



**MAY 2019**

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This brief was made possible with the support of Blue Shield of California Foundation.

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# **Engaging Health Care Organizations in Violence Prevention:**

## **POTENTIAL CALIFORNIA STRATEGIES & FUNDING SOURCES**

Health plans, providers, and other health system stakeholders are increasingly seeking ways to address a range of upstream factors that influence health outcomes, quality of care, and costs in their communities. One such upstream factor is exposure to violence and the resulting trauma, whether community-level violence, intimate partner violence (IPV), domestic violence (DV), or violence in other forms. This document provides an overview of investments and programs that health care payers and providers could support to address and prevent the impacts of violence. This is not intended as an exhaustive list or review but rather as a starting point for those who are interested in thinking through opportunities. The strategies are limited to those that are feasible given current regulation and funding in California though the categories of funding sources and strategy focus will be relevant in other states as well. The strategies are separated into those intended for Medi-Cal Managed Care Plans (MCPs) and for other health care delivery stakeholders as described in the tables below. Commercial health plans, with more limited regulatory restrictions, could also elect to engage in this sphere; however, there may be different levers to encourage commercial health plans to invest in these activities.

This document illustrates some of the routes that MCPs, health care delivery systems, hospitals, and other organizations can take to respond to violence and promote community violence prevention. The strategies included here illustrate that, depending on available resources and level of readiness, health care and health plan entities have several options to address and prevent violence among patient populations and in their communities. Action on these strategies requires buy-in from leadership, providers and the impacted communities, analysis of data and potential impact, new or expanded partnerships, and planning and monitoring.

**Table 1. Medi-Cal Managed Care Plans (MCPs) - Violence Prevention Strategies and Activities\***

Managed Care Plan Funding Source	Currently Feasible Strategies	Description and Violence Prevention Examples
<b>CAPITATION PAYMENTS</b>	<b>Implement already covered services</b>	<ul style="list-style-type: none"> <li>■ Stakeholders and MCPs can emphasize strategies that are already covered and can be included in the medical loss ratio (MLR) numerator and MCP capitation rate setting.</li> <li>■ For example, MCPs, providers and other stakeholders can take advantage of provisions that support screening and response for violence exposure among enrollee populations. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program covers Staying Healthy Assessment Questionnaires and follow-up with children, and Medi-Cal covers HRSA-recommended adult preventive services without cost sharing including screening and counseling for domestic and interpersonal violence.<sup>1-3</sup></li> </ul>
	<b>Build a robust network of providers</b>	<ul style="list-style-type: none"> <li>■ MCPs can ensure that an appropriate network of providers is available to survivors. This includes behavioral health providers as well as non-medical providers like domestic violence advocates and community health workers who are trained to work with survivors.</li> </ul>
	<b>Utilize value-added services</b>	<ul style="list-style-type: none"> <li>■ Stakeholders and MCPs can increase support for “value-added” services. Plans have some flexibility to provide services that are not included in the state Medicaid benefit package, but that could improve quality outcomes and/or reduce costs. Value-added services are not required to be medical in nature.<sup>4</sup> For example, services provided by domestic violence advocates such as safety planning, referrals to safe housing, care management, and network building across agencies all have the potential to improve the health and well-being of survivors.<sup>5</sup></li> <li>■ These services can be considered in the numerator of the MLR (as part of a quality initiative) but cannot be considered for the purposes of capitation rate setting.<sup>6,7</sup></li> </ul>
<b>INCENTIVES</b>	<b>Set violence-prevention related targets</b>	<ul style="list-style-type: none"> <li>■ MCPs have the ability to create community-health aligned Pay for Performance (P4P) incentives to providers. An MCP could offer their network providers an incentive aligned with violence prevention, such as achieving a high-level of screening for exposure to violence or high rates of appropriate case management for enrollees identified with exposure to violence.<sup>8</sup> Additional incentives could be awarded to network providers who develop partnerships with IPV advocates, or who co-locate IPV advocates in their facilities.</li> </ul>
<b>RESERVES (discretionary funds)</b>	<b>Fund community health initiatives</b>	<ul style="list-style-type: none"> <li>■ MCPs can determine how to allocate reserve resources and could choose to invest in community-health-improvement programs. Some MCPs have established an official grantmaking mechanism such as LA Care’s Community Health Investment Fund and Partnership HealthPlan of California’s SDOH Innovation Grants.<sup>9</sup></li> <li>■ MCPs, through their established community investment fund or through their Board of Directors, could elect to fund violence prevention-focused organizations and programs in the community. For example, in 2017, LA Care’s Community Health Investment Fund provided \$6 million in funding to programs and services addressing several social determinants of health, including exposure to violence.<sup>10</sup> CalOptima dedicated over \$20 million to community grants in 2018 to address priority social determinants of health.<sup>11</sup></li> <li>■ There are several models for intensive case management and support for individuals at high-risk of experiencing violence. For example, the Marketplace Solutions and Incentives Project (MSIP) pairs data analytics to review health records and identify individuals at high-risk and then partners with a community based organization to provide personalized support. Initial pilot testing has indicated significant reductions in incidence of violence and health care utilization.<sup>12</sup></li> </ul>
	<b>Develop and implement provider training</b>	<ul style="list-style-type: none"> <li>■ MCPs can use discretionary funds to develop a training curriculum on universal education for IPV, and to implement the training to providers. Domestic violence advocates can provide the training and simultaneously develop relationships for future referrals.</li> </ul>

