breaking the cycle of intimate partner violence

Addressing Intimate Partner Violence through the CalAIM Population Health Management Program

blue of california
foundation

Mathematica.

Contents

Tables

Exhibits

Executive Summary

Intimate partner violence (IPV) is a widespread, multigenerational problem in California that has dangerous and cascading health and social risks for individuals, families, and communities. Because more than 10 million Californians (80 percent of all those in Medi-Cal) are enrolled in a managed care plan, these plans have an opportunity to contribute to addressing and preventing IPV, particularly among people with low income and those that are most vulnerable to its harmful effects. As part of California Advancing and Innovating Medi-Cal (CalAIM), the California Department of Health Care Services is launching the Population Health Management program in January 2023. The CalAIM Population Health Management program will require managed care plans and their networks and partners to respond to members' social needs within the communities they serve. The new Population Health Management program will create a standardized data-driven approach to ensure that all Medi-Cal managed care members across the state can access prevention and wellness services and tailored interventions, based on their needs and preferences, along the continuum of care.

This policy brief discusses opportunities and strategies for including evidence-informed and practice-based IPV services in the Population Health Management program.[1] Together with managed care plans, the California Department of Health Care Services should pursue the seven recommendations listed in Table 1 through the strategies summarized in the brief:

Table 1. Recommendations for addressing IPV by PHM domain

Recommendations
Domain 1: PHM strategy and PNA
1. MCPs should include aggregated IPV data in analyses of SDOH and HRSN in PNAs.
2. MCPs should partner with and support CBOs with expertise in IPV services to better understand the impact of IPV and implement community-level efforts to address and prevent it.
Domain 2: Gathering member information
1. MCPs should train health care providers and staff on culturally competent, trauma-informed approaches to universal education, screening, counseling, and referrals for IPV using a recommended evidence-informed model from the state and contracting with IPV service organizations to add information about local services and considerations.
2. MCPs should contract with IPV service organizations to incorporate IPV-related considerations and requirements into referral systems.
3. MCPs should adhere to applicable privacy laws, ensure that patients consent to sharing data, promptly report instances of providers breaking consent agreements, and allow withholding of sensitive information.
Domain 3: Understanding risk
1. When stratifying patients into risk tiers, MCPs should ensure that patients with current or historical IPV are eligible for care management services because of the significant health and social risks associated with IPV.
Domain 4: Providing services and supports
1. MCPs should contract with CBOs with expertise in IPV to educate providers and offer tailored, setting-specific responses or additional supportive services for all patients, including priority populations, to better connect patients to primary health and behavioral services.

CalAIM = California Advancing and Innovating Medi-Cal; CBO = community-based organization; DHCS = Department of Health Care Services; HRSN = health-related social needs; ICD = International Classification of Diseases; IPV = intimate partner violence; MCP = managed care plan; PHM = Population health management; PNA = population needs assessment; SDOH = social drivers of health

I. Introduction

The California Advancing and Innovating Medi-Cal (CalAIM) Population Health Management (PHM) program presents a tremendous opportunity for Medi-Cal managed care plans (MCPs) to adopt evidence-informed and practice-based strategies to support communities striving to prevent intimate partner violence (IPV) and to ensure that IPV survivors receive the health care and social support services they need to heal and thrive.[2] This policy brief presents recommendations and action-oriented strategies for MCPs to address IPV under the PHM program.

IPV is a public health crisis in California, posing dangerous and cascading health and social risks for individuals and their families. Among California residents, 35 percent of women and 31 percent of men report experiencing violence from their partner at some point in their lives.[3] These figures are especially alarming, given that experiencing IPV leads to long-term negative effects on women's and men's physical and behavioral health across their life spans.[4,5,6,7,8]

Understanding when IPV occurs can help identify critical points for focusing prevention and intervention strategies. Young adults have the highest prevalence of exposure to IPV when compared with other age groups nationally,[9] and the majority (nearly 75 percent) of women experiencing IPV first do so before age 25.[10] Many women report that abuse started or intensified when they became pregnant, making pregnancy an especially risky time for IPV.[11] Annually, IPV occurs in approximately 324,000 pregnancies in the United States.[12] IPV is also a leading contributor to pregnancy-associated suicide and homicide, independent of demographic and contextual factors; thus, pregnancy is a crucial period for IPV prevention and intervention to prevent serious injury and maternal mortality.[13] Exposure to IPV increases the risk of negative outcomes, such as sexually transmitted infections and unintended pregnancy; moreover, IPV leads to additional complications during pregnancy, such as pelvic fracture, placental abruption, stillbirth, preterm birth, low birthweight, fetal injury, and maternal mortality and morbidity.[14] IPV intersects with behavioral health challenges, often leading to mental health challenges such as depression and anxiety, or it contributes to existing conditions.[15] IPV is closely intertwined with key health-related social needs (HRSNs) and social drivers of health (SDOH). Experiencing IPV amplifies social risks: unstable housing, food insecurity, limited social supports and social isolation, and disruptions to employment.[16]

In 2020, Medi-Cal began the five-year CalAIM initiative to transform Medi-Cal into a health delivery system that supports whole-person care and addresses the social drivers of health.[17] The PHM program component of CalAIM will establish a cohesive, statewide approach to ensure that Medi-Cal members have access to a comprehensive program that improves health outcomes. The PHM program also seeks to promote health equity and provide services and supports that lead to long, healthy, and happy lives. The California Department of Health Care Services (DHCS) will launch the PHM program in January 2023. The PHM program will require MCPs and their networks and partners to respond to members' social needs within the communities they

Population Health Program Accreditation Standards

- Data integration
- Population assessment
- Population segmentation
- Targeted interventions
- Practitioner support
- Measurement and quality improvement ◢

From: National Committee for Quality Assurance PHM standards

serve, while also meeting the National Committee for Quality Assurance's standards for PHM as well as other DHCS statewide PHM standards.[18] In tandem with the PHM program rollout, DHCS is building a statewide PHM service designed to collect and integrate disparate information to support DHCS's vision for PHM.[19]

The priority populations for the PHM program—children and youth, pregnant and postpartum individuals, and those with behavioral health needs—are at heightened risk for IPV and associated negative health outcomes.[20] Following the recommendations and adopting the strategies in this brief will help MCPs address and prevent IPV and improve the health of these populations.

There are four domains of the CalAIM PHM program: (1) population health management strategy and population needs assessment (PNA), (2) gathering member information, (3) understanding risk, and (4) providing services and supports. These domains provide the framework for the IPV-specific recommendations in this brief. (Appendix A summarizes the DHCS goals for each PHM domain.) The next section summarizes the recommendations and strategies, and a discussion of supporting evidence, examples, and considerations follows.

II. Recommendations and Strategies

A. Overview

Implementing PHM with attention to IPV requires an "overarching data-driven strategy that prioritizes collaboration with community partners."[19] We describe evidence-informed and practice-based recommendations that do not require federal authorization for how DHCS and Medi-Cal MCPs can incorporate IPV considerations and services when implementing the PHM program. The recommendations presented in this brief are based on an evidence scan and interviews with key informants. (See Appendix B for details about the approach.) We organize these recommendations by PHM program domain and provide the evidence we gathered that supports each recommendation, along with actionable strategies. Table 2 summarizes the recommendations and associated strategies, and detailed descriptions and examples for each follow.

Table 2. Summary of recommendations and related actionable strategies

Recommendations	Actionable strategies
Domain 1: PHM strategy and PNA	
1. MCPs should include aggregated IPV data in analyses of SDOH and HRSN in PNAs.	1.1. Identify and include state and local-level IPV data in PNAs.[a]
2. MCPs should partner with and support CBOs with expertise in IPV services to better understand the impact of IPV and implement community-level efforts to address and prevent it.	2.1. Provide in-kind or financial support to compensate IPV service organizations for their contributions to the PNA process.
	2.2. Demonstrate commitment to building a shared vision by adding CBOs with expertise in IPV to their governing boards to consistently include a CBO perspective.
	2.3. Develop or join community coalitions, such as the Los Angeles County Domestic Violence Council, that include representatives from local public health agencies (particularly those working to prevent and address IPV), IPV advocacy organizations, and survivors, to improve communication and coordination between health plans and CBOs.
	2.4. Partner with CBOs that support IPV prevention strategies.
Domain 2: Gathering member information	
3. MCPs should train health care providers and staff on culturally competent, trauma-informed approaches to universal education, screening, counseling, and referrals for IPV using a recommended evidence-informed model from the state and contracting with IPV service organizations to add information about local services and considerations.	3.1. Engage IPV service organizations or advocates to educate all health care staff (frontline and back-end staff) about the prevalence and impacts of trauma and IPV and how to respond.
	3.2. Engage IPV service organizations or advocates to train health care providers and staff to use a universal education approach; this involves sharing resources such as crisis hotlines, speaking to patients about elements of healthy versus unhealthy relationships and the health effects of violence, and offering resilience building interventions where needed.
	3.3. Develop guidance on how providers can bill for administering universal education through the screening and brief counseling benefit.
	3.4. Require health care providers to consistently include an IPV question in HRSN screenings, coupled with universal education and resource sharing, regardless of whether a patient completes the screening or screens negative for IPV.
	3.5. Engage IPV service organizations or advocates to train health care providers (including health educators, case managers, community health workers, patient navigators, and social workers or other clinicians who conduct HRSN and IPV education and screening) to appropriately support and follow up on IPV disclosures.

Recommendations	Actionable strategies
	3.6. Ensure that health care provider training includes guidance on how to correctly document IPV experiences in the electronic health record using ICD-10 codes, as well as how to record non-biased and sensitive clinical notes that: – Trust patients and avoid conveying disbelief. – Exercise care when using quotes. – Recognize and remove stigmatizing phrases. – Focus on strengths and humanizing details.[b] – Consult with the patient about what to include in the documentation.
	3.7. Carefully consider ways to harness plan-level data on IPV, such as the percentage of health care providers who are offering universal education and screening, to identify topics for further training or providers who could benefit from additional training.
4. MCPs should contract with IPV service organizations to incorporate IPV-related considerations and requirements into referral systems.	4.1. Facilitate effective IPV CBO buy-in to referral platforms by incorporating these entities into the development of data sharing efforts and demonstrating a commitment to prioritize survivor privacy and safety, providing information about the benefits of referral technology to CBOs, and offering support with implementation and technical challenges.
	4.2. DHCS should require that community information exchanges include IPV service organizations (after robust discussions about confidentiality and training for the staff at the community information exchange about IPV).
5. MCPs should adhere to applicable privacy laws, ensure that patients consent to sharing data, promptly report instances of providers breaking consent agreements, and allow withholding of sensitive information.	5.1. Explore technological modifications to limit personally identifiable information used in electronic invoicing and referral systems, legal modifications such as time-limited consent, and contract amendments with partners that include appropriate privacy protections.
	5.2. DHCS and MCPs should engage with survivors and IPV advocacy organizations to determine the precautions necessary to ensure that standards meet survivors' privacy needs and protect safety.
Domain 3: Understanding risk	
6. When stratifying patients into risk tiers, MCPs should ensure that patients with current or historical IPV are eligible for care management services because of the significant health and social risks associated with IPV.	6.1. Risk stratifications should incorporate HRSN and SDOH data.
	6.2. Providers should properly document IPV with appropriate ICD-10 codes, and MCPs should consider those codes in determining members' health and social risks.

