IPV Measures Framework

Managed Care Plan Toolkit | 2026

Overview

This framework proposes **process, outcome, and balancing measures** to support Managed Care Plans (MCPs) implementing the IPV toolkit. Measures are organized across six domains (Education, Screening, Referral, Linkage, Follow-Up, Equity) and extended to include workforce/training and balancing measures.

Each measure is designated by **level of accountability**: **MCP** (plan-level - network contracts, aggregated data, policy), **Practice** (provider/site-level - encounter-based, EHR-documented), or **Both** (reported at each level separately). All measures should be **stratified by race/ethnicity and language** as possible.

Measures are aligned with the USPSTF Grade B IPV Screening Recommendation, DHCS PHM and Birthing Care Pathway requirements, CalAIM ECM/CS service lines, and existing MCAS/NCQA quality measures.

Measure Levels

MCP	**MCP-level:** Accountability sits with the plan - network contracts, training oversight, aggregated data, EOB monitoring, equity reporting, VBP arrangements, QI/PDSA oversight.
Practice	**Practice-level:** Accountability sits with the provider site - encounter-based delivery, EHR documentation, chart-level data. MCPs monitor these through network reporting.
Both	**Both:** Reported at each level separately. The MCP tracks the aggregated rate across the network; each practice tracks its own site-level rate.

Measure Types

Process	**Process:** activities being delivered as designed - CUES intervention offered, screens completed, referrals made. Primary levers MCPs and practices control directly.
Outcome	**Outcome:** changes in member health, safety, and care engagement. Take longer to move - track over 12–24 month periods.
Balancing	**Balancing:** unintended consequences of IPV program implementation - staff burden, privacy risk, member distress. Every QI effort needs at least one.

Notes for MCP Teams

- **Baseline first.** Document a baseline for each measure before setting targets. Readiness assessment data (PD1) will calibrate starting points.
- **Use the six domains as a QI diagnostic.** If screening rates are high but referral rates are low, the gap is in disclosure response - not awareness. The six-domain structure helps locate where to intervene.
- **PDSA cycles are small tests of change.** Each measure should generate a small, specific tests of change - not a comprehensive overhaul. PDSAs build iteratively: test one change with one provider/one team, learn from it, adjust, then spread. Start with the area where the data shows the biggest gap.
- **Set your own targets.** The scorecard includes sample targets for reference, but MCPs should set their own targets based on their baseline data, population, and community context. Do not treat the sample targets as requirements.
- **Equity is not a column - it is a lens.** Stratified data should be reviewed at every QI meeting. When equity gaps emerge, they should be the starting point for the next small test of change.

Proposed Measures by Domain

Level	Measure	Why It Matters	Type	Numerator	Denominator	Data Source	Equity Stratification
EDUCATION							
Practice	**% of Eligible Members Offered IPV Education Annually**	IPV education increases awareness of available resources and supports early help-seeking - offered universally so members do not need to disclose to receive information that could affect their safety and health	**Process**	Eligible members who were offered IPV education at a qualifying visit during the year	All eligible members attributed to the practice	*EHR encounter data/claims; outreach data*	Stratify by race/ethnicity, language, age, parity, geography
SCREENING							
Both	**% of Eligible Members Screened for IPV Annually**	Preventive care quality - annual screening ensures it is not a one-time event and aligns with USPSTF Grade B recommendation	**Process**	Members who received at least one IPV screen using a validated tool (HARK, HITS, or equivalent) in the calendar year	All eligible attributed members (MCP: aggregated across network; Practice: site-level)	*EHR encounter data/claims*	Stratify by race/ethnicity, language, geography
MCP	**IPV Screening Rate - Perinatal Members**	IPV risk remains elevated postpartum; perinatal screening is a DHCS Birthing Care Pathway requirement and critical for maternal safety	**Process**	Pregnant/postpartum members screened at a prenatal or postpartum visit (aligns with PPC: Postpartum Care MCAS measure)	All pregnant/postpartum attributed members	*Claims; EHR perinatal registry; DHCS Birthing Care Pathway reporting*	Stratify by race/ethnicity; monitor for gaps among Black, Indigenous, and Latina members
REFERRAL & RESPONSE							
Both	**% Positive Screens with Documented Support and Referral Linkage**	Continuity of care to needed services - screening without a documented response is insufficient; every	**Process**	Members with a positive IPV screen who have documented support and referral linkage	All members who screened positive (MCP: aggregated; Practice: site-level)	*Referral tracking systems; EHR extraction; closed-loop referral platform*	Stratify by race/ethnicity, language; note refusal rates separately