Managed Care Plan Funding Source	Currently Feasible Strategies	Description and Violence Prevention Examples
<b>SPECIAL PROGRAMS</b>	<b>Targeted case management &amp; Whole Person Care</b>	<ul style="list-style-type: none"> <li>■ Targeted Case Management (TCM) helps eligible Medi-Cal enrollees access needed social, medical, educational, and other services. Eligible populations include individuals who are in danger of or have a history of family violence and physical, sexual or emotional abuse. Case management activities include development of a care plan, referrals to other providers, programs, or services, and monitoring and follow-up. However, under the State Plan Amendment for this program, TCM is overseen and authorized by county health authorities, and is not required to meet state-wideness or comparability of services requirements.<sup>13-15</sup></li> <li>■ The Whole Person Care pilot includes provisions for new services and infrastructure related to coordinating services for designated populations. Supporting trauma-informed practices is explicit in some of the counties' projects and all of the eligible groups are likely to have disproportionately experienced violence and trauma (homeless, recently incarcerated, behavioral health diagnoses, etc.).</li> </ul>

\*For definitions of MCP funding terms, see Funding Terms Glossary on page 6.

In addition to the strategies listed above, there are other potential avenues that are not currently possible without state action (i.e., by the California Department of Health Care Services). These strategies vary in feasibility depending on the level of effort to implement state changes, existing data, and resources. Some of the strategies requiring state action include:

- Provide MCPs incentives. For example, a certain percentage of capitation payments could be provided to invest in upstream interventions that improve quality, such as an incentive to improve community violence prevention.
- Adjust program requirements to include specific services. For example, the state could require that MCPs screen for SDOH, including violence exposure.
- Require MCPs to re-invest in the communities they serve. For example, the state could require that MCPs re-invest a certain percentage of profits in community-determined health priorities such as violence prevention.
- Incorporate risk adjustment for social determinants of health into the MCP capitation payments. For example, the state could use data on rates of violence by zip code to increase capitation payments for patient populations at a higher risk.

## Hospitals, Health Systems, and Health Centers

A range of health system entities could implement the strategies described in Table 2. As with the strategies above, the activities may be paid for through direct reimbursement; as part of capitation; through incentive payments; or from general operating, discretionary, or community benefit funds. The methods for paying for these activities vary greatly depending on the type of entity (e.g., hospital, provider group, health center) and their payment and risk arrangements.