Recommendations	Actionable strategies
Domain 4: Providing services and supports	
7. MCPs should contract with CBOs with expertise in IPV to educate providers and offer tailored, setting-specific responses or additional supportive services for all patients, including priority populations, to better connect patients to primary health and behavioral services.	7.1. DHCS, MCPs, and IPV service organizations should offer specific guidance and IPV-related training for providers working with the pregnant and postpartum priority population in the CalAIM PHM program.
	7.2. Support disrupting the cycle of violence by working with IPV service organizations to train pediatric providers on a two-generation IPV intervention approach using a standard curriculum and covering IPV services during home visits.
	7.3. Contract IPV service or advocacy organizations to educate providers on trauma-informed care and survivors' multifaceted needs. Providers working with priority populations that disclose past or current IPV should co-create treatment plans with patients that support survivors' health and reduce harm, and providers should offer warm referrals for appropriate follow-up care. Treatment plans should include immediate safety planning, mental and behavioral health care, and appropriate social services such as housing and legal supports.
	7.4. DHCS should add IPV-related services to the list of community supports and partner with IPV advocates and service organizations to develop guidance for strategies that MCPs can use to safely cover IPV services.
	7.5. Cover services for IPV survivors provided by a wide range of community-based, non-medical social support organizations that employ trauma-informed practices, including community health workers and *promotores*.
	7.6. Contract with IPV service organizations that employ community health workers to address IPV and other HRSNs in the community.
	7.7. Develop a template with standard contract language to engage CBOs.

[a] Sources for community-level indicators of IPV include the Behavioral Risk Factors Surveillance System and the discontinued California Women's Health Survey. Other sources for county-level data, such as County Health Rankings, provide estimates of community safety, which include IPV and other exposure to community violence. A compendium describing other publicly available data sources is available on the Violence Against Women website at https://vawnet.org/material/data-sets-related-violence-against-women.

[b] Casau, A., and M.C. Beach. "Words Matter: Strategies to Reduce Bias in Electronic Health Records." Center for Health Care Strategies, October 2022. Available at https://www.chcs.org/media/Words-Matter-Strategies-to-Reduce-Bias-in-Electronic-Health-Records_102022.pdf. Accessed November 14, 2022

CalAIM = California Advancing and Innovating Medi-Cal; CBO = community-based organization; DHCS = Department of Health Care Services; HRSN = health-related social needs; ICD = International Classification of Diseases; IPV = intimate partner violence; MCP = managed care plan; PHM = Population health management; PNA = population needs assessment; SDOH = social drivers of health

B. Population health management strategy and population needs assessment (CalAIM PHM Domain 1)

The new PHM program will require MCPs to collaborate with community leaders and community-based organizations (CBOs) to develop a PNA structure, engage meaningfully with the community throughout the PNA process, and align with local initiatives to assess needs. MCPs must also demonstrate their commitment to the communities where they operate and contribute percentages of their annual net income to community reinvestment activities. Once finalized, the PHM Service will strengthen DHCS's understanding of population health trends, which can include IPV prevalence, and improve oversight.[21]

Recommendation 1. MCPs should include aggregated IPV data in analyses of SDOH and HRSNs in population needs assessments.

The collection and analysis of public health surveillance data on IPV supports efforts to identify populations at risk, inform prevention strategies and programs, and assess trends over time. IPV is a societal problem that occurs across racial, ethnic, gender, and socioeconomic groups; however, people with low incomes and those living in under-resourced communities face multiple, compounding barriers to safely exiting violent relationships. Community factors, such as areas with easy access to drugs and alcohol or where neighbors do not know each other, and concentrated disadvantage, such as high rates of unemployment and poverty and low rates of educational and economic opportunities, have a significant, positive association with IPV incidents; clearly, community conditions impact the geographic distribution of IPV.[22,23] MCPs' investments in social needs interventions, such as ensuring adequate housing and food and improving affordability and access to care for survivors, helps decrease the risk of violence. This highlights the critical importance of employing prevention and intervention strategies at the community level, in addition to offering individual services that support those experiencing or at risk for IPV.[24,25]

- **Strategy 1.1. MCPs should identify and include state and local-level IPV data in PNAs.** This might involve collaborating with local partners and jurisdictions to collect existing data on the prevalence of IPV in communities broadly and in the PHM priority populations. Data sources could include large national and regional data sets and local IPV, HRSN, and safety metrics available through IPV service organizations and jurisdictions (Exhibit 1). Links to additional domestic violence-specific data sets are available on the VAWnet website.

Exhibit 1. Sources of IPV-related data

National, state, and regional IPV data sources (examples)	**Local IPV metrics (examples)**
• Behavioral Risk Factor Surveillance System • National Crime Victimization Survey • California Women's Health Survey (1997–2012 only) • County Health Rankings (includes estimates of community safety, IPV, violence exposure)	• Crisis hotline calls • Adults and children served by IPV-related CBOs • Criminal IPV cases • IPV-related mortality by municipality • Community interviews or focus groups

Local IPV organizations might be able to contribute data points such as the numbers of crisis hotline calls, adults and children served, shelter beds, and unmet requests for shelter because of lack of funding or capacity. Local jurisdictions might be able to provide data related to the number of IPV cases referred to the district attorney's office and number of IPV-related deaths in the county.[26] MCPs should identify disparities in IPV rates by factors such as race or ethnicity and socioeconomic status.[27] In addition to quantitative data on IPV prevalence in the MCP member population, plans should also incorporate qualitative interviews or focus groups with IPV organizations and survivors to better understand the impact of IPV, survivors' needs, and gaps in services.[28] For example, CalOptima, an MCP, used a community input process to conduct their PNA, and thus identified IPV as a priority issue.[29]

Recommendation 2. MCPs should partner with and support CBOs with expertise in IPV services to better understand the impact of IPV and implement community-level efforts to address and prevent it.[30]

MCPs must partner with and support cross-sector community coalitions to understand and address contributing factors to IPV, as well as the factors that lead to greater IPV prevalence in some communities—especially historically overburdened and under-resourced communities. MCPs could partner with the California Partnership to End Domestic Violence to facilitate statewide, regional, and local connections. Under the Centers for Disease Control and Prevention's DELTA FOCUS program, the California Partnership to End Domestic Violence was one of 10 statewide multisector coalitions including health care providers and CBOs that raised awareness of IPV prevention practices, built public health capacity to address and prevent IPV, and shared data and evaluation findings. The California Partnership to End Domestic Violence and other DELTA FOCUS coalitions used the approaches in Exhibit 2 to create IPV awareness:[31]

Exhibit 2. Community coalition approaches to raising awareness of IPV

- Provide resources, curriculum, and training to interested parties
- Respond to external queries for information
- Provide subject matter expertise to external organizations
- Present at professional meetings, events, and conferences
- Disseminate medical, social media, and electronic communications
- Create publications for external audiences
- Provide continuing education

To learn more about IPV, the Santa Clara County Board of Supervisors convened a multisector IPV Blue Ribbon Task Force from January 2016 through June 2017 and hired a contractor to conduct a needs assessment and recommend ways to address IPV.[32] MCPs and CBOs can work together to build awareness and understanding of IPV's prevalence, protective and risk factors, and impact on health. CBOs and IPV organizations can contextualize and ground community-level data with their direct-service expertise and understanding of the strengths and needs of their clients and community. For example, the IPV service organizations interviewed for this brief emphasized that social factors—unstable housing and financial insecurity, for example—affect an individual's ability to leave an abusive partner. IPV organizations also underscored that survivors often need mental health counseling, and the demand for these services far exceeds the supply. Furthermore, IPV amplifies other social risks: it contributes to housing loss, food insecurity, unstable employment, social isolation, and poor mental and behavioral health. Engaging at the community level can position MCPs to foster interventions that address the underlying societal causes of violence, such as poverty, housing instability, unemployment, racism, ableism, and sexism.[33]

- **Strategy 2.1. MCPs should provide in-kind or financial support to compensate IPV service organizations for their contributions to the PNA process.** Through meaningful partnerships with IPV service organizations, MCPs can support community-level prevention strategies to address IPV by aligning resources and funding prevention and intervention initiatives. For example, MCPs could offer coalitions logistical support, such as free meeting space for convening, training, or workshops. MCPs could fund community collaboratives' ongoing work to engage community voice, build trust, foster resident leadership, and advance action-oriented systems change to address disparities and promote equity with culturally specific and tailored approaches well-suited for the local community. This can also

"Public health and health plans tend to speak a different language. We are, as local health departments, trying to honor and reorganize ourselves in more of a provider way to be more able to exchange information and be a hub for resources.… The challenge is that everyone is overwhelmed, and we aren't talking to each other and only come together in crisis. And yet, there is a promise of everyone covered in California. The positive is we have an incentive to collaborate, but the challenge is the normal sort of tensions that have always existed."

—Public health official

help MCPs fulfill accreditation requirements through the National Committee for Quality Assurance. Strong community partnerships are a learning opportunity for all entities: CBOs can learn more about helping IPV survivors gain access to health care, and MCPs can learn more about the life-saving services IPV organizations offer. Additionally, cross-disciplinary training sessions with health providers, mental health professionals, and IPV advocacy organizations will help staff feel more comfortable making cross-agency referrals.[34]

- **Strategy 2.2. MCPs should demonstrate commitment to building a shared vision by adding CBOs with expertise in IPV to their governing boards to consistently include a CBO perspective.** Although several interviewees working outside the health care system noted that they are open to building partnerships with MCPs, they expressed concern about the power imbalance. One interviewee noted that it seems as though nonprofit organizations "are not considered a player in this game. So, our interest is really in creating something that will allow us to continue to do our work, but not be so restricted by our existing forms of funding." Another interviewee reflected that effective partnership may require health plans to step back "from driving the conversation or driving the solutions to partnering with others and letting others kind of lead that conversation."

