV prevention and intervention strategies to promote maternal physical and mental health?
4. How can integrating these interventions help managed care plans meet DHCS' Comprehensive Strategy Bold Goals and Medi-Cal's Accountability Set measures for prenatal and postpartum care performance?
5. How can doulas and community health workers help to prevent and address IPV among pregnant people with current or historical experiences of IPV?

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