

**CALIFORNIA IPV
& HEALTH POLICY
LEADERSHIP
COHORT**

-September 2018-



ADDRESSING INTIMATE PARTNER VIOLENCE AS A SOCIAL DETERMINANT OF HEALTH IN CLINICAL SETTINGS

INTRODUCTION | Intimate partner violence¹ (IPV) directly impacts 1 in 4 women and 1 in 7 men in the US, as well as their family members, friends, and communities. IPV is a leading contributor to injuries, chronic health issues, high-risk health behaviors, and creates a significant strain on the healthcare system. Trauma-informed, evidence-based prevention and intervention strategies have proved effective in reducing the incidence and health impact of IPV. These strategies require commitment to local and state level responses led by California's domestic violence advocates, healthcare providers, policymakers, healthcare systems, and funders. As healthcare delivery systems and the policy landscape are rapidly transforming, there is an opportunity to scale successful programs, policies, and innovations across the state of California to better prevent and address IPV and improve health.

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**FUTURES
WITHOUT VIOLENCE**

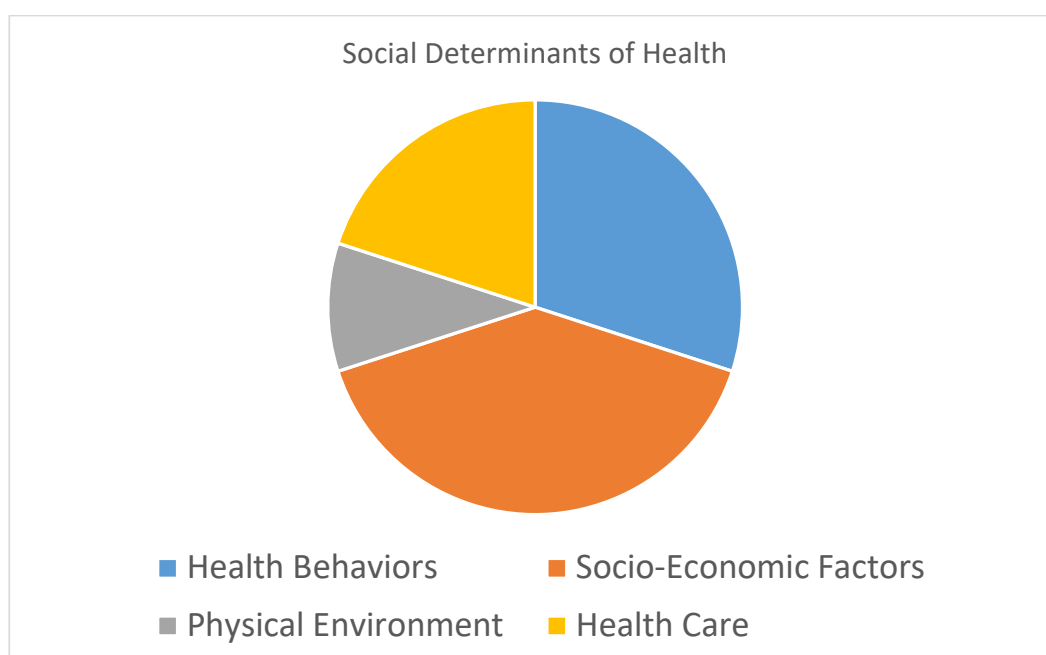
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Traditional delivery of healthcare services tends to focus on treating medical conditions, and yet a growing body of evidence demonstrates that social and environmental factors are equal or just as important to health outcomes and the likelihood of disease and illness. These factors, or social determinants of health (SDOH), are defined by the World Health Organization as “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.”²

Importantly, health systems are starting to assess their patients for a variety of SDOH, such as income, housing, education, and employment. Several assessment tools have been developed to help providers identify and understand their patients' unmet needs. Some of these tools include standard questions about exposure to intimate partner violence (IPV), while others treat such inquiries as optional. This paper analyzes the implementation efforts of various SDOH assessment initiatives and promotes the inclusion of IPV questions. First, existing nationally recognized tools—such as PRAPARE and Health Leads—were identified and reviewed, as well as resources available to organizations for collecting data and addressing patients' SDOH needs. Next, a small number of community health centers using the identified tools were interviewed to better understand the process and outcomes of their assessment work. Two SDOH assessment tools, six online referral sites, and two printed resources were reviewed. Finally, lessons learned were compiled and policy recommendations were developed.