- **Strategy 2.3. MCPs should develop or join community coalitions, such as the Los Angeles County Domestic Violence Council, that include representatives from local public health agencies (particularly those working to prevent and address IPV), IPV advocacy organizations, and survivors, to improve communication and coordination between health plans and CBOs.** Many community coalitions or regional collaborations, such as the Los Angeles County Domestic Violence Council and the East San Jose PEACE Partnership, have made important progress to address IPV and other complex SDOH. MCPs should identify these existing collaborative efforts, such as Accountable Communities for Health, and supplement, not supplant them.

  > *"Get in partnership with the people who are front and center and who are already centering those community voices, whether it's on a population level they're centering those voices or on an individual level."*
  >
  > —Domestic violence prevention program consultant

- **Strategy 2.4. MCPs should partner with CBOs that support IPV prevention strategies.** Because IPV is intertwined with other SDOH, addressing one social disadvantage may also improve other social factors. One interviewee observed, "As you move upstream, prevention is prevention for most poor outcomes." Multiple forms of violence—sexual violence, IPV, teen dating violence, and child abuse, for example—often have contributing factors in common.[35,36] A strong evidence base for educating young adults about healthy relationships demonstrates reduced violence perpetration and victimization, enhanced conflict resolution skills, and improved knowledge and attitudes about healthy relationships.[37,38,39] Many interviewees said their organizations offer prevention programs (such as educating youth about healthy relationships, engaging fathers, and offering bystander training), but all noted that there is not enough funding to support these initiatives.

As part of the requirement for MCPs to reinvest in their communities, they could invest in mitigating social and structural risk factors for IPV and support evidence-based, evidence-informed, and promising strategies known to prevent IPV (Exhibit 3).

Exhibit 3. Community-based strategies shown to prevent IPV [40,41,42]

- School-based health interventions on healthy relationships
- Community education and media campaigns on violence prevention
- Youth- and parent-centered programs on healthy relationships and positive parenting
- Community-based programs that address survivors' safety needs and other HRSNs
- Home visitation programs that include positive parenting and safety planning
- Clinical perinatal programs that include IPV education and referrals
- Economic and policy-focused approaches that promote systemic change to prevent IPV

MCPs should collaborate with local health jurisdictions to reinforce funding to prevent violence and promote safe communities using culturally and linguistically appropriate strategies, including emphasizing the opportunity for IPV prevention in resilience-building strategies for adverse childhood experiences. California recently invested $300 million to modernize the state's public health system to support protecting and enhancing the health of all Californians. The California Department of Public Health "envisions a strong local public health infrastructure in all communities built upon partnerships fostered with key stakeholders across a multitude of sectors to address health disparities and social determinants of health, such that we foster the conditions in which everyone can be healthy regardless of race, ethnicity, gender identity, sexual orientation, geography, or income level."[43]

C. Gathering member information (CalAIM PHM Domain 2)

DHCS expects each MCP to gather and use a variety of data to conduct PHM, including internal plan data and external information such as provider referrals and member screening and assessments. DHCS will require MCPs to hold network providers accountable for all preventive screenings for adults, per recommendations from the United States Preventive Services Task Force (USPSTF), including screening women of reproductive age (18–44) for IPV. Of note, DHCS's statewide PHM Service will also give MCPs, providers, counties, MCP members, and other authorized users access to comprehensive, historical data on members' health history, needs, and risks; it will also enhance data accuracy and timeliness by allowing members to update their information.[44]

Recommendation 3. MCPs should train health care providers and staff on culturally competent, trauma-informed approaches to universal education, screening, counseling, and referrals for IPV using a recommended evidence-informed model from the state and contracting with IPV service organizations to add information about local services and considerations.

Understanding IPV and trauma. Effective screening and referral for IPV requires an approach that is trauma informed, or that recognizes the impact of current and past traumas on patients' health and well-being and promotes healing in a safe and supportive environment. Survivor-centered approaches recognize that survivors have expertise, a voice, and agency in their own lives. These approaches support survivors' autonomy to disclose IPV in their own time and access resources through a variety of channels to match their readiness and self-defined needs.[45]

MCPs can draw upon survivor-informed research to build a comprehensive health care approach for all patients at risk of or experiencing IPV. Although the purpose of screening for HRSN is to connect patients to resources that will support their health and safety, disclosure of IPV is not the goal for many reasons. Fear of judgment, shame, worries about data privacy issues, and concerns about child welfare involvement make disclosure challenging, and the disclosure itself may amplify a survivor's immediate risk of harm; thus, rates of disclosure in health care settings are typically much lower than the known prevalence of IPV.[46] Relying solely on patients' disclosure of HRSN, including experiences of IPV, may fail to provide many patients with crucial information and resources. Experts therefore recommend a universal education approach, which involves training health care providers about the prevalence of IPV and encouraging them to discuss it with all patients whether they suspect IPV or not. Universal education seeks to empower patients with knowledge about available resources and ways to access them.

- **Strategy 3.1. MCPs should engage IPV service organizations or advocates to educate all health care staff (frontline and back-end staff) about the prevalence and impacts of trauma and IPV and how to respond.** MCPs should offer ongoing training to help all staff responsible for universal education, screening and assessment and response to recognize the complexities surrounding IPV, such as the physical and emotional impact of trauma and the compounding difficulties IPV creates for accessing other resources.[47] Refresher trainings to update staff on IPV issues and help them keep those issues in mind are particularly important for staff in positions where turnover is frequent. MCPs also must provide clear information about available services that health professionals and staff who might have personal experiences of IPV can access.

- **Strategy 3.2. MCPs should engage IPV service organizations or advocates to train health care providers and staff to use a universal education approach; this involves sharing resources such as crisis hotlines, speaking to patients about elements of healthy versus unhealthy relationships and the health effects of violence, and offering resilience building interventions, when needed.** Universal education ensures that all patients can recognize safety risks when they arise and have access to resources when they need them, regardless of whether they disclose IPV. As the name implies, providers should have these conversations with all patients. Futures Without Violence developed an evidence-based model for implementing universal education called CUES (Confidentiality, Universal Education and Empowerment, Support) and detailed guidance on implementing this approach.[48] For example, universal education practices encourage health care providers to take the steps in Exhibit 4.

When a patient discloses experiencing IPV, providers should respond with validating and supportive language, thank the patient for sharing it with them, assess other immediate health and social risks, and ask if the patient would like assistance connecting with local community resources. Universal education is also appropriate for mental health settings.[49] For example, the CUES intervention, tested across settings, achieved increases in IPV disclosure, knowledge of harm-reduction strategies, and likeliness of ending unsafe relationships.[50,51] Ideally, provider training will include interactive components that allow participants to practice these techniques and offer guidance on providing culturally responsive support and ensuring resources and materials are accessible to non-English speaking patients and people with disabilities who use adaptive technology (Exhibit 4).

Exhibit 4. Best practices for providers when offering universal education on IPV

Providing universal education

- Ensure some part of the patient consultation is private, with no one else in the room.

- Describe the limits of confidentiality with patients so they can decide what they are comfortable sharing.

- Reassure patients that they do not have to answer yes to any screening questions to get information about community services and supports.

- Explain how different experiences can affect health and give reasons for asking the questions.

- One model for universal education is CUES.

Responding to IPV disclosures

- Use validating and supportive language.

- Thank the patient for sharing with you.

- Assess other immediate health and social risks and co-create a safety plan.

- Ask whether the patient would like assistance connecting to local community resources and provide referrals.

Ensuring equity

- Ensure resources and materials are accessible to non-English speaking patients.

- Ensure accessibility for people with disabilities who use adaptive technology.

- **Strategy 3.3. MCPs should develop guidance on how providers can bill for administering universal education through the screening and brief counseling benefit.** Offering instruction and clarification through a memo or guidance document will support providers to offer universal education.

Asking the IPV question. HRSN screenings present an important opportunity to gather information about IPV and to offer support to survivors. Some existing literature provides evidence that HRSN screening and referral can not only support patients in meeting social needs but also may improve patient satisfaction and overall health.[52] The USPSTF's 2018 evidence review provides strong evidence that IPV screening and referral to supportive services, specifically for women of reproductive age, can reduce exposure to IPV, and prevent harm.[53,54] Trainings on screening should emphasize that the majority of individuals experiencing IPV do not disclose IPV to clinicians or seek help through the health care system. Those survivors who do disclose generally do so after multiple screenings with providers they trust.

Despite the USPSTF recommendation for routine clinician screening for IPV among women of reproductive age, rates are consistently low for several reasons. Providers report that lack of time and reimbursement, lack of clear protocols, limited knowledge and comfort with IPV, absence of an IPV referral network, and patient privacy concerns prevent them from screening patients.[55,56] Even when screening does occur, it may not be appropriately documented, especially if IPV is not the reason for the appointment. These factors contribute to the under-identification of IPV in administrative medical data and underscore the importance of systems-level policies, procedures, and linkages to IPV community resources to support provider training and screening practices.[57] By embedding procedures, health care

systems can integrate assessment templates into electronic health records with prompts to support and guide providers on how to respond to positive screens.[58]

- **Strategy 3.4. MCPs should require health care providers to consistently include an IPV question in HRSN screenings, coupled with universal education and resource sharing, regardless of whether a patient completes the screening or screens negative for IPV.** Clinical staff working with two of the PHM priority populations (that is, pregnant and postpartum people as well as children and youth) should follow professional association guidance for screening for IPV, abuse, or strangulation. The American College of Obstetricians and Gynecologists recommends that physicians screen all women for IPV at periodic intervals, offer ongoing support, and review available prevention and referral options. The American Academy of Pediatrics recommends routine IPV screening of caregivers.[59,60] Recognizing the importance and value of screening for HRSN, the Centers for Medicare & Medicaid Services (CMS) issued

  > **Several screening tools accurately detect IPV:**
  > - HARK (Humiliation, Afraid, Rape, Kick) tool
  > - HITS (Hurt, Insult, Threaten, Scream)
  > - E-HITS (Extended—Hurt, Insult, Threaten, Scream)
  > - PVS (Partner Violence Screen)
  > - WAST (Woman Abuse Screening Tool).
  >
  > The US Preventive Services Task Force recommendation statement is available at: https://jamanetwork.com/journals/jama/fullarticle/270

  a final rule requiring inpatient and long-term care hospitals to screen admitted patients for five HRSNs, including interpersonal safety. CMS will require hospitals to report their overall rate of screening and the screen-positive rate for each HRSN, and it might also add HRSN screening to the Merit-based Incentive Payment System in the future, which would affect physician groups.[61]

Responding to IPV. Appropriate responses to disclosures require empathy and willingness to help address survivors' varied health and social support needs. However, some providers are reluctant to screen for IPV because they feel helpless and unsure what they should do in the case of a disclosure. One interviewee said they tell health care providers who are reluctant to discuss IPV because they feel powerless to help that **empathic listening** is itself an intervention.