Level	Measure	Why It Matters	Type	Numerator	Denominator	Data Source	Equity Stratification
		positive screen requires action		to an IPV-related service			
Practice	**% with Documented Support/Counseling After Disclosure**	Preventive care quality - counseling after disclosure is distinct from referral and reflects CUES fidelity (the S: Support step)	Process	Members with a positive screen who have documented support or counseling contact in the EHR or chart	Members who screened positive and did not decline	*Chart review/registry; EHR extraction*	Stratify by race/ethnicity, language
LINKAGE							
MCP	**# of Contracted or Partnered Providers Serving IPV Survivors**	Community connected IPV experts are critical to the care team - network adequacy for IPV is a structural MCP-level responsibility	Process	Number of active CBO or provider contracts/MOUs specifically covering IPV services in the reporting period	Reported as absolute count and per 100,000 attributed members	*MOUs; Partner database; CalAIM CS/ECM network rosters*	Assess geographic coverage; ensure rural and underserved area reach
MCP	**% Referred Successfully Linked to Service**	Community connected IPV experts and services are critical to the care team - linkage is the outcome that referral is working toward	Outcome	Members who screened positive and were connected to ≥1 IPV-related service (CBO, ECM, CS, CHW, legal, housing) within 60 days	Members who screened positive (*aspirational; dependent on CBO availability)	*Closed-loop referral platform; ECM/CS enrollment data; MCP care management records*	Stratify by race/ethnicity, language, geography; monitor CBO capacity gaps
FOLLOW-UP							
Both	**% with Follow-Up Documented Within 30 Days**	Measures care coordination response - ensures members are not lost after initial referral or disclosure	Process	Members with a positive IPV screen who have a documented follow-up contact within 30 days of referral	Members with a completed referral (MCP: aggregated; Practice: site-level)	*EHR/care management data; closed-loop referral platform*	Stratify by race/ethnicity, language
MCP	**IPV-Related ED Utilization**	Effective IPV response should reduce preventable ED visits - a key ROI indicator for executive buy-in	Outcome	ED visits with an IPV-related ICD-10 code (T74.x, T76.x, Z69.x) among attributed members	Per 1,000 member-months	*Claims data; DHCS encounter data*	Stratify by race/ethnicity; monitor for changes over time