Source Authors: Analysis and Adaptation from the University of Wisconsin Population of Health's Institute's County Health Rankings Model, 2010

LESSONS FROM THE FIELD

EARLY STAGE OF IMPLEMENTATION

SDOH assessment shows great promise | SDOH assessment is still in the early stages of implementation and testing in California. Nevertheless, SDOH assessment is consistent with other data collection requirements, and many community clinics and Federally Qualified Health Centers (FQHCs) have been doing similar work for some time. SDOH assessment is therefore perceived to have great potential to improve patient health outcomes. The following are key lessons learned from the field.

PRIOR TO IMPLEMENTATION

- It is important to create and sustain **multi-sector partnerships** that include representation from health and IPV services sectors.
- It is important to identify an **internal provider champion** who can motivate staff and illustrate the healthcare system's top-down embrace of SDOH assessment.
- **Implement policies that include IPV prevention and response** as core program elements.
- Provide **ongoing training on motivational interviewing, trauma-informed strategies, and patient engagement** to all staff who will be responsible for administering the assessment.
- Healthcare sites should **compile resource lists** and be prepared to refer patients to different types of services to address their social needs. If the site does not have its own list of resources, consider using online resources, such as 211, Healthify, and Aunt Bertha.
- Healthcare institutions should **embed SDOH assessment templates into electronic health records (EHR)** and create prompts that guide providers on how to respond to positive SDOH screens.
- Where possible, healthcare sites should **pre-populate the SDOH assessment tool with information collected via the Uniform Data System (UDS)** and other screening tools.
- It is important to **define when a referral is considered “closed” or “completed”** to ensure consistent practices and reporting. For example, is a referral considered complete when the referral agency's contact information is provided to the patient, if a warm transfer is conducted, if a patient makes an appointment with the referral agency, or if a patient secures needed services from the referral agency?
- Healthcare providers should **educate patients about the SDOH assessment process before they begin administration**. Trusted frontline staff can distribute handouts, use educational materials, and display posters to help explain what the assessment is and its purpose.
- **Include questions about organizational IPV prevention and response** efforts to existing quality assurance and quality improvement procedures.

DURING IMPLEMENTATION

- To **incorporate SDOH assessment into the regular patient workflow**, use health educators, case managers, Promotoras, patient navigators, or other frontline staff to administer the assessment tool in person or by telephone prior to the provider visit.
- Although SDOH data collection is minimal so far, pilot sites anticipate powerful opportunities to use SDOH data to inform interventions, referrals, collaborative programs, and financial investments. **SDOH data collection should be standardized and centralized** to facilitate trending and comparative analyses.
- Healthcare sites should provide a full **list of local resources**³ to patients even if they don't complete the SDOH assessment or if they screen negative for IPV. This ensures that key resources will be shared with IPV survivors who may choose not to disclose, or for them to share with friends and family. It is important to develop a **feedback loop** so referring providers know if their patients secured the help they need. This will require informed consent from the patient and information sharing agreements between providers in compliance with Health Insurance Portability and Accountability Act (HIPAA) and Violence Against Women Act (VAWA).
- Once data is collected and analyzed, health centers will need to determine appropriate **community organizations with which to partner and collaborate** in order to provide all of the necessary support services to improve issues

The **CALIFORNIA IPV & HEALTH POLICY LEADERSHIP COHORT**, funded by Blue Shield of California Foundation (BSCF) and facilitated by Futures Without Violence, is a network comprised of a dozen local, state, and national organizations that are committed to improving health outcomes for Californians by promoting practice and policy change that addresses IPV as a health issue. The cohort is designed to bring together diverse voices to initiate, inform, and advance California-based health and IPV work to:

1. Promote shared learning and multi-sectoral collaboration among leaders in health and IPV;
2. Develop policy and practice briefs to promote application of multi-sectoral collaboration strategies that improve prevention and response to IPV and survivor health; and
3. Provide leadership in local, regional, and statewide work groups, conferences and trainings to promote and disseminate cohort-developed resources.