> *"Caring is an intervention. I cannot solve systemic racism on my own. I can't create a living wage. I cannot solve community-level food insecurity. With patients, I'm like, 'I'm so sorry.' And that itself is an intervention, right? I'm so sorry and I promise to work at it. I promise I'm in the fight with you."*
>
> —Family practice clinician

- **Strategy 3.5. MCPs should engage IPV service organizations or advocates to train health care providers (including health educators, case managers, community health workers, patient navigators, and social workers or other clinicians who conduct HRSN and IPV education and screening) to appropriately support and follow up on IPV disclosures.**[62,63] Provider training should emphasize the importance of conducting safety assessments to determine whether patients are in immediate danger, safety planning, and adapting a care plan that takes past or current partner interference into consideration. Additionally,

strong formalized partnerships with IPV service organizations facilitate warm referrals in which the health care provider makes a personal referral to a known IPV service organization.[64]

Documenting IPV. Providers should document and code the IPV discussion and disclosure, using preventive service codes to indicate IPV education and using social intervention codes to indicate the patient received referrals, with clinical notes.[65]

/////////////////////
"I've definitely had the experience of patients pursuing a restraining order or other legal support and having very little 'credible' information to go on other than their medical records."

—Health plan medical director

- **Strategy 3.6. MCPs should ensure that provider training includes guidance on how to correctly document IPV experiences in the Electronic Health Record (EHR) using ICD-10 codes, as well as how to record non-biased and sensitive clinical notes.** Exhibit 5 describes how providers can write EHR notes that support patient-centered care and respect privacy.

Exhibit 5. Strategies for appropriate EHR documentation of IPV experiences

- Trust patients and avoid conveying disbelief.
- Exercise care when using quotes.
- Recognize and remove stigmatizing phrases.
- Focus on strengths and humanizing details.[a]
- Consult with the patient about what to include in the documentation.

[a] Casau, A., and M.C. Beach. "Words Matter: Strategies to Reduce Bias in Electronic Health Records." Center for Health Care Strategies, October 2022. Available at https://www.chcs.org/media/Words-Matter-Strategies-to-Reduce-Bias-in-Electronic-Health-Records_102022.pdf.

Another interviewee pointed out that accurate medical records can also serve as an important legal resource for survivors seeking restraining orders or child custody, for example. Protecting patient privacy in the electronic health record and clinical notes is paramount. Recommendations for safeguarding privacy are detailed later in this brief.

- **Strategy 3.7. MCPs should carefully consider ways to harness plan-level data on IPV, such as the percentage of health care providers who are offering universal education and screening, to identify topics for further training or providers who could benefit from additional training.** The Office of Evaluation and Inspections, a component of the Office of Inspector General for the U.S. Department of Health and Human Services, is studying the challenges primary care clinicians face related to IPV screening and referrals. On a rolling basis beginning on January 9, 2023, the Office of Inspector General launched an invitation-only IPV survey to primary care clinicians who treated adult (that is, age 18 or older) Medicaid enrollees in 2021. The survey focuses on clinicians' IPV screening and referral practices, the challenges they encounter related to these services, and potential measures that might improve the screening for IPV. Aggregated responses will inform recommendations to

address the screening of patients experiencing IPV. The most recent Facility Site Review and Medical Record Review requirements from DHCS already incorporate a review of provider IPV screening. These findings will provide helpful guidance for MCPs. Health plans often track rates of screening for IPV and HRSNs, which can be informative process measures. Plans might also want to track health providers' identification of IPV to understand more about a group or individual provider's training needs. For example, no documented instances of IPV over several months would suggest that providers might need more education on screening and universal education or could benefit from practicing role playing the universal education discussion to make them feel more comfortable.

MCPs can also use plan-level data to understand how the MCP is responding to IPV and measure the quality of the care enrollees receive. The end goal is to measure health outcomes after an intervention to understand whether addressing safety and social risk factors has a positive impact on health outcomes.

Recommendation 4. MCPs should contract with IPV service organizations to incorporate IPV-related considerations and requirements into referral systems.

With the increasing recognition of the significant impact social factors have on health, providers have growing access to tools to support referrals to community-based services. Some tools offer online directories, tools that facilitate coordination of services and referrals, and closed-loop referral platforms that allow the provider or care-coordinator to confirm whether patients can access the needed services. These tools have the potential to route patients, including those experiencing or at risk of IPV, to key services and enhance patient trust in providers. IPV service organizations that participate in referral platforms could equip health providers to support survivors more effectively. However, participating in closed-loop referral systems can pose significant challenges for CBOs, including IPV service organizations. Common barriers to participation are concerns about privacy and confidentiality of data, limited capacity, strained resources, and lack of coordination across multiple reporting systems. Research on CBOs' participation in closed-loop referral systems showed that even when CBOs received free access to the systems, they still faced barriers with indirect costs such as training staff, developing new workflows, and implementing new IT infrastructure.[66,67] CBOs also encountered challenges keeping up with increased workloads due to referrals from health care providers, with no commensurate change in funding or resources.[68,69] In many cases, the reporting and client management systems CBOs used were incompatible with the referral platforms, or several health systems asked CBOs to participate in different closed-loop referral systems. This created duplicative reporting, requiring CBOs to enter the same information multiple times.[70,71 72,73]

> The National Health Resource Center on Domestic Violence offers an organizational assessment tool for hospitals and ambulatory care settings to monitor a health system's progress in improving the response to IPV.

- **Strategy 4.1. MCPs should facilitate effective IPV CBO buy-in to referral platforms by incorporating these entities into the development of data sharing efforts and demonstrating a commitment to prioritize survivor privacy and safety, providing information about the benefits of referral technology to CBOs, and offering support with implementation and technical challenges.** MCPs could prioritize survivors' privacy and safety by requiring training on IPV-specific confidentiality procedures for CBOs participating in referral platforms. IPV organizations typically accept referrals by phone call, which does not require submitting patient details electronically. MCPs

would have to demonstrate the added value of electronic referral platforms and provide technical assistance resources and additional funding to change IPV service organizations' preferred practices for receiving referrals.

- **Strategy 4.2. DHCS should require that community information exchanges include IPV service organizations (after robust discussions about confidentiality and training for the staff at the community information exchange about IPV).** San Diego 2-1-1's community information exchange is a promising model for developing a data sharing system across sectors with meaningful inclusion of CBOs and IPV service organizations.[74] DHCS should consider how this model can be adapted and scaled to encourage data sharing between MCPs, health care providers, and community partners in other areas of the state. As community information exchanges and referral platforms proliferate, DHCS should require inclusion of CBOs that address survivors' specific needs.

Recommendation 5. MCPs should adhere to applicable privacy laws, ensure that patients consent to sharing data, promptly report instances of providers breaking consent agreements, and allow withholding of sensitive information.

The PHM program requires safeguarding members' privacy and autonomy when gathering member information, including sharing information only within the confines of the law and in accordance with a member's preferences.

For IPV survivors, disclosing information can have serious negative consequences, such as harmful retaliation from their partner. 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.[75] Interviewees highlighted that privacy concerns and related complexities present an opportunity for innovation, for technology experts to develop "smart solutions." To prioritize survivors' safety, health systems must adhere to applicable privacy laws (such as California Law AB 1184, approved on September 22, 2021)[76] and build additional safeguards into data-sharing agreements and information technology systems.[64,77] This will address patient concerns and make providers feel more comfortable discussing IPV. One interviewee's organization had an arrangement with a health center to assign individuals referred from a domestic violence shelter a unique identification that would flag their information as highly sensitive. Unfortunately, a health center receptionist wasn't aware of this arrangement, and loudly asked if the patient was from the IPV organization. This breach of privacy underscores

California Law AB 1184: Revisions to the Confidentiality of Medical Information Act (approved 9/22/2021)

This law protects the privacy of people who receive sensitive services, such as those related to IPV. It specifies the following requirements for health plans:

1. Health plans must communicate about sensitive services using their patient's preferred communication method.

2. Health plans cannot share sensitive service information with any individual other than the patient (including the primary subscriber or policyholder on the health plan)

3. Patients receiving sensitive services must not be required to obtain permission from the primary subscriber or policyholder on the health plan.

why IPV training needs to include all health staff.

- **Strategy 5.1. MCPs should explore technological modifications to limit personally identifiable information used in electronic invoicing and referral systems, legal modifications such as time-limited consent, and contract amendments with partners that include appropriate privacy protections.** Exhibit 6 demonstrates the privacy precautions North Carolina added to protect IPV survivors in their Healthy Opportunities Pilot program. Program designs must strictly adhere to informed consent at all levels and at every point that data might be shared.

- **Strategy 5.2. DHCS and MCPs should engage with survivors and IPV advocacy organizations to determine the precautions necessary to ensure that standards meet survivors' privacy needs and protect safety**. 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. For example, the North Carolina Coalition Against Domestic Violence has collaborated with the North Carolina Department of Health and Human Services and Unite Us, the state's referral platform, to develop the Healthy Opportunities Pilot's referral system and referral processes that carefully consider survivors' needs.

Exhibit 6. North Carolina's Healthy Opportunities Pilot and survivor consent process

Background: As part of its Healthy Opportunities Pilot, North Carolina is finalizing its data and referral platform and processes. Participating health plans screen enrollees for health and social needs, and if enrollees screen positive for any needs that can be addressed through services covered by the Healthy Opportunities Pilot, they refer the enrollee to a care manager who works with the patient to understand their needs and refer them to a Human Service Organization (HSO), such as a domestic violence agency, that can provide the needed services.