Level	Measure	Why It Matters	Type	Numerator	Denominator	Data Source	Equity Stratification
MCP	**Prenatal Care Engagement - IPV-Positive Members**	IPV increases risk of preterm birth and low birthweight; sustained prenatal engagement is a direct health outcome (aligns with PPC: Timeliness of Prenatal Care MCAS measure)	**Outcome**	Perinatal members with a positive IPV screen who had ≥4 prenatal visits (or adequate visits per gestational age)	Perinatal members with a positive IPV screen	*Claims; EHR perinatal registry; DHCS Birthing Care Pathway data*	Stratify by race/ethnicity; compare to IPV-negative perinatal members
EQUITY							
MCP	**Equity-Stratified Performance Reporting**	Non-stratified reporting masks disparities; all measures must be disaggregated to drive equity	**Process**	IPV-related metrics reported with stratification by race/ethnicity (and language where available)	All IPV-related measures reported in the period	*MCP QI reports; DHCS PHM reporting*	Non-stratified reporting is incomplete reporting
MCP	**Screening Rate Gap by Race/Ethnicity**	Equity is not a byproduct - it requires explicit measurement; IPV disproportionately affects communities of color	**Outcome**	Difference in IPV screening rate between the highest and lowest performing racial/ethnic subgroups	Reported as percentage point gap	*Claims; EHR with race/ethnicity data; DHCS PHM reporting*	Core equity measure - this IS the stratification
WORKFORCE & TRAINING							
MCP	**% of Provider Network Training in IPV Education, Screening & Response (Onboarding & Annual)**	Provider scope of competency - MCPs are responsible for ensuring their contracted network meets CUES training requirements (onboarding & annual)	**Process**	Provider network sites with ≥80% of clinical staff completing CUES training	Total contracted provider network sites	*Learning Management System (LMS); MCP training records*	Stratify by safety-net vs. non-safety-net; FQHC; rural/urban
MCP	**MCP Staff CUES Training Completion**	MCP care management and outreach staff are a direct service channel; their training drives ECM/CHW referral quality	**Process**	MCP clinical and care management staff who completed CUES training in the reporting period	Total MCP staff designated for IPV-related roles	*LMS; MCP internal training records*	Monitor by role type; ensure CHW, doula, ECM staff are included

Level	Measure	Why It Matters	Type	Numerator	Denominator	Data Source	Equity Stratification
BALANCING MEASURES							
Both	**Member Reported Experience of Support Services**	Member-centric outcome - the CUES intervention should feel safe, respectful, and supportive; if it causes distress or feels coercive, the approach needs adjustment	Balancing	Members who reported feeling safe and supported when IPV was raised during a health care encounter	Members surveyed who were screened for IPV	*Survey data synthesis (MCP); Survey data tabulation (Practice)*	Oversample by race/ethnicity, language; incorporate Voices from the Field
MCP	**Privacy Protections and EOB Monitoring**	Patient safety & information sharing protections - inadvertent disclosure via EOB or EHR can endanger survivors; MCPs control EOB suppression	Balancing	Documented incidents of privacy risk related to IPV (EOB disclosures, patient portal visibility concerns, documentation errors)	Reported per quarter	*Claims management; privacy incident logs*	Monitor for disproportionate impact on members with shared insurance
Practice	**Care Team Experience & Workflow Burden**	Provider feedback on CUES feasibility - if staff find the intervention workflow unworkable or feel underprepared, fidelity will erode; this measure identifies where a small test of change is needed	Balancing	Staff reporting high workflow burden, documentation errors, or low confidence in IPV referral	Reported per quarter as % of staff surveyed	*Staff pulse survey; QI team reports; reflective supervision records*	Disaggregate by clinic type, staffing model, population served

MCAS Measure Alignment

The table below maps five existing MCAS touchpoints where IPV education, screening, and response can be embedded without creating new administrative burden. These are MCP-level accountability items - the plan is responsible for ensuring provider contracts and training support delivery at these touchpoints.

MCAS Measure	IPV Touchpoint	Why This Matters for IPV	IPV Metric to Embed
PPC: Timeliness of Prenatal Care	Prenatal care visits are the primary opportunity window for perinatal IPV screening	IPV increases risk of preterm birth and low birthweight; early identification is preventive	% perinatal members offered IPV education at prenatal visit; prenatal care engagement rate for IPV-positive members
PPC: Postpartum Care	Postpartum visit is a critical re-engagement point - IPV risk does not end at delivery	IPV risk remains elevated postpartum; CUES intervention and support prevent postpartum depression and promote safety	% postpartum members screened for IPV at postpartum visit; % with documented referral linkage if positive
Depression Screening & Follow-Up	IPV is a major driver of depression and anxiety - co-occurring screening is clinically appropriate and operationally efficient	IPV intersects with behavioral health outcomes; depression screening visits are natural IPV touchpoints	% members screened for both depression and IPV in the same encounter; referral linkage rate for members positive on both screens
Well-Child Visits First 30 Months	Well-child visits capture caregivers - an opportunity to offer IPV education to parents/guardians in early parenting contexts	Captures caregiver engagement; ACEs framing supports trauma-informed care narrative	% caregivers offered IPV education at well-child visits; documentation of IPV education delivery at WCV encounters
Chlamydia Screening	Chlamydia screening visits (typically adolescent/young adult reproductive health) are an opportunity to deliver the CUES intervention	Opportunity context for clinical interaction with reproductive-age members; aligns with adolescent health special population pathway	% members at chlamydia screening visits who also received the CUES intervention; documentation rate of CUES delivery