The briefs were co-authored by cohort members participating in 3 subgroups: Promoting Health Advocacy in Domestic Violence Programs; Addressing IPV as a Social Determinant of Health in Clinical Settings; and Integrating Community Level IPV Prevention in Community Health Assessments and Health Improvement Plans. All three briefs were developed to highlight current best and promising practices, offer relevant resources, and recommend policy changes within these focus areas.

POLICY AND PRACTICE RECOMMENDATIONS

- **Include the IPV question(s) in SDOH assessment.** While IPV questions may be optional for SDOH assessment, many sites already include and ask the questions in their interview process. Asking the IPV question(s) to determine if a patient has need for support services can promote better health and safety outcomes. The IPV question should be asked at every visit to address the patient's unmet social needs and assess barriers to care. If the question is optional, make it standard; if it is standard, ensure it is asked routinely. In doing so, clinics will better understand the needs of individual patients, as well as the population served.
- Sites using SDOH assessment tools should **collect data not only to address patient and community needs, but also to track improvements in health outcomes and any associated cost savings due to SDOH assessment.**
- **Develop a plan for sustainability.** One challenge to providing necessary services that address SDOH is that current payment and billing models do not support most SDOH activities. To make this work sustainable, continue to refine and develop an innovative financial model for health center reimbursement that leverages the unique strengths of health centers and positions them to continue the work of addressing SDOH with patients through options, such as:
 - Providing clinics flexibility through an **alternative payment model** where non-billable providers can be used for assessments and care coordination/navigation to be able to balance the return on investment for this work;
 - **Engaging health plans, hospitals, health districts, and other key stakeholders to provide support for this work** either through paying or incentivizing clinics to collect, assess, and provide SDOH resources, or paying for or providing resources needed by patients;
 - Identifying different funding streams and opportunities to **braid funding** that provides clinics doing SDOH assessment the ability to address larger community needs and better leverage resources.

None of the sustainability options mentioned above should be considered stand-alone. One or more could be viable as part of a sustainability plan.

CONCLUSION

In short, although SDOH assessment is in its early stages, it shows great promise in identifying patient needs and facilitating improved health outcomes. Regardless of which tool is used, SDOH assessment should always inquire about IPV so providers can understand the breadth of issues and challenges their patients are facing, explain to patients how exposure to family violence can affect their health, assist with safety planning, and connect patients to IPV support resources in the community.

RESOURCES

GENERAL RESOURCES

Domestic Violence Healthcare Partnerships: A toolkit for creating and sustaining multi-sector partnerships | dvhealthpartnerships.org

California Partnership to End Domestic Violence, includes a catalog of health resources for advocates | cpedv.org/national-and-state-links

Prevention Institute Expanding Collaborative Capacity to Prevent Domestic Violence
preventioninstitute.org

John Snow, Inc., features the Building Evidence on Domestic Violence initiative | bit.ly/2uG7IVy

SDOH TOOLS

PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences): Nationwide tool developed by the National Association of Community Health Centers and others to assess a patient's social risks | nachc.org/research-and-data/prapare/

Health Leads: "Patient Social Needs Screening Toolkit" developed by Health Leads, a nonprofit social enterprise, to establish intervention strategies to integrate into healthcare systems | healthleadsusa.org

ONLINE REFERRAL RESOURCES

One Degree: Self-help website for social and economic services. | 1degree.org

Aunt Bertha: Online application connecting people and programs. | auntbertha.com

Healthify: Professional platform providing "end-to-end" care connections. | healthify.us

Purple Binder: Connects people with care and community services. | purplebinder.com

NowPow: Knowledge utility application providing healthcare to self-care information. nowpow.com/

211: Central source and referral service for health and human services. | 211.org

1. Intimate partner violence, also referred to as domestic violence, is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner's consistent efforts to maintain power and control over the other. Learn more about the dynamics, signs, and prevalence of domestic violence at the National Coalition Against Domestic Violence website at <http://www.ncadv.org/learn-more/what-is-domestic-violence>
2. http://www.who.int/social_determinants/sdh_definition/en/
3. For more information about creating referral systems and feedback loops to track referral outcomes, read Domestic Violence and Health Care Partnerships Improve Survivor Health Access: Data pilot key findings and recommendations at <http://bit.ly/2QISPMb>