Process for obtaining consent: Recognizing that some survivors who screen positive for having experienced or being at risk for experiencing domestic violence will not want to access services through the Healthy Opportunities Pilot or through an HSO, the state built in two steps at which consent must be obtained from enrollees:

1. A care manager responsible for referring enrollees to HSOs must obtain consent from the enrollee that they are willing to participate in and access services through the Healthy Opportunities Pilot.

2. After an enrollee is referred to an HSO, such as a domestic violence agency, to meet their social needs, the participating HSO is required to obtain additional time-limited consent from the enrollee that specifies the period during which the HSO can share the enrollee's information with other predefined entities. The HSO provider must verbally explain what providing consent entails, including which entities will have access to the enrollee's information and for how long. The enrollee may then provide or decline consent. Declining to consent will not impact survivors' ability to access needed services, but the services will not be reimbursed.

D. Understanding risk (CalAIM PHM Domain 3)

Risk stratification and segmentation (RSS) has the potential to support integrated care and help practices understand patients' needs, improve health outcomes, and reduce expenditures by targeting and tailoring care to high-need patients.[78,79] The PHM program seeks to support whole-person care by assessing members' individual risks for developing complex health issues, based on a constellation of data sources

(Exhibit 7). Understanding this risk will enable MCPs to proactively offer prevention, wellness, disease management, and care management programs, as appropriate. DHCS expects MCPs to use data analytics to preemptively identify members with rising risk levels—including not only medical risk but also social risk. DHCS's statewide PHM Service will have a single, statewide, open-source population RSS methodology with standardized risk-tier criteria that will place all Medi-Cal members into high-risk, medium-rising risk, and low-risk tiers.[19] MCPs must use the PHM Service (once available) to access and utilize the required data sources—in accordance with federal and state privacy rules and regulations—to drive RSS.

Exhibit 7. Data sources for gathering information and informing risk stratification[19]

• Screenings or assessments	• Lab results
• Claims and encounters	• Admissions, discharges, and transfers
• Available social needs	• Race/ethnicity
• Electronic health records	• Sexual orientation and gender identity
• Referrals	• Justice system involvement
• Behavioral health	• Housing
• Pharmacy	• Developmental and adverse childhood experiences screenings and resilience building strategies (for members under 21)
• Utilization	
• Disengaged member reports	

Recommendation 6. When stratifying patients into risk tiers, MCPs should ensure that patients with current or historical IPV are eligible for care management services because of the significant health and social risks associated with IPV.

The human and economic costs of not identifying people with a history of IPV or those at risk is staggering. IPV elevates risk, with long-term cascading implications. A longitudinal study found that, compared with women without IPV, women who experience IPV have higher health care utilization for mental health services, substance abuse services, hospital outpatient visits, emergency department visits, and acute inpatient care admissions during and after violence.[80] Health care utilization remained 20 percent higher 5 years after women's abuse ended, relative to women without IPV, and annual health care costs were 19 percent higher for women with a history of IPV.[81] Yet level of risk may be dynamic, which is why routine analysis and synthesis of multiple sources of data is important.

- **Strategy 6.1. Risk stratifications should incorporate HRSN and SDOH data.** Because IPV is closely linked with other social risks, risk stratifications that incorporate HRSN and SDOH data may also address risk factors for experiencing IPV. As described above, many individuals experiencing IPV may not have routine access to health care or may not ever disclose IPV, highlighting the importance of also considering other key data in RSS, including disengaged member reports and other social needs data from CalFresh and CalWORKs. Strategies to prevent rising risk and address health and social needs through referrals to community services and care coordination support will "raise all boats" as one interviewee described it. Therefore, whether IPV is identified or not, a patient's lack of engagement with health care, coupled with data on social needs, still has the potential to generate proactive strategies and meaningful interventions to support health and safety.

- **Strategy 6.2. Providers should properly document IPV with appropriate ICD-10 codes, and MCPs should consider those codes in determining members' health and social risks.** Proper documentation of IPV with appropriate ICD-10 codes is a straightforward mechanism to indicate and elevate a member's risk related to IPV. Evidence suggests that providers do not identify the vast majority of individuals experiencing violence through documentation with current ICD codes. For example, a study of all emergency department and inpatient hospital visits for adults in California from 2016 to 2018 found that IPV was documented in less than 0.1 percent of visits, using any of the five relevant ICD-10 codes.[82] Before documenting an individual's disclosure of IPV, the clinician should discuss safety and explicitly explain reasons for documenting the IPV in the medical record and describe who will have access to the information.

E. Providing services and supports (CalAIM PHM Domain 4)

The PHM program presents an opportunity to strengthen access to primary care and optimize care coordination and care transitions for survivors of IPV and those at risk. Under the PHM program, MCPs must ensure every member has access to primary care and an appropriate level of care management, including care coordination, navigation, and referrals for all health care and social needs. Although individuals experiencing IPV have significant, long-lasting health consequences, interviewees shared that many individuals experiencing IPV cannot prioritize their health and access preventive screenings or annual medical visits because of immediate safety concerns and urgent social risks. It is critical that providers seize the opportunity to provide tailored survivor-centered interventions and referrals to supportive services during clinical encounters.

Recommendation 7. MCPs should contract with CBOs with expertise in IPV to educate providers and offer tailored, setting-specific responses or additional supportive services for all patients, including priority populations, to better connect patients to primary health and behavioral services.

MCPs should contract with CBOs with expertise in IPV to train providers on brief interventions to help address the survivor's immediate safety and well-being and co-create a care plan that takes partner interference into consideration. Health providers could facilitate discussions about managing or anticipating partner interference with access to medications, food, transportation, or health care and partner-imposed restrictions on housing options. In connection with reproductive and sexual health, partners may interfere with contraception or pressure a survivor to become pregnant.[83] Understanding these and similar concerns enables providers and patients to develop effective care plans to improve health.

Because survivors are also at higher risk for multiple social risk factors, they may need a variety of social services and trauma-informed care coordination, which community-based IPV service organizations are best positioned to provide. For example, people who cause harm may engage in financial abuse (such as withholding money or sabotaging employment) or restrict a survivor's ability to work. Survivors should receive assistance in navigating services for job placement, transportation, and financial supports that can help them achieve financial independence. Survivors may need essential legal services for personal protection orders, help with dissolving marriages or domestic partnerships, or assistance with securing custody of children. In addition, survivors with children need access to childcare and parenting support, with secure places to send their children while they pursue employment or housing or attempt to meet other social needs.

- **Strategy 7.1. DHCS, MCPs, and IPV service organizations should offer specific guidance and IPV-related training for providers working with the pregnant and postpartum priority population in the CalAIM PHM program.** Clinicians providing reproductive health services are well-positioned to offer patients information about healthy relationships, recognize IPV and signs of reproductive coercion, and suggest alternative contraceptive methods such as long-acting, reversible contraception, including implants and intrauterine devices, which partners cannot control. If a clinician confirms or suspects exposure to IPV, it is appropriate to consider the pregnancy high-risk. Clinicians can take important steps to support a survivor's health and safety, such as coordinating interventions and support services and ensuring postpartum follow-up. Additionally, trained counselors can support the survivor with prenatal cognitive-behavioral interventions, including education about abuse and safety behaviors. These approaches may improve health outcomes for mothers and infants and possibly interrupt intergenerational cycles of family violence.[84]

  Home visitation services with pregnant and perinatal people offer an important opportunity for intervention. It is critical for the continuum of services offered under PHM to recognize the intragenerational impacts of IPV and seize opportunities to link family members to needed supports and services.[85] Children who witness or experience IPV have a heightened risk of mental health disorders and future violence victimization or perpetration in adolescence and adulthood.

- **Strategy 7.2. MCPs should support disrupting the cycle of violence by working with IPV service organizations to train pediatric providers on a two-generation IPV intervention approach using a standard curriculum and covering IPV services during home visits.** Women experiencing IPV during pregnancy are three times more likely to report symptoms of depression in the postnatal period than pregnant women who do not experience IPV.[86] IPV is a consistent predictor of postpartum depression, with the severity of depressive symptoms increasing with the severity of IPV. Therefore, pediatric visits are also

> **Home visitation programs can effectively disrupt intergenerational cycles of violence with the following activities:**[a]
>
> - Educating pregnant and postpartum people about IPV and resources
> - Screening for IPV (when safe to do so)
> - Connecting mothers with IPV experiences or risk of IPV and their children to community resources and behavioral health services
> - Talking 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.[b]
>
> [a] Family Violence Prevention Fund. "Realizing the Promise of Home Visitation: Addressing Domestic Violence and Child Maltreatment." n.d.
>
> [b] Sharps, P.W., L.F. Bullock, J.C. Campbell, J.S. Alhusen, S.R. Ghazarian, S.S. Bhandari, and D.L. Schminkey. "Domestic Violence Enhanced Perinatal Home Visits: The DOVE Randomized Clinical Trial." Journal of Women's Health, vol. 25, no. 11, November 2016, pp. 1129–1138.

important opportunities for postpartum depression screening with referrals to mental health services.[87,88] In addition to pediatric visits with IPV screenings and referrals, home visiting services are an important opportunity for intervention.

- **Strategy 7.3. MCPs should contract with IPV service or advocacy organizations to educate providers on trauma-informed care and survivors' multifaceted needs. Providers working with priority populations that disclose past or current IPV should co-create treatment plans with patients that support survivors' health and reduce harm, and providers should offer warm referrals for appropriate follow-up care. Treatment plans should include immediate safety planning, mental and behavioral health care, and appropriate social services such as housing and legal supports.** Care coordination, counseling, and referral services can meaningfully improve the health and safety and address the social needs of IPV survivors and their families.[89,90,91] Providers working with priority populations are well-positioned to follow clinical guidelines and best practices to identify and respond to IPV and provide warm referrals to essential behavioral health and community services to support health and safety for survivors and their families.[92]

- **Strategy 7.4. DHCS should add IPV-related services to the list of community supports and partner with IPV advocates and service organizations to develop guidance for strategies that MCPs can use to safely cover IPV services.** DHCS encourages MCPs to offer up to 14 community supports. Although the existing approved list of community supports does not include IPV services, several covered supports could be critically important for survivors' safety and healing, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, and short-term post-hospitalization housing for IPV survivors with injuries requiring hospitalization.