Sample Scorecard: Measures at a Glance

Populate actual data quarterly and annually. Sample targets are shown for illustration - MCPs should set their own targets based on baseline data and community context. **MCP-level** and **Practice-level** scorecards are shown separately - MCPs should share the practice-level scorecard with contracted provider sites.

● Target Met - within 0pp of target or above	● Near Target - within 5pp below target	● Needs Attention - >5pp below target

MCP-Level Scorecard

Domain	Metric	Level	Target	Result	Status
Screening	% perinatal members screened (network-wide)	MCP	≥85%	*[enter]*	NEAR TARGET
Referral	% positive screens with documented referral linkage (agg.)	MCP	≥95%	*[enter]*	NEEDS ATTENTION
Linkage	% referred successfully linked to service	MCP	≥70%*	*[enter]*	TARGET MET
Follow-Up	% with follow-up documented within 30 days (agg.)	MCP	≥80%	*[enter]*	NEAR TARGET
Equity	Screening rate gap by race/ethnicity (pp gap)	MCP	≤5pp	*[enter]*	TARGET MET
Privacy	Privacy/EOB incidents (Balancing)	MCP	0	*[enter]*	TARGET MET
Workforce	% network sites with ≥80% staff CUES-trained	MCP	≥80%	*[enter]*	NEAR TARGET
Workforce	% MCP staff CUES training complete	MCP	≥90%	*[enter]*	TARGET MET
Partnerships	# contracted IPV CBO/provider partners	MCP	Baseline+	*[enter]*	NEAR TARGET

Practice-Level Scorecard

Domain	Metric	Level	Target	Result	Status
Education	% eligible members offered IPV education annually	**Practice**	≥90%	*[enter]*	**NEAR TARGET**
Screening	% eligible members screened for IPV annually	**Practice**	≥85%	*[enter]*	**TARGET MET**
Referral	% positive screens with documented support and referral	**Practice**	≥95%	*[enter]*	**NEEDS ATTENTION**
Referral	% with documented support/counseling after disclosure	**Practice**	≥90%	*[enter]*	**NEAR TARGET**
Follow-Up	% with follow-up documented within 30 days	**Practice**	≥80%	*[enter]*	**NEAR TARGET**
Experience	Member reported experience of support services (Balancing)	**Practice**	≥90%	*[enter]*	**TARGET MET**
Workflow	Care team workflow burden (Balancing)	**Practice**	<20%	*[enter]*	**TARGET MET**

** Linkage target (≥70%) is aspirational and dependent on community resource availability, CBO capacity, and member acceptance of referral(s).*

Data Infrastructure & Exchange Considerations

Robust data infrastructure is a prerequisite for collecting the measures in this framework. The table below maps each data type to its source, exchange mechanism, and readiness considerations for MCPs.

