Proposed New Measure for HEDIS®[1] MY 2027: Intimate Partner Violence Screening and Follow-Up (PVS-E)

NCQA seeks comments on the proposed new HEDIS *Intimate Partner Violence Screening and Follow-Up* (PVS-E) measure for MY 2027.

Intimate partner violence is a prevalent public health issue affecting every demographic group, with approximately 1 in 4 women and 1 in 7 men experiencing intimate partner violence in their lifetime in the US.[2] Screening and follow-up for intimate partner violence provide a standardized way for health care teams to identify safety concerns and determine when additional assessment, support or referrals are needed. Screening and follow-up for intimate partner violence are supported by US clinical guidelines, including the United States Preventive Services Task Force and The Women's Preventive Services Initiative.

The proposed PVS-E measure assesses persons 12–64 years of age who met the following criteria:

1. *Intimate Partner Violence Screening:* The percentage of persons screened for intimate partner violence using a standardized instrument.
2. *Follow-Up on Positive Screen:* The percentage of persons receiving follow-up care within 7 days of a positive intimate partner violence screen finding.

Field testing and NCQA's Digital Feasibility Assessment demonstrated that the measure is feasible to implement. Advisory panelists and subject matter experts contributed guidance throughout development and expressed support for the measure.

NCQA seeks feedback on the following questions:

1. What is the best approach to integrating the CUES framework (which includes confidentiality, universal education and support) in the quality measure?
2. What follow-up time window should be specified (7 or 30 days) at the health plan level?
3. Should we consider including people with a date of death to help identify missed opportunities for intimate partner violence screening and follow-up?
4. Testing showed very small sample sizes for the Medicare population. Should we consider expanding the current measure to individuals aged 12-64 within the Medicare product line?
5. Are there unintended consequences we should consider, particularly related to the disclosure of patient sensitive information and the subsequent documentation in the clinical record?

Supporting documents include the draft measure specification and evidence workup.

NCQA acknowledges the contributions of the Health Equity Expert Workgroup, the Technical Measurement Advisory Panel and Intimate Partner Violence subject matter experts.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] Stylianou, M.A. *Economic Abuse Within Intimate Partner Violence: A Review of the Literature.* Violence and Victims. January 2018. https://connect.springerpub.com/content/sgrvv/33/1/3.full.pdf

Intimate Partner Violence Screening and Follow-Up (PVS-E)

Measure title	Intimate Partner Violence Screening and Follow-Up	**Measure ID**	PVS-E
Description	The percentage of persons 12 - 64 years of age who met the following criteria: • *Intimate Partner Violence Screening*: The percentage of persons who were screened for intimate partner violence using a standardized instrument. • *Follow-Up on Positive Screen:* The percentage of persons who received follow-up care within 7 days of a positive intimate partner violence screen finding.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**Developed with financial support from the Blue Shield of California Foundation.* Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends screening for intimate partner violence among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation) The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation) Futures Without Violence, a leading anti-violence advocacy organization that developed the CUES (Confidentiality, Universal Education, Empowerment, and Support) approach, recommends the CUES framework as a best-practice model for screening and responding to intimate partner violence (IPV) in clinical settings. CUES promotes universal education, ensuring that all patients receive brief, supportive messages about healthy relationships and IPV. This approach incorporates safe, confidential conversations and provides patients with referral resources. CUES has been shown to improve patient engagement, reduce stigma, and support early intervention for IPV. The Women's Preventive Services Initiative, a federally supported collaborative program led by The American College of Obstetricians and Gynecologists (ACOG), advises conducting yearly screenings for interpersonal and domestic violence among adolescents and women; and referring to initial intervention services when needed (intervention services include, but are not limited to, education, harm reduction strategies, referral to support services, and counseling). The National Academies of Sciences, in collaboration with the US Health and Human Services Department, Essential Health Care Services for Intimate Partner Violence Recommendation 1: The committee recommends that the Health Resources and Services Administration and all U.S. health care systems classify the following as essential health care services related to intimate partner violence (IPV): Universal IPV screening and inquiry, Universal IPV education, Safety planning, etc.		