- **Strategy 7.5. MCPs should cover services for IPV survivors provided by a wide range of community-based, non-medical social support organizations that employ trauma-informed practices, including community health workers and *promotores*.** Community health workers and *promotores* are trusted community members with lived experience or close ties to the communities they serve, with a long history of providing culturally appropriate, person-centered services that improve health outcomes, advance health equity, and reduce health care costs.[93] This workforce often helps address HRSNs and SDOH. To make community health workers more readily available, California approved a state budget on June 27, 2022, that included a health care workforce initiative that will invest $281.4 million to develop and deploy 25,000 community health workers by 2025.[94] In addition, to sustain and expand this workforce, California added community health worker services as a Medi-Cal benefit through a state plan amendment that went into effect July 1, 2022.[95] MCPs can provide a critical bridge for survivors by leveraging and expanding the existing workforce of community health workers to facilitate access to health and social services with culturally sensitive and trauma-informed care coordination.

- **Strategy 7.6. MCPs should contract with IPV service organizations that employ community health workers to address IPV and other HRSNs in the community.** One way to do this would be to directly contract with these CBOs to create pilot programs for community health workers to address IPV. Not all CBOs, however, have the resources or desire to be Medi-Cal providers. Another model that would enable smaller grassroots CBOs to participate in the community health worker benefit would involve a lead or backbone organization serving as the intermediary to MCPs, such as in the Pathways Community HUB Institute or a similar model.[96] These organizations would take on the tasks of billing and reporting to Medi-Cal, serve as fiscal intermediaries for smaller CBOs, and advocate on their behalf.

- **Strategy 7.7. Develop a template with standard contract language to engage CBOs with IPV expertise**. A contracting template will expedite MCPs' ability to work with and appropriately compensate CBOs with IPV expertise. California MCPs could consider reaching out to peers participating in North Carolina's Health Opportunity Pilots to request example language.

III. Conclusion and Next Steps

The CalAIM PHM program presents an opportunity for DHCS and MCPs to help address the needs of beneficiaries experiencing IPV and support those beneficiaries at risk for it. By training providers to appropriately educate and screen patients for IPV, building community partnerships with IPV service providers, and connecting survivors to important social and advocacy resources, DHCS and MCPs can empower survivors to get the support they need to improve health and well-being for themselves and their children. To ensure survivor-driven clinical and non-clinical services, DHCS should engage with IPV service organizations, advocates, and survivors to incorporate an IPV lens in the PHM strategy and PNA, develop guidance for health care providers regarding screening and referral to services, and support MCPs' coverage of community support services.

CalAIM's PHM program also presents a tremendous opportunity to help break the intergenerational cycle of violence by promoting universal education about healthy relationships and safety resources, helping to reduce children's exposure to violence within the home, and helping to ensure that children and adults who have experienced IPV can gain access to the services they need to heal. The recommendations in this brief will help address the needs of some of the most vulnerable Californians and support attainment of the PHM goal of ensuring Medi-Cal members can find a comprehensive program that leads to longer and healthier lives.

Appendices

Appendix A. PHM Program Goals

Table A.1. PHM program domains and goals[a]

PHM Program Goals
Domain 1: Population health management strategy and population needs assessment
Develop a clear understanding of members' health disparities and health and social needs at the level of each MCP.
Identify available resources and resource gaps that influence members' health and social needs.
Advance strong engagement with local communities.
Create a comprehensive strategy to address the specific disparities and resource gaps identified in the population needs assessment.
Domain 2: Gathering member information
Collect timely, dynamic, and accurate data on all members' needs and preferences to connect members to key services at the individual and family levels.
Safeguard member privacy and autonomy, which means sharing information only within the confines of the law and adhering to a member's preferences.
Cultivate trust through meaningful engagement with members, by communicating why questions are being asked and how member information will be used.
Gather and share data in a member-centered way between physical health, behavioral health, and social services, harnessing accessible modes to ask questions (e.g., electronically, during an existing appointment) to minimize duplication and reduce member screening fatigue.
Reduce bias through data standards that prevent stigma, health inequities, and adverse impacts on individuals and groups who have been economically, socially, culturally, or racially marginalized.
Domain 3: Understanding risk
Proactively identify all members who may benefit from services or interventions, such as prevention and wellness programs or basic PHM services.
Ensure the identification and stratification of members who stand to benefit most from additional interventions or specialized care management services and offer those members services.
Standardize data use to reduce bias and promote equity in risk stratification and segmentation and risk-tiering processes.
Domain 4: Providing services and supports
Basic PHM and care management will ensure that every member:
Has an appropriate, consistent, and timely source of care that meets the member's needs.
Has access to an assigned PCP and is engaged with primary care.
Receives all needed preventive services in coordination with the assigned PCP.
Has access to an appropriate level of care management (depending on the level of the member's health and social needs) through person-centered interventions, care coordination, navigation, and referrals across all health care and social services.
Transitional care will ensure every member:
Can transition to the least restrictive level of care that aligns with their preferences and meets their needs in a timely manner without care interruptions.
Receives the necessary coordination and support for a safe and secure transition with the lowest possible burden on the member.
Continues to have the support and service connections needed to be successful in their new environment.

[a]California Department of Health Care Services. "Population Health Management (PHM) Strategy and Roadmap July 2022." July 2022. Available at https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf.
MCP = managed care plan; PCP = primary care provider; PHM = population health management

Appendix B. Methods

Approach

We conducted an evidence scan and interviewed key informants. The evidence review included targeted Google Scholar searches with relevant key terms and a review of related gray literature. Additionally, we conducted 10 interviews in the fall of 2022 with subject matter experts from managed care plans, IPV advocates, experts on risk stratification and referral platform implementation, community-based organizations, and staff from the California Department of Public Health. We used a semi-structured interview protocol to guide our 60-minute interview discussions. We recorded our discussions and consulted transcripts to support coding of interview data. We then analyzed the data and abstracted high-level themes to answer research questions.

Research questions by PHM domain

Domain 1: Population health management strategy and population needs assessment
- How can MCPs expand existing models for incorporating community-level IPV prevention into community health needs assessments and community health improvement plans?
- How can MCPs tailor PHM strategies known to prevent IPV and support survivors and those at risk to the priority populations (children and youth, pregnant and postpartum individuals, and those with behavioral health needs)?

Domain 2: Gathering member information
- What sources of data should MCPs gather to identify survivors and those at risk? How can MCPs train providers to use trauma-informed approaches to gather this data?
- What are best practices for protecting privacy and coordinating closed-loop referrals for health and social services relating to IPV?
- What challenges and facilitators do CBOs experience in partnering with and accepting referrals from MCPs?

Domain 3: Understanding risk
- How should MCPs factor exposure to or experience of IPV into risk stratification?
- What challenges and facilitators do MCPs face when applying a risk factor approach to IPV?

Domain 4: Providing services and supports
- Of the services known to support IPV survivors or prevent future IPV, which should MCPs offer along the continuum of care?

References

[1] Mathematica reviewed published and gray literature, on-the-ground efforts, and emerging promising practices to identify these strategies. When applicable, we provide citations to evidence or best-practice guidelines. A detailed evidence analysis is beyond the scope of this brief.

[2] Mathematica reviewed published and gray literature, on-the-ground efforts, and emerging promising practices to identify these strategies. When applicable, we provide citations to evidence or best-practice guidelines. A detailed evidence analysis is beyond the scope of this brief.

[3] Smith, S.G., J. Chen, K.C. Basile, L.K. Gilbert, M.T. Merrick, N. Patel, M. Walling, and A. Jain. "The National Intimate Partner and Sexual Violence Survey (NISVS): 2010–2012 State Report." Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017. Available at https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf. Accessed November 14, 2022.

[4] Ibid., 1.

[5] Black, M.C. "Intimate Partner Violence and Adverse Health Consequences: Implications for Clinicians." *American Journal of Lifestyle Medicine*, vol. 5, no. 5, June 2011, pp. 428–439. https://doi.org/10.1177/1559827611410265.

[6] Miller, E., and B. McCaw. "Intimate Partner Violence." *New England Journal of Medicine*, vol. 380, no. 9, February 2019, pp. 850–857. https://doi.org/10.1056/NEJMra1807166.

[7] Warshaw, C., P. Brashler, and J. Gil. "Mental Health Consequences of Intimate Partner Violence." In *Intimate Partner Violence: A Health Based Perspective,* edited by C. Mitchell and D. Anglin. New York: Oxford University Press, 2009, pp. 147–170. Available at http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2015/10/Mitchell-Chapter-12.pdf. Accessed November 14, 2022.

[8] Breiding, M.J., K.C. Basile, J. Klevens, and S.G. Smith. "Economic Insecurity and Intimate Partner and Sexual Violence Victimization." *American Journal of Preventive Medicine*, vol. 53, no. 4, pp. 457–464. https://doi.org/10.1016/j.amepre.2017.03.021.

[9] Miller, E., and B. McCaw "Intimate Partner Violence." *New England Journal of Medicine,* vol. 380, 2019, pp. 850-857. Available at https://www.nejm.org/doi/full/10.1056/NEJMra1807166.

[10] Ramaswamy, A., U. Rajni, and A. Salganicoff "Intimate Partner Violence (IPV) Screening and Counseling Services in Clinical Settings." Kaiser Family Foundation, October 18, 2022. Available at https://www.kff.org/womens-health-policy/issue-brief/intimate-partner-violence-ipv-screening-and-counseling-services-in-clinical-settings/. Accessed November 14, 2022.

[11] ACOG. "Intimate Partner Violence." n.d. Available at https://www.acog.org/womens-health/faqs/intimate-partner-violence. Accessed November 14, 2022.

[12] Brownridge, D.A., T.L. Taillieu, K.A. Tyler, A. Tiwari, K.L. Chan, and S.C. Santos. "Pregnancy and Intimate Partner Violence: Risk Factors, Severity, and Health Effects." Violence Against Women, vol. 17, no. 7, 2011, pp. 858–881.

[13] Modest, A.M., L. Prater, and N.T. Joseph. "Pregnancy-Associated Homicide and Suicide: An Analysis of the National Violent Death Reporting System, 2008–2019." *Obstetrics & Gynecology*, vol. 140, no. 4, October 2022, pp. 565-573. https://doi.org/10.1097/AOG.0000000000004932.

[14] Pavey, A.R., G.H. Gorman, D. Kuehn, T.A. Stokes, and E. Hisle-Gorman. "Intimate Partner Violence Increases Adverse Outcomes at Birth and in Early Infancy." *Journal of Pediatrics*, vol. 165, no. 5, 2014, pp. 1034–1039.