Data Type / Measure Category	Source & Exchange Mechanism	Readiness Considerations for MCPs
Education & Screening (CUES intervention delivery, IPV screen completion)	Claims/encounter data (CPT/LOINC codes); EHR extraction; outreach system data	**Activate IPV CPT/LOINC/ICD-10 codes** in provider-facing EHR templates (OCHIN, eClinicalWorks, Epic) Confirm codes are mappable to claims submitted to MCP Validate that CUES intervention steps (C, UE+E, S) are documentable as distinct encounter elements
Referral & Linkage (closed-loop referral, service connection)	Closed-loop referral platforms (Unite Us, findhelp); ECM/CS encounter data; care management systems	**Establish MOU/data sharing agreements** with CBO partners to enable closed-loop confirmation Map referral platform data fields to MCP reporting requirements Assess whether Unite Us or equivalent is active in all MCP service areas Review social referral platform paper (PHLC) for data sharing protocol guidance
Follow-Up & Care Coordination (30-day follow-up, ECM enrollment)	EHR care management notes; ECM/CHW encounter data; CalAIM reporting	**Standardize follow-up documentation** in EHR templates to enable extraction Confirm CalAIM ECM reporting includes IPV flag for enrolled members Assess MCP care management system capacity to track IPV-specific touchpoints
Privacy & EOB (privacy incident monitoring, EOB suppression)	Claims management system; privacy incident log; member communications system	**Review EOB suppression protocols** for IPV-related services (may inadvertently appear on shared insurance EOBs) Assess patient portal visibility settings for IPV-related documentation Pull from PHLC data sharing considerations paper for protocol guidance
Equity Stratification (race/ethnicity, language, geography)	MCP enrollment data; DHCS PHM demographic data; claims with race/ethnicity fields	**Confirm race/ethnicity and language fields** are populated in MCP enrollment data

Data Type / Measure Category	Source & Exchange Mechanism	Readiness Considerations for MCPs
		Identify linkage between claims and enrollment data for stratification Assess SOGI data availability for LGBTQ+ disaggregation where feasible Plan for quarterly stratified reporting cadence per DHCS PHM requirements
Member Experience (survey data, Voices from the Field)	Member experience survey (CAHPS supplement or custom); qualitative Voices from the Field data	**Determine survey instrument:** adapt existing CAHPS supplement or develop targeted IPV experience questions Oversample by race/ethnicity and language; include members with positive and negative screen results Plan for annual collection; use Voices from the Field input to inform question framing

Suggested Measurement Phasing

MCPs at different stages of IPV implementation will not collect all measures at once. The phasing below is tied to the toolkit's readiness framework (Current State → Testing State → Future State).

Phase	Getting Started (Yr 1)	Building (Yr 1–2)	Sustaining (Yr 2+)
Focus	Establish infrastructure; document baseline	Improve delivery rates; train workforce; build CBO network	Drive outcomes; close equity gaps; sustain financially
MCP-Level Priority Measures	• IPV Policy Adopted • Cross-Functional Team Established • Readiness Assessment Complete • IPV Coding Activated in EHR/Claims • CUES Training - MCP Staff • Data infrastructure audit complete	• % Network Training in IPV Education & Response (≥80%) • # Active CBO/IPV Partnerships • Perinatal Screening Rate (≥85%) • % Positive Screens with Referral Linkage (≥95%) - aggregated • % Follow-Up within 30 Days - aggregated • Privacy/EOB Monitoring (Balancing)	• % Referred Successfully Linked to Service (≥70%) • IPV-Related ED Utilization (↓ from baseline) • Prenatal Engagement - IPV-Positive Members • Equity Gap - Race/Ethnicity (≤5pp) • Equity-Stratified Reporting (100%) • VBP/Incentive Arrangement for IPV
Practice-Level Priority Measures	• CUES Training Complete (onboarding) • Baseline screening rate documented	• % Eligible Members Offered IPV Education (≥90%) • % Eligible Members Screened Annually (≥85%) • % Positive Screens with Referral/Support (≥95%) • % with Counseling After Disclosure (≥90%) • Care Team Workflow Burden (Balancing)	• % Follow-Up within 30 Days (≥80%) • Member Reported Experience (≥90%) • CUES Annual Refresh Training

Aligned with: USPSTF Grade B IPV Screening Recommendation | DHCS PHM & Birthing Care Pathway | CalAIM ECM/CS | MCAS/NCQA Quality Measures