Citations	US Preventive Services Task Force et al. “Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement.” *JAMA* 329,16 (2018):167–87. Futures Without Violence. Educate Health Providers on How to Respond to Intimate Partner Violence. National Health Resource Center on Domestic Violence. (2023). https://ipvhealth.org/wp-content/uploads/2024/04/Evidence-behind-CUES_2024.pdf Women’s Preventive Services Initiative (WPSI) “Interpersonal and domestic violence recommendations.” ACOG Foundation. (2024). https://www.womenspreventivehealth.org/recommendations/interpersonal-and-domestic-violence/ National Academies of Sciences, Engineering, and Medicine (NASEM). “Essential Health Care Services Addressing Intimate Partner Violence.” Washington, DC: The National Academies Press. (2024): Chapter 5, 124-129. https://doi.org/10.17226/27425.
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial. • Medicaid.
Stratifications	Age as of the start of the measurement period. • 12–17 years. • 18–44 years. • 45-64 years. Administrative Gender. • Administrative Gender of Female (AdministrativeGender code female). • Administrative Gender of Male (AdministrativeGender code male). • Other. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to the *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine that the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.

Definitions

Intimate partner violence screening instrument

A standard assessment instrument normalized and validated for the appropriate patient population. Eligible screening instruments and eligible screening questions with thresholds for positive findings are outlined in the Table 1 and Table 2 below. Screening for IPV using the HITS (Hurt, Insult, Threat, Scream) or Accountable health communities (AHC) health-related social needs screening (HRSN) tools must be administered in entirety and have a Total Safety Score. Answers to any one or more of the IPV screening questions in Table 2 can be counted for IPV screening.

Table 1: Intimate Partner Violence Complete Screening Instruments

Screening Tool	Total Safety Score LOINC Code	Positive Score
HITS (Hurt, Insult, Threat, Scream)	95614-4	≥10

Table 2: Intimate Partner Violence Screening Questions

Instruments	Questions	Question LOINC Codes	Positive Finding
HARK (Humiliation, Afraid, Rape, Kick)	Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	76500-8	Yes LA33-6
HARK (Humiliation, Afraid, Rape, Kick)	Within the last year, have you been afraid of your partner or ex- partner?	76501-6	Yes LA33-6
HARK (Humiliation, Afraid, Rape, Kick)	Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	76502-4	Yes LA33-6
HARK (Humiliation, Afraid, Rape, Kick)	Within the last year have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	76503-2	Yes LA33-6
Intimate Partner Violence 4 (IPV-4)	In the past year, did a current or former partner make you feel cut off from others, trapped, or controlled in a way you did not like?	106924-4	Yes LA33-6
Intimate Partner Violence 4 (IPV-4)	In the past year, did a current or former partner make you feel afraid that they might try to hurt you in some way?	106923-6	Yes LA33-6
Intimate Partner Violence 4 (IPV-4)	In the past year, did a current or former partner pressure or force you to do something sexual that you didn't want to do?	106926-9	LA33-6
Intimate Partner Violence 4 (IPV-4)	In the past year, did a current or former partner hit, kick, punch, slap, shove, or otherwise physically hurt you?	106927-7	Yes LA33-6

Initial population	*Measure item count:* Person. *Attribution:* Enrollment. • *Benefit:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. *Ages:* 12 - 64 years of age and older at the start of the measurement period. *Event:* None.
Denominator Exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	**Denominator 1:** The initial population minus denominator exclusions. **Denominator 2:** Persons from numerator 1 with a positive finding or intimate partner violence between January 1 and December 24 of the measurement period.
Numerator	**Numerator 1—Intimate partner violence screening.** Persons in denominator 1 with a documented result for intimate partner violence screening performed between January 1 and December 24 of the measurement period. **Numerator 2—Follow-up on positive screen.** Persons in denominator 2 who received follow-up care (Intimate Partner Violence Procedures Value Set) on or up to 7 days after the date of the first positive finding. ***Note**: Follow-up care may include assistance, counseling, coordination, education, evaluation of eligibility, provision or referral.*
Summary of changes	• This is a first-year measure.