**Table 2. Hospitals, Health Systems, and Health Centers - Violence Prevention Strategies and Activities**

Strategy Focus	Description and Violence Prevention Examples
<b>Community Assessment</b>	<ul style="list-style-type: none"> <li>■ Tax-exempt hospitals are required to complete a community health needs assessment (CHNA) in accordance with requirements of the Affordable Care Act. The CHNA is intended to guide tax-exempt hospitals' investments in the community to improve wellbeing and health. The CHNA process also generally highlights community input.<sup>16</sup></li> <li>■ Hospitals and health systems can include violence and violence prevention indicators (such as rates of intimate partner violence) as key data points of their CHNAs. Additionally, hospitals should ensure that community input includes representation from organizations addressing violence.</li> </ul>
<b>Health Care Site-Based Interventions</b>	<ul style="list-style-type: none"> <li>■ Several programs and models focus on intervening at health care sites with individuals who have recently survived violent incidents. One strategy, discussed above, is to have a co-located domestic violence advocate. Another is to establish or partner with a hospital-based violence intervention programs (HVIP). HVIPs are accredited programs that engage victims of violence while they are in the hospital to reduce the rates of recurrence and future violent injuries.<sup>17</sup> As of December 2018, there were 34 HVIPs nationally.<sup>18</sup> Two examples of HVIPs include: <ul style="list-style-type: none"> <li>– The Wraparound Project at Zuckerberg San Francisco General Hospital provides: 1) culturally competent case management, 2) maximized behavior change opportunities for recent victims of violence and, 3) risk reduction services such as mental health services and vocational training. The program has reported a 70% decrease in recurrence of violence among participants.<sup>19,20</sup></li> <li>– The Cure Violence model addresses violence as an epidemic disease using the following framework: 1) interrupting the spread of violence, 2) reducing the risk of individuals at the highest risk of violence, 3) changing community norms, 4) continually analyzing data to identify changes, and 5) providing training and technical assistance to implement the model correctly.<sup>21</sup></li> </ul> </li> </ul>
<b>Partnerships and Multi-Sector Responses</b>	<ul style="list-style-type: none"> <li>■ A number of other sectors have mandates to respond to and prevent violence. Health care organizations can initiate or participate in partnerships across sectors that look to work together strategically and efficiently. For example, The Cardiff Violence Prevention Model is a multi-agency violence prevention strategy, involving hospitals and health systems, law enforcement, public health agencies and community violence prevention programs. Hospitals and health systems gather anonymized information for each victim of violence admitted (including time of the incident, weapons involved, etc.).<sup>22</sup> The hospital or health system reports then this data to law enforcement. In turn, law enforcement maps where and when violence occurs, and concentrates resources on certain "hot spot" locations at peak times for violence. The Cardiff Model has been piloted in the US, including at the Grady Memorial Hospital in the Atlanta metropolitan area where varied strategies such as improving lighting, starting after-school programs, securing vacant lots and increasing security has led to a decrease in crime.<sup>23</sup></li> </ul>
<b>Trauma Informed Systems</b>	<ul style="list-style-type: none"> <li>■ By implementing trauma-informed approaches, hospitals and health systems can 1) realize the widespread impact of trauma and understands potential paths for recovery; 2) recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3) respond by fully integrating knowledge about trauma into policies, procedures, and practices; and 4) seek to actively resist re-traumatization.<sup>24,25</sup></li> <li>■ For example, the Center for Youth Wellness (CYW) in San Francisco has developed a clinical practice focused on addressing toxic stress, including exposure to violence. CYW's approach includes evaluating children for their social histories, training staff, providing integrated and responsive care, conducting research on intervention strategies, etc.</li> </ul>
<b>Violence Exposure in SDOH Assessments</b>	<ul style="list-style-type: none"> <li>■ As social determinants of health (SDOH) assessments become more widespread, hospitals, health systems and health centers should include interpersonal violence questions. Existing screening tools, such as National Association of Community Health Centers' PRAPARE tool and Health Leads' Patient Social Needs Screening Toolkit include interpersonal violence and/or community violence question options.<sup>26,27</sup> To incorporate such questions into the care team workflow, SDOH templates should be embedded into the clinic or hospital's electronic health record. Providers or other frontline staff should explain the purpose of the assessment to patients before they administer it, and sites should compile a list of local resources related to violence exposure.</li> <li>■ In addition to addressing individual patient's needs for support and services, the data collected can also be used to track community trends and health outcomes related to exposure to violence. Collection of such data should be standardized to allow for follow-up analysis and planning.<sup>28</sup></li> </ul>
<b>Coding, Billing for Violence-Related Services</b>	<ul style="list-style-type: none"> <li>■ Health care sites can train relevant staff in coding and billing for violence-related services to help encourage the provision, recording, and reimbursement of these services. For example, guidance is needed for providers, and billing and coding staff, on maintaining privacy and appropriate diagnosis (ICD-10) and treatment (CPT) codes required for documentation and reimbursement.<sup>29</sup></li> </ul>

