

CALIFORNIA IPV & HEALTH POLICY LEADERSHIP COHORT

-September 2018-

INTEGRATING COMMUNITY LEVEL IPV PREVENTION IN COMMUNITY HEALTH ASSESSMENTS AND COMMUNITY HEALTH IMPROVEMENT PLANS

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

AUTHORS

JEREMY CANTOR, Senior Consultant, JSI Research & Training Institute, Inc.

LAURA HOGAN, Program Consultant, Futures Without Violence

KRISTA NIEMCZYK, Public Policy Manager, California Partnership to End Domestic Violence

CHRISTINE SMITH, Public Policy Coordinator, California Partnership to End Domestic Violence

LISA FUJIE PARKS, Associate Program Director, Prevention Institute

ERICA VILLA, Manager of Community Partnerships, Next Door Solutions to Domestic Violence



**FUTURES
WITHOUT VIOLENCE**

blue  of california
foundation

Blue Shield of California Foundation is an independent licensee of the Blue Shield Association



The California IPV and Health Policy Leadership Cohort explored policy and practice changes that increase the capacity to move upstream to address community-level factors contributing to intimate partner violence (IPV). The need to promote prevention at the community level is well-documented, but there are no mechanisms in place to support local initiatives, nor are sources of funding and coordination clear. This brief shares recommendations that elevate consideration of IPV in ongoing planning, implementation, and evaluation processes within the health and public health sectors.

A scan was conducted to identify publicly available and easily accessible community health assessments and community health improvement plans for California counties, hospitals, health plans, and other health institutions. A set of assessments and plans were collected, and those that mention IPV were reviewed to determine how IPV was included. Finally, representatives from a handful of county public health departments, hospitals and health plans were interviewed to learn more about:

- their planning group and initial capacity building;
- data collection, analysis methods, and tools;
- decision-making to identify health priorities; and
- analysis and decision-making to develop a community health improvement plan and prioritize strategies.

LESSONS FROM THE FIELD

Community Health Assessment & Improvement Planning: Local Health Jurisdictions

Community health assessment (CHA) is one of public health's core functions. Moreover, the CHA is a core element of public health department accreditation—a national voluntary effort to advance quality and consistency across public health. According to the National Association of City and County Health Officials (NACCHO), they “provide information for problem and asset identification and policy formulation, implementation, and evaluation,” and help gauge how well a public health system is fulfilling its functions.^{2, 3} As part of ongoing health improvement processes, a CHA provides data to identify priority issues.

A subsequently developed community health improvement plan (CHIP) includes strategies for action and mechanisms for accountability.⁴ According to NACCHO, “a variety of tools and processes may be used to conduct a community health improvement process; the essential ingredients are community engagement and collaborative participation.”⁵ Together, CHAs and CHIPs become foundational tools for addressing community health priorities. Nationally, an increasing number of health assessments and improvement plans are applying a social determinants of health lens to address the underlying contributors to health and safety conditions, and build capacity for upstream, population-level health promotion strategies, rather than focusing on individual health behaviors.

A scan of recent CHAs and CHIPs in California revealed the following:

- Organizations with expertise in understanding and addressing IPV are largely not included in CHA/CHIP planning groups.
- The level of community engagement undertaken as part of a CHA/CHIP varies by county. Factors that shape the level of engagement include county size, orientation of the public health department, frameworks used to guide the process, and time/resources dedicated to the effort. As a whole, it appears that processes including more community engagement result in elevation of issues related to violence and trauma, pointing to the importance of this issue to the community.
- Many local health departments are identifying violence and trauma, including adverse childhood experiences (ACES), as health priorities.
- IPV, when integrated into a CHA/CHIP, is typically included under the broader umbrella of violence and community safety.
- While there are many resources to help public health departments in designing CHA/CHIP processes, there is a dearth of guidance on how to explicitly and comprehensively address IPV. Such guidance may be valuable and necessary for communities to more fully understand the extent, nature, and dynamics of IPV and how to effectively address and prevent it.