Data element tables

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table PVS-E-1/2/3: Data Elements for Intimate Partner Violence Screening and Follow-Up

Metric	Age	Administrative Gender	Data Element	Reporting Instructions
Screening	12-17	Male	InitialPopulation	For each stratification, repeat per metric
FollowUp	18-44	Female	Exclusions	For each stratification, repeat per metric
	45-64	Other	Denominator	For each Metric and Stratification
	Total	Unknown	Numerator	For each Metric and Stratification
		Total	Rate	(Percent)

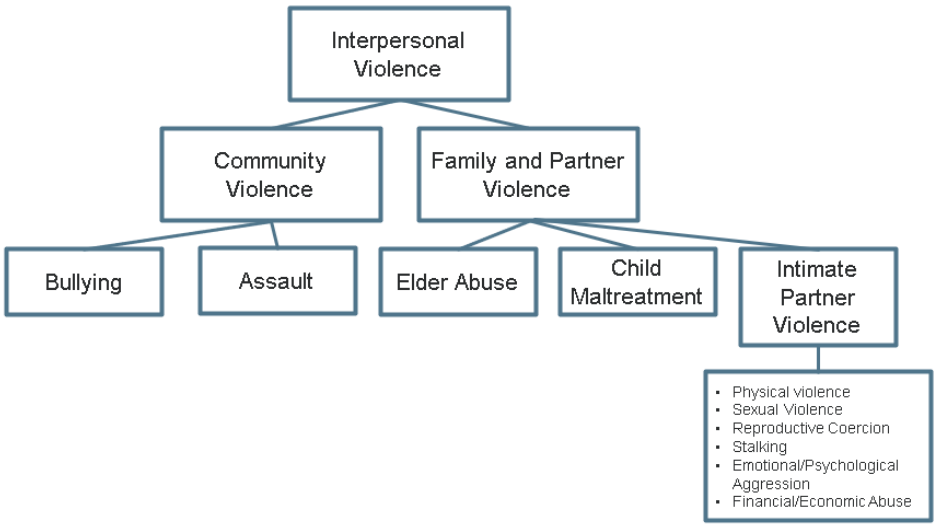
Intimate Partner Violence Screening and Follow-Up (PVS-E)
Measure Workup

Topic Overview

Intimate partner violence (IPV) is a subset of interpersonal violence. Interpersonal violence involves the use of physical force or power, and may be physical, sexual or psychological (Mercy et al., 2017). It includes family or partner violence and community violence, and Figure 1 demonstrates the various domains of interpersonal violence. Community violence occurs among non-familial individuals and typically occurs in institutional settings such as schools or workplaces. Family violence includes child maltreatment, elder maltreatment, dating violence and intimate partner violence (IPV always refers to intimate partner violence throughout this document) (Mercy et al., 2017). Experiencing one form of violence, such as exposure to childhood abuse, increases likelihood of experiences of other forms of violence, such as IPV in adulthood (Cueva, 2021). Thus, experiencing any form of violence predisposes individuals to other forms of violence—creating compounded vulnerabilities to the negative impacts of violence.

This literature review and measure focus on IPV because it has the strongest evidence base and clinical actions for screening and providing interventions are supported by US clinical guidelines; however, other forms of family and partner violence are prevalent and need addressing. For example, elder maltreatment has an estimated prevalence of 25.2 percent, and child maltreatment has an estimated prevalence of 13.8 percent (Dong et al., 2019). The measure does not exclude children and older adults but aligns with the strongest evidence base and clinical guidelines.

Figure 1. IPV Hierarchy Definition and Domains



Intimate Partner Violence Definitions

The Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) as “physical violence, sexual violence, stalking, and psychological aggression by a current or former intimate partner” (CDC, 2016). The nuances of each act of violence recognized as IPV are detailed below, but it is important to note that all these forms of IPV can intersect.

Physical Violence: Physical violence may include pushing, shoving, grabbing, throwing objects, beating, slapping, kicking, strangling or using a weapon (Khanna et al., 2018). Physical violence is a common form of IPV and is associated with higher rates of depression, post-traumatic stress disorder (PTSD) symptoms, and somatic anxiety (Karr et al., 2024). In primary care and emergency department (ED) settings, 37 to 50 percent of women reported physical violence within their lifetimes, with 10 to 18 percent reporting physical violence in the past year (Beydoun et al., 2017).