## Funding Terms Glossary

**Managed Care Capitation Rate:** The capitation rate is the amount the state contracts to pay a MCP per enrolled Medi-Cal member per month (PMPM). Roughly 80% of California's Medi-Cal members are enrolled in managed care. The capitation rate is set based on services designated in California's state plan; spending on quality initiatives intended to improve access and quality of care; and non-benefit costs such as administration and operations, taxes and regulatory fees, contributions to reserves, cost of capital, etc. Actuaries will calculate rates using past utilization of services, the prices paid for past utilization, and trend factors that account for projected program changes and/or changes in prices in the future. Capitation rates are reset by the state every 2 years dependent on approval from the Centers for Medicare and Medicaid Services.

**Value-Based Payments:** Value-based payments (VBPs) are payments that a payer makes to a provider that incent delivery of "value," or quality for a given unit of cost, rather than simply paying for a service regardless of the outcomes produced. Value-based payments to providers come in two major categories: risk-based payments with quality reporting and outcome-based payments. Risk-based payments are usually a fixed amount of money paid to a provider for a member (a capitation rate) in exchange for the provider assuming responsibility for the care and quality outcomes for that member. Outcomes-based payments are contingent upon achieving a certain outcome as opposed to providing a certain service. The term Pay for Performance is one outcomes-based payment model. Shared savings are another type of outcomes-based payment where a provider only receives savings if certain total-cost-of-care and quality goals are met. MCPs can build VBPs into their agreements with providers to incentivize certain activity (e.g., inputting additional data into EHRs) or outcomes (e.g., reducing health-care setting acquired infections). The state also has leeway to require MCPs to implement VBPs and also to set incentive payments for plans to achieve themselves.

**Value-Based Purchasing:** This is a term used to describe a state Medicaid agency's practice of trying to incentivize value when contracting with MCPs. States can provide incentive dollars or withhold a portion of the MCP rate contingent on MCPs achieving certain outcomes. In California, Medi-Cal uses performance on the External Accountability Set (EAS), a set of population health measures, to do auto-assignment of Medi-Cal members who do not select a provider. This is a form of value-based purchasing at the state level in managed care in California.

**Medical-Loss Ratio:** The ACA established an 85% benchmark for the Medical-Loss Ratio (MLR) for health plan spending, and California has been enforcing MLR requirements since 2011. The MLR is calculated by adding spending on services, quality improvement expenses, and fraud prevention expenses (often referred to collectively as the "numerator") and dividing by capitation revenue minus any taxes and fees (often referred to as the "denominator"). If community health improvement spending can be counted in the numerator, then it contributes to keeping the MLR at or above 85% (a plan with an MLR below 85% might be compelled to spend on services or quality improvement activities that support community health); if not, plans will see such spending as being taken from a limited amount of administrative, discretionary resources and plan profits.