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

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

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

Community Health Needs Assessments: Tax-Exempt Hospitals

In California, 1994 legislation required all tax-exempt hospitals to conduct a community health needs assessment (CHNA). This framework served as a national model for similar provisions in the Affordable Care Act enacted in 2010, and the Internal Revenue Service (IRS) published final rules⁶ for all tax-exempt hospitals' CHNAs in 2014. Over the next 6-12 months, nonprofit hospitals will update their CHNAs and develop a community benefit plan to guide community investments. There is no common template for CHNAs, however hospitals are required to make their CHNA widely available by posting on their websites and California community benefit plans are posted publicly.⁷ Some hospitals work collaboratively in a region to produce a single CHNA for the city or county that multiple hospitals rely on to develop individual hospital community benefit plans.

The CHNA process is data driven, and therefore an important first step is ensuring the data reflects best available information and incorporates local stakeholder input. A review of CHNAs indicates that unintentional injury, violence, and abuse often are referenced as significant needs; however, this does not ensure a focus on IPV, child trauma, or related topics in community benefit plans. Some hospitals conduct focus groups or community input meetings to inform their CHNA or community benefit plan. Even where this is not a practice of local hospitals, community stakeholders can offer written input or request a meeting with hospital staff overseeing the development of the plan.

Community Health Assessments: Health Institutions and Multi-Sector Collaborations

Other health institutions and local health collaboratives, such as health plans, for-profit hospitals, accountable care organizations and Accountable Communities for Health (CACHI),⁸ do not follow required or consistent comprehensive assessments or planning processes. However, there are many such efforts in local communities, and together they represent a significant opportunity to elevate and prioritize IPV as part of local health improvement priorities.

- A number of Medi-Cal managed care plans (MCPs) have taken the initiative to conduct needs assessments that include community input processes. For example, CalOptima's recently completed assessment identified IPV as a priority issue. Additionally, many MCPs invest in community priorities through either a direct allocation of reserves or a community benefit entity.
- In California, health care districts (HCDs) collect local tax assessments to support healthcare access and health improvement. HCDs are governed by a board of directors that reviews priorities and strategic directions. There are a few examples of HCDs funding community responses to IPV and trauma.⁹
- Health plans have latitude to spend on quality improvement projects and implement value-based payments for providers. These mechanisms could be used to encourage allocation of resources to IPV response and prevention.
- The CACHI works as a collaborative body to address an agreed-upon health condition through a comprehensive set of strategies. Increasingly, violence and trauma are being elevated as priorities.





POLICY AND PRACTICE RECOMMENDATIONS

These policy and practice recommendations are offered for state and local practitioners within the health, public health, and violence prevention sectors, as well as for funders interested in these topics. These recommendations can help ensure the distinct IPV prevalence patterns, contributing factors, dynamics, and solutions are reflected in ongoing community health assessment and improvement processes.

- 1. Create and sustain multi-sector collaboration that includes representation from health, public health, and IPV services sectors.**
 - Violence prevention and response organizations should actively participate in broad-based multi-sector collaborations. Victimes of Crime Act (VOCA) funds can be leveraged to support health advocacy, and participation in these collaborations are an important element of that work.
 - Health and public health sectors are encouraged to prioritize partnership and financing strategies to support sustainable integration of IPV prevention and intervention in multi-sector collaborations.
- 2. Elevate IPV prevention and response as a core strategy to successfully address multiple health conditions.**
 - IPV and violence prevention organizations can proactively reach out to local hospitals and public health departments with qualitative and quantitative data about strengths, needs and gaps in the areas of services, as well as prevention strategies.
 - Healthcare organizations, such as community clinics and health centers, should proactively provide data and information about local challenges and solutions to address IPV through clinical practice to health plans, hospitals, and health departments.