Sexual Violence: Sexual violence involves sexual acts that are non-consensual (either the person did not give consent or was unable to) (University of California Sexual Violence Prevention & Response, n.d.). This form of IPV also includes sexual assault, which includes physical force, threat, intimidation, or taking advantage of the intoxicated state of a person, as well as sexual harassment, which involves unwelcomed sexual advances, requests for sexual favors, or conduct of a sexual nature (University of California Sexual Violence Prevention & Response, n.d.). Nearly 1 in 5 women (18.3%) and 1.4 percent of men experience forced penetration, attempted forced penetration, or substance facilitated forced penetration (Black et al., 2011). More than half of these female survivors reported being raped by an intimate partner. Sexual violence has profound physical, emotional, and psychological impacts on individuals and their communities.

Reproductive Coercion: Reproductive coercion is a specific form of IPV which intersects violence and reproductive health and involves explicit attempts to impregnate a partner against their will, coercion to have unprotected sex, or interfering with contraception to promote pregnancy (Anderson et al., 2018). Data from the 2010 National Intimate Partner and Sexual Violence Survey (NISVS) revealed that 8.6 percent of women and 10.4 percent of men experienced reproductive coercion within their lifetime (Basile et al., 2021).

Stalking: Stalking in terms of IPV refers to harassing or threatening behavior that an individual engages in repeatedly and is an obsessive behavior that is aimed at controlling, intimidating, or instilling fear in their partner or former partner (Tjaden et al., 1998). According to data from the NISVS, the lifetime prevalence of stalking was 9.2 percent for women and 2.4 percent for men (CDC, 2014). One study found that instances of stalking escalate after separation and describes how IPV can remain prevalent through exertion of control over women in nonphysical forms (Li, 2023).

Emotional/Psychological Aggression: Emotional and psychological aggression is a type of non-physical abuse that aims to erode a partner's sense of self-worth and confidence (Stylianou, 2018). This includes behaviors that degrade a partner's logic and reasoning, and can manifest through behaviors such as insults, name-calling, or causing public embarrassment (Stylianou, 2018). The abuser uses these tactics to undermine the partner's value in order to exert control or dominance in the relationship (Stylianou, 2018). Results from the NISVS suggest almost half of women (49.4%) experience any psychological aggression by a partner within their lifetimes, with 6.7 percent reporting such experiences within the last 12 months (Leemis et al., 2022). Rates were similar for men with 45 percent reporting psychological aggression within their lifetime and 7 percent experiencing it within the last 12 months (Leemis et al., 2022). The most common forms of coercive control reported (in order from most to least prevalent) were tracking/demanding to know where their partner is, making decisions for the partner, destroying something important to them, threatening suicide or self-harm, and socially isolating them from friends and family (Leemis et al., 2022).

Financial/Economic Abuse: Financial or economic abuse includes behaviors which intend to control a partner's ability to acquire, use, or maintain resources, threaten economic security, or minimize potential for self-sufficiency (Stylianou, 2018). This may take the form of interfering with employment, dictating spending, stealing money or property, refusing to contribute financially to expenses, or generating debt through coercion or fraud (Adams et al., 2020). Amongst 1,823 women who called the National Domestic Violence Hotline, half of them had partners who had generated debt in their name either through coercion or fraud (Adams et al., 2020). Other studies have found that financial abuse occurs in 99 percent of cases of domestic violence, but 78 percent of Americans do not realize that financial abuse is a form of IPV (Adams, n.d.). Financial abuse can have immediate degrading effects on quality of life (Adams et al., 2019).

IPV Importance and Prevalence

The prevalence of IPV in the United States remains a significant public health issue, affecting individuals across varying demographics, age, gender, and socioeconomic status. Approximately 1 in 4 women and 1 in 7 men will experience severe violence perpetrated by an intimate partner (Stylianou, 2018). While research on male-to-female IPV has been more extensive, it is important to note that IPV occurs in both directions (Khanna et al., 2018). Furthermore, prevalence and experiences of IPV vary in diverse populations; a section below describes IPV in marginalized communities including the LGBTQ+ community, women of color, and immigrant women.