[15] Stewart, D.E., and S. N. Vigod. "Mental Health Aspects of Intimate Partner Violence." *Psychiatric Clinics of North America*, June 2017, vol. 40, no. 2, June 2017, pp. 321–334.

[16] Futures Without Violence. "Healing Centered Approaches to Screen and Intervene for Social Determinants of Health Including Intimate Partner Violence." 2022. Available at https://healthpartnersipve.org/wp-content/uploads/2022/09/SDOH-and-IPV-paper-2022-FINAL.pdf. Accessed November 14, 2022.

[17] California Department of Health Care Services. "CalAIM: Our Journey to a Healthier California for All." n.d. Available at https://www.dhcs.ca.gov/calaim. Accessed November 14, 2022.

[18] National Committee for Quality Assurance. "Population Health Program Accreditation Standards." n.d. Available at https://www.ncqa.org/programs/health-plans/population-health-program-accreditation/benefits-support/standards/. Accessed November 14, 2022.

[19] California Department of Health Care Services. "Population Health Management (PHM) Strategy and Roadmap July 2022." July 2022. Available at https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf. Accessed November 14, 2022.

[20] Miller, E., and B. McCaw. "Intimate Partner Violence." *New England Journal of Medicine,* vol. 380, no. 9, February 2019, pp. 850–857. https://doi.org/10.1056/NEJMra1807166.

[21] Ibid., 16.

[22] Voith, L.A. "Understanding the Relation Between Neighborhoods and Intimate Partner Violence: An Integrative Review." *Trauma, Violence & Abuse,* vol. 20, no. 3, July 2019, pp. 385–397. https://doi.org/10.1177/1524838017717744.

[23] McDowell, M., and D. Reinhard. "Community Characteristics and the Geographic Distribution of Intimate Partner Violence: A Partial Test of Social Disorganization Theory." *Journal of Interpersonal Violence,* vol. 28, April 2022, 8862605221092070.

[24] Sources for community-level indicators of IPV include the Behavioral Risk Factors Surveillance System and the discontinued California Women's Health Survey. Other sources for county-level data, such as County Health Rankings, provide estimates of community safety, which include IPV and other exposure to community violence. A compendium describing other publicly available data sources is available on the VAWnet website. Available at https://vawnet.org/material/data-sets-related-violence-against-women

[25] VAWnet. "Data Sets on & Related to Violence Against Women." 2021. Available at https://vawnet.org/material/data-sets-related-violence-against-women. Accessed October 10, 2022.

[26] "Working Together to Promote Healthy and Safe Relationships in Santa Clara County: A Report on the Santa Clara County Intimate Partner Violence Blue Ribbon Task Force." June 2017. Available at https://womenspolicy.sccgov.org/sites/g/files/exjcpb1076/files/promote-healthy-safe-relationship.pdf. Accessed November 27, 2022.

[27] California Department of Public Health Violence Prevention Initiative. *Preventing Violence in California, Volume 1: The Role of Public Health.* May 2017. Available at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Violence%20Prevention%20Initiative/Preventing%20Violence%20in%20California%20-%20The%20Role%20of%20Public%20Health.pdf. Accessed November 14, 2022.

[28] Cantor, J., L. Hogan, K. Niemczyk, C. Smith, L. Fujie Parks, and E. Villa. "Integrating Community Level IPV Prevention in Community Health Assessments and Community Health Improvement Plans." California: Futures Without Violence and Blue Shield of California Foundation, September 2018. Available at https://www.preventioninstitute.org/sites/default/files/publications/Integrating%20Community%20Level%20IPV%20Prevention%20Into%20CHAs%20%20CHIPs_0.pdf. Accessed November 14, 2022.

[29] Ibid., 24.

[30] Using a memorandum of understanding can help health plans formalize partnerships with community-based IPV service organizations and define each partner's responsibilities

[31] Estefan, L.F., T.L. Armstead, M.S. Rivera, M.C. Kearns, D. Carter, J. Crowell, R. El-Beshti, et al. "Enhancing the National Dialogue on the Prevention of Intimate Partner Violence." *American Journal of Community Psychology*, vol 63, no. 1-2, February 2019, pp. 153-167.

[32] County of Santa Clara Office of Women's Policy and Harder + Company Community Research. "Working Together to Promote Healthy and Safe Relationships in Santa Clara County." June 2017. Available at https://harderco.com/wp-content/uploads/2017/08/Working-Together-to-Promote-Healthy-and-Safe-Relationships_FINAL.pdf. Accessed January 9, 2023.

[33] Niolon, P.H., M. Kearns, J. Dills, K. Rambo, S. Irving, T. L. Armstead, and L. Gilbert. *Preventing Intimate Partner Violence: A Technical Package of Programs, Policies, and Practices.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017.

[34] Ibid., 28.

[35] Wilkins, N., B. Tsao, M.F. Hertz, R. Davis, and J. Klevens. "Connecting the Dots: An Overview of the Links among Multiple Forms of Violence." U.S. Department of Health & Human Services, Centers for Disease Prevention and Control. 2014. Available at https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf. Accessed November 14, 2022.

[36] Klevens, J., and M. Metzler. "Bringing a Health Equity Perspective to the Prevention of Child Abuse and Neglect." In *Re-Visioning Public Health Approaches for Protecting Children*, edited by B. Lonne, D. Scott, D. Higgins, and T. Herrenkohl. Springer, 2019. https://doi.org/10.1007/978-3-030-05858-6_13.

[37] Finnie, R.K.C., D.L. Okasako-Schmucker, L. Buchanan, D. Carty, H. Wethington, S.L. Mercer, K.C. Basile, et al. "Intimate Partner and Sexual Violence Prevention Among Youth: A Community Guide Systematic Review." *American Journal of Preventive Medicine*, vol. 62, no. 1, January 2022, pp. e45–e55. https://doi.org/10.1016/j.amepre.2021.06.021.

[38] Lee, C., and J.S. Wong. "Examining the Effects of Teen Dating Violence Prevention Programs: A Systematic Review and Meta-Analysis." *Journal of Experimental Criminology,* vol. 18, September 2020, pp. 1–40. https://doi.org/10.1007/s11292-020-09442-x.

[39] Niolon, P.H., A.M. Vivolo-Kantor, A. J. Tracy, N.E. Latzman, T.D. Little, S. DeGue, K.M. Lang, et al. "An RCT of Dating Matters: Effects on Teen Dating Violence and Relationship Behaviors." *American Journal of Preventive Medicine*, vol. 57, no. 1, July 2019, pp. 13–23. https://doi.org/10.1016/j.amepre.2019.02.022.

[40] Basile, K.C., S. DeGue, K. Jones, K. Freire, J. Dills, S.G. Smith, and J.L. Raiford. *STOP SV: A Technical Package to Prevent Sexual Violence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016. Available at https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf. Accessed November 14, 2022.

[41] Fujie Parks, L., C. Castaldi, R. Davis, J. Price, and A. Somji. "A Health Equity and Multisector Approach to Preventing Domestic Violence: Toward Community Environments That Support Safe Relationships in California." Prevention Institute, 2017. Available at https://www.preventioninstitute.org/publications/health-equity-and-multisector-approach-preventing-domestic-violence. Accessed November 14, 2022.

[42] Prevention Institute & National Sexual Violence Resource Center. "A Health Equity Approach to Preventing Sexual Violence." June 2021. Available at https://www.nsvrc.org/sites/default/files/2021-06/health_equity_approach_to_preventing_sv_final508_0.pdf. Accessed November 14, 2022.

[43] California Department of Public Health. "Spending Plan for Public Health Infrastructure Investment 2022–23." January 2022. Available at https://www.cdph.ca.gov/Pages/Spending-Plan-for-Public-Health-Infrastructure-Investment.aspx. Accessed November 14, 2022.

[44] Ibid., 16.

[45] Machtinger, E.L., K.B. Davis, L.S. Kimberg, N. Khanna, Y. Cuca, C. Dawson-Rose, and M. Shumway. "From Treatment to Healing: Inquiry and Response to Recent and Past Trauma in Adult Health Care." *Women's Health Issues,* vol. 29, no.2, March 2019, pp. 97–102. https://doi.org/10.1016/j.whi.2018.11.003.

[46] Feder, G.S., M. Hutson, J. Ramsay, and A.R. Taket. "Women Exposed to Intimate Partner Violence: Expectations and Experiences When They Encounter Health Care Professionals: A Meta-Analysis of Qualitative Studies." *Archives of Internal* Medicine, vol. 166, no. 1, January 2006, pp. 22–37.

[47] Ibid., 38.

[48] IPV Health Partners. "Adopt the Evidence-Based Intervention." 2018. Available at https://ipvhealthpartners.org/adopt/. Accessed October 10, 2022.

[49] Todahl, J., A. Nekkanti, and S. Schnabler. "Universal Screening and Education: A Client-Centered Protocol for Normalizing Intimate Partner Violence Conversation in Clinical Practice." *Journal of Couple & Relationship Therapy*, vol. 19, no. 4, October 2020, pp. 322–346.

50 Miller, E., S. Goldstein, H.L. McCauley, K. A. Jones, R. N. Dick, J. Jetton, J. G. Silverman, et al. "A School Health Center Intervention for Abusive Adolescent Relationships: A Cluster RCT." *Pediatrics*, vol. 135, no. 1, 2015, pp. 76–85.

[51] Miller, E., and J. Anderson. "The 'CUES' Approach to Address IPV/Human Trafficking and Intersections with HIV in Primary Care: What's the Evidence?" Pittsburgh, PA: Children's Hospital of Pittsburgh of UPMC Adolescent Medicine, 2018. Available at https://www.futureswithoutviolence.org/wp-content/uploads/Demo-Site-Webinar-3-Final.pdf. Accessed November 11, 2022.

[52] Ruiz Escobar, E., S. Pathak, and C.M. Blanchard. "Screening and Referral Care Delivery Services and Unmet Health-Related Social Needs: A Systematic Review." *Preventing Chronic Diseases*, vol. 18, August 2021, E78. Available at https://pubmed.ncbi.nlm.nih.gov/34387188/.

[53] U.S. Preventive Services Task Force. "Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening." October 23, 2018. Available at https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening. Accessed October 10, 2022.

[54] Although other populations and age groups experience IPV, research is currently limited on IPV screening and intervention within these groups.