- Prepare resident leaders, organizations, advocates, and activists to participate in CHNA/CHA/CHIP processes and other local decision-making processes—for example, testifying to a board of supervisors or guiding how to speak from lived experience in a way that is healing and empowering and mitigates re-traumatization.
3. **Develop a roadmap for hospitals, public health departments and health plans to create CNAs, CHIPs and community benefit plans that are informed by an understanding of trauma, violence, gender and racial equity, resilience and prevention.**
 - Outline a rationale for why preventing violence and trauma are high impact health improvement strategies in maternal outcomes, child development and chronic disease prevention.
 - Provide training for healthcare staff on the health impacts of violence and trauma, and on strategies for prevention, assessment and response.
 - Identify program approaches, direct service ideas, provider training resources, and organizational practice change initiatives to assist in developing plans.
 - Raise awareness with community violence prevention and DV advocacy programs about the process for CHNAs and CHIPs.
 4. **Develop a set of IPV related population-level data, quality metrics and performance measures for health plans and providers. Key stakeholders that support IPV prevention and response can:**
 - Support the development and dissemination of IPV-related quality metrics and performance measures for health plans and providers.
 - Collect baseline data and prepare case studies on funding and programs supported by health plans and other health institutions.
 - Develop data visualization, data storytelling, infographics and dashboard templates for local programs to use with hospitals, health plans, and health departments.

CONCLUSION

There is increasing momentum to recognize the prevalence and impact of IPV in health and behavioral health outcomes. There is also significant opportunity to leverage existing and emerging healthcare and public health assessment and planning processes to accelerate efforts. The recommendations detailed here provide a starting place for stakeholders who are interested in developing a multi-faceted, strategic approach to elevate IPV prevention and response as a central part of health improvement.

RESOURCES

California Partnership to End Domestic Violence: Includes a catalog of health resources for advocates | <https://www.cpedv.org/national-and-state-links>

Prevention Institute Expanding Collaborative Capacity to Prevent Domestic Violence, SAFE framework, and THRIVE framework | www.preventioninstitute.org

John Snow, Inc., features the Building Evidence on Domestic Violence Initiative | <https://bit.ly/2uG7IVy>

National Association of County and City Health Officials, Mobilizing for Action through Planning and Partnerships (MAPP) planning resources | <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment>

Hospital Community Benefit Toolkit and Searchable Resources | <http://www.communitybenefitinsight.org/?page=info.links>

California tax-exempt community benefit plans | <https://www.oshpd.ca.gov/HID/CommunityBenefit/Plans.html>

Kaiser Permanente CHNA platform | <https://www.communitycommons.org/groups/community-health-needs-assessment-chna/chna-data-platform/home/>

California Department of Public Health Violence Prevention Initiative | <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/ViolencePreventionInitiative.aspx>

California Department of Public Health Fusion Center | <https://www.cdph.ca.gov/Programs/FCSD/Pages/FusionCenter.aspx>

Internal Revenue Service (IRS) final rules implementing additional requirements for charitable hospitals section of the Affordable Care Act | <https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable>

1. Intimate partner violence, also referred to as domestic violence, is the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, psychological violence, and emotional abuse. The frequency and severity of domestic violence can vary dramatically; however, the one constant component of domestic violence is one partner's consistent efforts to maintain power and control over the other. Learn more about the dynamics, signs, and prevalence of domestic violence at the National Coalition Against Domestic Violence website at <http://www.ncadv.org/learn-more/what-is-domestic-violence>
2. Public Health Accreditation Board. Accessed July 19, 2018 at <http://archive.constantcontact.com/fs030/1102084465533/archive/1103695445388.html#LETTER.BLOCK21> For more information, visit http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1863
3. Institute of Medicine of the National Academies. (2003) The Future of the Public's Health in the 21st Century. Washington, DC: The National Academies Press.
4. Durch J.S., Bailey L.A., & Stoto M.A. (1997). Improving Health in the Community: A Role for Performance Monitoring. Washington, DC: National Academy Press.
5. Community Health Assessment and Improvement Planning. Accessed July 19, 2018 at <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment>.
6. View at <https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable>
7. Access at <https://www.oshpd.ca.gov/HID/CommunityBenefit/Plans.html>
8. For more informations, <http://cachi.org/>
9. For an example, visit <http://www.achd.org/childrens-advocacy-center-moves>