**Reserves and Profits:** Managed care plans are required to carry reserves in order to maintain fiscal solvency. The expenditure of reserve funds is largely at the discretion of the MCP governing board. In recent years, some California plans have amassed reserves that are in excess of their minimum requirement. Some MCPs, especially public Medi-Cal plans, have decided to reinvest these excess reserve funds in the communities they serve. Other MCPs systematically allocate funds to a community investment office or philanthropy. Reserve funds have been used to support community-health initiatives focused on improvements that impact all community members.

## References

1. American Academy of Pediatrics. *Bright Futures: California*. 2019: <https://brightfutures.aap.org/states-and-communities/Pages/California.aspx>
2. Gates A, Ranji U & Snyder L. *Coverage of Preventive Services for Adults in Medicaid*. Kaiser Family Foundation. November 2014: <https://www.kff.org/medicaid/issue-brief/coverage-of-preventive-services-for-adults-in-medicaid/>
3. James L & Schaeffer S. *Interpersonal and Domestic Violence Screening and Counseling: Understanding new Federal rules and providing resources for Health Providers*. Futures without Violence. May 2012: [https://www.futureswithoutviolence.org/userfiles/file/HealthCare/FWV-screening\\_memo\\_Final.pdf](https://www.futureswithoutviolence.org/userfiles/file/HealthCare/FWV-screening_memo_Final.pdf)
4. Crumley D, Lloyd J, Pucciarello M & Stapelfeld B. *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*. Center for Health Care Strategies. December 2018: <https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf>
5. Sullivan C. *Understanding How Domestic Violence Support Services Promote Survivor Well-being: A Conceptual Model*. Journal of Family Violence, July 2018: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5760592/>
6. JSI, Center for Health Care Strategies, Inc. & California Accountable Communities for Health Initiative. *Discussion Paper: Opportunities for Medi-Cal to Support Community Health Initiatives*. May 2018: <https://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=21605&thisSection=Resources>.
7. Bachrach D, Guyer J, Meier S, Meerschaert J & Brandel S. *Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools*. The Commonwealth Fund. January 2018: <https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review>
8. JSI, Center for Health Care Strategies, Inc. & California Accountable Communities for Health Initiative. *Discussion Paper: Opportunities for Medi-Cal to Support Community Health Initiatives*. May 2018: <https://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=21605&thisSection=Resources>
9. Ibid.
10. The Children's Partnership. *Health Begins Where Children Live, Learn, and Play: Advancing Health Equity*. May 2018: <https://www.childrenspartnership.org/wp-content/uploads/2018/06/Health-Begins-Where-Children-Live-Learn-and-Play-Advancing-Health-Equity.pdf>
11. CalOptima. *Community Grant Opportunities*. 2019: <https://www.caloptima.org/en/Community/CommunityGrants.aspx>
12. Marketplace Solutions and Incentives Project, *Collaborating with Health Plans to Reduce Costs through Community-based Violence Prevention: The MSIP Approach*. 2018: <https://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=22380&thisSection=Resources>
13. California Department of Health Care Services. *Targeted Case Management and Managed Care Plan Memorandum of Understanding Protocols*. January 2015: [https://www.dhcs.ca.gov/formsandpubs/Documents/ACLSS%20PPLs/2015/Targeted\\_Case\\_Management\\_and\\_Managed\\_Care\\_Plan\\_MOU.pdf](https://www.dhcs.ca.gov/formsandpubs/Documents/ACLSS%20PPLs/2015/Targeted_Case_Management_and_Managed_Care_Plan_MOU.pdf)
14. California Department of Health Care Services. *State Plan Under Title XIX of the Social Security Act: Targeted Case Management Services*. December 2017: [https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM%20SPAs/SPA%202017/CA\\_SPA\\_17-037.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM%20SPAs/SPA%202017/CA_SPA_17-037.pdf)
15. California Department of Health Care Services. *Targeted Case Management Overview*. N.d. <https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/Manuals/TCM%20Provider%20Manual/Section%201.pdf>
16. Cantor J, Hogan L, Niemczyk K, Smith C, Parks LF, & Villa E. *Integrating community level IPV prevention in community health assessments and community health improvement plans*. California IPV & Health Policy Leadership Cohort. September 2018: [http://www.ochealthiertogether.org/content/sites/ochca/Local\\_Reports/OCWHP\\_Policy\\_Brief\\_2018\\_Integrating\\_Community\\_Level\\_IPV\\_Prevention\\_Into\\_CHAs\\_CHIPs.pdf](http://www.ochealthiertogether.org/content/sites/ochca/Local_Reports/OCWHP_Policy_Brief_2018_Integrating_Community_Level_IPV_Prevention_Into_CHAs_CHIPs.pdf)
17. National Network of Hospital-Based Violence Intervention Programs. *About: The Emergence of a Network*. 2019: <http://nnhvip.org/mission/>
18. Conway C. *Beyond the Bullet: Wraparound Project is Breaking the Cycle of Violence*. University of California San Francisco. December 2018: <https://www.ucsf.edu/news/2018/12/412651/beyond-bullet-breaking-cycle-violence>