[55] Perone, H.R., N.A. Dietz, J. Belkowitz, and S. Bland. "Intimate Partner Violence: Analysis of Current Screening Practices in the Primary Care Setting." *Family Practice*, vol. 39, no. 1, February 2022, pp. 6–11.

[56] Alvarez, C., G. Fedock, K.T. Grace, and J. Campbell. "Provider Screening and Counseling for Intimate Partner Violence: A Systematic Review of Practices and Influencing Factors." *Trauma, Violence & Abuse,* vol. 18, no. 5, December 2017, pp. 479–495.

[57] Clark, C.J., L.M. Renner, and M.E. Logeais. "Intimate Partner Violence Screening and Referral Practices in an Outpatient Care Setting." *Journal of Interpersonal Violence,* vol. 35, nos. 23–24, December 2020, pp. 5877–5788.

[58] Interiano, A., C. Keltner, D. Knoll, and A. Sonenshine. "Addressing Intimate Partner Violence as a Social Determinant of Health in Clinical Settings." California IPV and Health Policy Leadership Cohort, September 2018.

[59] The America College of Obstetricians and Gynecologists. "Intimate Partner Violence." Committee Opinion, no. 518. February 2012. Available at https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence. Accessed November 23, 2022

[60] Thackeray, J.D., R. Hibbard, M.D. Dowd, the Committee on Child Abuse and Neglect, and the Committee on Injury, Violence, and Poison Prevention. "Intimate Partner Violence: The Role of the Pediatrician." *Pediatrics*, vol. 125, no. 5, 2010, pp. 1094–1100. https://doi.org/10.1542/peds.2010-0451.

[61] Centers for Medicare and Medicaid Services. "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation." *Federal Register.* August 10, 2022. Available at https://www.federalregister.gov/documents/2022/08/10/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the . Accessed December 23, 2022

[62] Sprague, S., K. Madden, N. Simunovic, K. Godin, N.K. Pham, M. Bhandari, and J.C. Goslings. "Barriers to Screening for Intimate Partner Violence." *Women & Health*, vol. 52, no. 6, 2012, pp. 587–605.

[63] Portnoy, G., R. Colon, G. Gross, L. J. Adams, L. A. Bastian, and K. M. Iverson. "Patient and Provider Barriers, Facilitators, and Implementation Preferences of Intimate Partner Violence Perpetration Screening." *MC Health Services Research*, vol. 20, no. 1, August 13, 2020, pp. 1–12.

[64] O'Rourke, L. "Evaluating Social Service Referral Platforms: Considerations for Domestic and Sexual Violence Referrals." Futures Without Violence, July 2022. Available at https://policy.futureswithoutviolence.org/wp-content/uploads/2022/09/Evaluating-Social-Service-Referral-Platforms-Considerations-for-Domestic-and-Sexual-Violence-Referrals-Policy-Memo.pdf. Accessed November 14, 2022.

[65] Futures Without Violence. "Healing Centered Approaches to Screen and Intervene for Social Determinants of Health Including Intimate Partner Violence." 2022. Available at https://healthpartnersipve.org/wp-content/uploads/2022/09/SDOH-and-IPV-paper-2022-FINAL.pdf. Accessed November 14, 2022.

[66] Cartier, Y., C. Fichtenberg, and L.M. Gottlieb. "Implementing Community Resource Referral Technology: Facilitators and Barriers Described by Early Adopters." *Health Affairs,* vol. 39, no. 4, April 2020. https://doi.org/10.1377/hlthaff.2019.01588.

[67] Trenton Health Team. "HARP Research Findings." Trenton, NJ: Trenton Health Team. October 2021. Available at https://trentonhealthteam.org/reports/harp-research-findings/. Accessed November 14, 2022.

[68] Hogg-Graham, R., K. Edwards, T.L. Ely, M. Mochizuki, and D. Varda. "Exploring the Capacity of Community-Based Organizations to Absorb Health System Patient Referrals for Unmet Social Needs." *Health and Social Care in the Community*, vol. 29, no.2, March 2021, pp. 487–495. https://doi.org/10.1111/hsc.13109.

[69] Centers for Medicare and Medicaid Services. "Cross-Sector Data Sharing to Address Health-Related Social Needs: Lessons Learned from the Accountable Health Communities Model." October 2022. Available at Accountable Health Communities Model | CMS Innovation Center.

[70] Ibid., 68.

[71] Ibid., 70.

[72] Ibid., 60.

[73] Christensen, K., J. Soucie, and S. Hudson Scholle. "Implementing a Community Referral Platform: Recommendations From a Real-World Implementation Experience." National Committee for Quality Assurance, December 2020.

[74] San Diego 2-1-1. "Community Information Exchange." n.d. Available at https://ciesandiego.org/. Accessed October 10, 2022.

[75] Futures Without Violence. "California's Domestic Violence & Mandatory Reporting Law: Requirements for Health Care Practitioners." n.d. Available at https://www.futureswithoutviolence.org/userfiles/file/HealthCare/mandatory_calif.pdf. Accessed November 14, 2022.

[76] California Legislature. "AB 1184 Medical Information: Confidentiality." Pub. Law. No. 22-410. September 22, 2021. Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1184. Accessed September 28, 2021.

[77] Futures Without Violence. "Health Information Technology and Health Information Exchange: Privacy Principles for Protecting Victims of Domestic Violence." September 2013. Available at http://ipvhealth.org/wp-content/uploads/2017/02/Privacy-Principles-for-Protecting-Victims-of-Domestic-Violence.pdf. Accessed October 10, 2022.

[78] Vuik, S.I., E.K. Mayer, and A. Darzi. "Patient Segmentation Analysis Offers Significant Benefits for Integrated Care and Support." *Health Affairs,* vol. 35, no. 5, May 2016, pp. 769–775.

[79] Wagner, J., J.D. Hall, R.L. Ross, D. Cameron, B. Sachdeva, D. Kansagara, D. J. Cohen, et al. "Implementing Risk Stratification in Primary Care: Challenges and Strategies." *Journal of the American Board of Family Medicine,* vol. 34, no.4, July–August 2019, pp. 585–595. https://doi.org/10.3122/jabfm.2019.04.180341.

[80] Rivara, F.P., M.L. Anderson, P. Fishman, A.E. Bonomi, R.J. Reid, D. Carrell, and R.S. Thompson. "Healthcare Utilization and Costs for Women with a History of Intimate Partner Violence." *American Journal of Preventive Medicine,* vol. 32, no. 2, February 2007, pp. 89–96.

[81] Rivara, F.P., M.L. Anderson, P. Fishman, A.E. Bonomi, R.J. Reid, D. Carrell, R.S. Thompson. "Healthcare Utilization and Costs for Women with a History of Intimate Partner Violence." *American Journal of Preventive Medicine,* vol. 32, no. 2, 2007, pp. 89–96.

[82] Adhia, A., R. Rebbe, A. Lane Eastman, R. Foust, and E. Putnam-Hornstein. "Intimate Partner Violence-Related Emergency Department and Hospital Visits in California Following the ICD-10-CM Transition, 2016–2018." *Journal of Interpersonal Violence.* October 2022.

[83] Blue Shield of California Foundation. "DVHCP Final Report." San Francisco, CA: BSCF, 2017.

[84] Kiely, M., A.A. El-Mohandes, M.N. El-Khorazaty, S.M. Blake, and M.G. Gantz. "An Integrated Intervention to Reduce Intimate Partner Violence in Pregnancy: A Randomized Controlled Trial." *Obstetrics and Gynecology,* vol. 115, 2010, pp. 273–283.

[85] For more information on proactive and responsive services to support the intergenerational impact of IPV see the following report containing recommendations for Medi-Cal managed care to prevent and address IPV: https://blueshieldcafoundation.org/sites/default/files/Medi-Cal%20Recomendations%20Brief%2011.17.pdf.

[86] Howard, L.M., S. Oram, H. Galley, K. Trevillion, and G. Feder. "Domestic Violence and Perinatal Mental Disorders: A Systematic Review and Meta-Analysis." *PLoS Medicine,* vol. 10, no. 5, May 2013, e1001452.

[87] Kothari, C.L., M.R. Liepman, R. Shama Tareen, P. Florian, R.M. Charoth, S.S. Haas, J.W. McKean, et al. "Intimate Partner Violence Associated with Postpartum Depression, Regardless of Socioeconomic Status." *Maternal and Child Health Journal*, vol. 20, no. 6, June 2016, pp. 1237–1246.

[88] Bair-Merritt, M., B. Zuckerman, M. Augustyn, and P.F. Cronholm. "Silent Victims—An Epidemic of Childhood Exposure to Domestic Violence." *New England Journal of Medicine,* vol. 369, no. 18, 2013, pp. 1673–1675.

[89] De Marchis, E.H., E. Brown, B. Aceves, V. Loomba, M.J. Molina, Y. Cartier, H. Wing, et al. *State of the Science on Social Screening in Healthcare Settings: Executive Summary.* San Francisco, CA: Social Interventions Research and Evaluation Network, 2022. Available at https://sirenetwork.ucsf.edu/sites/default/files/2022-06/State-of-Science-Executive-Summary%5B13%5D.pdf#:~:text=State%20of%20the%20Science%20of%20Screening%20in%20Healthcare,of%20racially%2C%20ethnically%2C%20and%20linguistically%20diverse%20patient%20populations. Accessed October 10, 2022.

[90] Women's Preventive Services Initiative. "Screening for Interpersonal and Domestic Violence." n.d.

[91] Dichter, M.E., S.N. Ogden, A. Tuepker, K.M. Iverson, and G. True. "Survivors' Input on Health Care-Connected Services for Intimate Partner Violence." *Journal of Women's Health,* vol. 30, no.12, December 2021, pp. 1744–1750. http://doi.org/10.1089/jwh.2020.8585.

[92] Ibid., 79.

[93] Centers for Disease Control and Prevention. "Community Health Worker Resources." February 2022. Available at https://www.cdc.gov/chronicdisease/center/community-health-worker-resources.html. Accessed November 14, 2022.

[94] State of California. "Enacted Budget Summary." June 2022. Available at https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf. Accessed December 2, 2022.

[95] Centers for Medicare & Medicaid Services. "State Plan Amendment (SPA) #: 22-0001." July 2022. Available at https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf. Accessed September 1, 2022.

[96] Agency for Healthcare Research and Quality. "Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes." Rockville, MD: Agency for Healthcare Research and Quality, January 2016. Available at https://www.ahrq.gov/innovations/hub/index.html. Accessed January 9, 2023.

mathematica.org   website