19. The Wraparound Project. 2016: <https://vimeo.com/139321826>
20. Conway C. *Beyond the Bullet: Wraparound Project is Breaking the Cycle of Violence*. University of California San Francisco. December 2018: <https://www.ucsf.edu/news/2018/12/412651/beyond-bullet-breaking-cycle-violence>
21. Cure Violence. *The 5 Required Components of Cure Violence*. 2019: <http://cureviolence.org/the-model/implementation/5-required-criteria-cure-violence/>
22. Hobor G, Leviton L. *The Cardiff Violence Prevention Model*. Centers for Disease Control and Prevention. November 2018: <https://www.cdc.gov/violenceprevention/fundedprograms/cardiffmodel/index.html>
23. Hobor G, Leviton L. *A Successful Model That Predicts and Prevents Violence*. June 2018: <https://www.rwjf.org/en/blog/2018/06/successful-model-that-predicts-and-prevents-violence.html>
24. Health Research & Educational Trust. *Hospital Approaches to Interrupt the Cycle of Violence*. Hospitals in Pursuit of Excellence. March 2015: <http://www.hpoe.org/Reports-HPOE/2015/2015-violence-prevention.pdf>
25. Substance Abuse and Mental Health Services Administration. *Trauma-Informed Approach and Trauma-Specific Interventions*. April 2018: <https://www.samhsa.gov/nctic/trauma-interventions>
26. National Association of Community Health Centers. *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*. 2019: <http://www.nachc.org/research-and-data/prapare/>
27. Health Leads. *The Health Leads Screening Toolkit*. September 2018: <https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/>
28. Interiano A, Keltner C, Knoll D, Sonenshine A. *Addressing Intimate Partner Violence as a Social Determinant of Health in Clinical Settings*. California IPV & Health Policy Leadership Cohort. September 2018: [http://www.ochealthiertogether.org/content/sites/ochca/Local\\_Reports/OCWHP\\_Policy\\_Brief\\_2018\\_Addressing\\_IPV\\_as\\_an\\_SDOH\\_in\\_Clinical\\_Settings.pdf](http://www.ochealthiertogether.org/content/sites/ochca/Local_Reports/OCWHP_Policy_Brief_2018_Addressing_IPV_as_an_SDOH_in_Clinical_Settings.pdf)
29. The American College of Obstetricians and Gynecologists. *Coding for Intimate Partner Violence*. N.d. <https://www.acog.org/-/media/Departments/Toolkits-for-Health-Care-Providers/Postpartum-Toolkit/ppt-coding-ipv.pdf?dmc=1&ts=20190108T1902176220>