The National Survey on Teen Relationships and Intimate Violence found that 37 percent of 12 to 18-year-olds reported intimate violence in the current or past year of dating, and 69 percent reported experiencing adolescent relationship abuse within their lifetimes (Taylor et al., 2016). Thus, experiences of IPV begin early on and affect adolescents as young as 12. Lifetime IPV is perpetuated by a multitude of factors including cultural norms and the treatment of women, adverse childhood experiences or witnessing domestic abuse, lack of economic resources, or use of alcohol (Khanna et al., 2018).

Impacts of IPV

Impact of IPV on health

IPV significantly impacts life expectancy both directly and indirectly. Research has found that women who were exposed to domestic abuse face a heightened risk of all-cause mortality (Chandan et al., 2020). A systematic review found that approximately 50 percent of female U.S. homicide victims are murdered by intimate partners (Graham et al., 2021). Nearly 290,000 years of potential life were lost in 26 states over a decade-long study (Graham et al., 2021). In terms of homicide, women are twice as likely to be shot and killed by an intimate partner compared to other perpetrators (Sorenson, 2017). Many studies and reports highlight that a substantial number of women killed by intimate partners experienced prior abuse. Data from the CDC's National Violent Death Reporting System shows that around 20 percent of female intimate partner homicide victims had a documented history of prior abuse from their killer (CDC, 2024). This further aligns with broader research that suggests there is a strong connection between prior IPV and lethal outcomes among women. While IPV can result in death in cases of severe physical violence, IPV is also associated with chronic conditions which deteriorate health and affect life expectancy.

IPV has profound impacts on an individual's mental health and can contribute to depression, anxiety and suicidal behavior. The prevalence of mental health problems for women with a history of IPV was 47.6 percent in 18 studies of depression, 17.9 percent in 13 studies of suicidality, and 63.8 percent in 11 studies of PTSD (Golding, 1999). Women who were sexually abused show a 12-to-20-fold increase in suicide attempts *(*Bugeja et al., 2017). A study in a birth setting found that mothers who experienced economic abuse were 1.9 times more likely to exhibit depression than mothers who had not experienced economic abuse (Stylianou, 2018). According to a systematic review, women who were exposed to IPV were significantly more likely to develop PTSD, depression, and anxiety within a 12-month period (Bacchus et al., 2018). The review emphasized that the recurrence and chronic nature of IPV exacerbates the severity of mental health issues (Bacchus et al., 2018).

Financial importance and cost-effectiveness

The economic burden of IPV encompasses medical care, mental health services, legal services, and loss of productivity Impacts from injury, mental health conditions, premature death, and time spent on litigations. IPV is associated with increased healthcare utilization costs given the need for care to address mental health and/or physical injuries (Anderson et al., 2007). In 2012, the lifetime cost of IPV was $103,767 per female survivor and $23,414 per male survivor, adding up to a US population burden of almost $3.6 trillion (Peterson et al., 2018). This estimate included $2.1 trillion in medical costs (59% of the total), $1.3 trillion (37%) in lost productivity, $73 billion (2%) in litigation and criminal justice costs, and $62 billion (2%) in other costs (Peterson et al., 2018). The total annual healthcare expenses for women who experience physical IPV are high, reaching around $4.1 billion annually in medical and mental health services; emotional or psychological abuse lead to healthcare costs that are less straightforward to estimate (CDC, 2008). Unlike physical injuries, which can be immediately recorded and

treated, the lifelong impact of emotional abuse may require long-term therapy and medications, thus increasing indirect healthcare and productivity losses that accumulate over a survivor's lifetime (IWPR, 2017).

However, there is also a paradoxical impact of IPV on healthcare access that may lead to inappropriate reductions in healthcare utilization. Women who experience physical violence may refrain from attending a health care facility due to fear, shame, or embarrassment of experiencing IPV (Chojenta et al., 2019). This reluctance results in delayed treatment, worsened health outcomes, and higher healthcare costs in consequence. One study found that survivors of IPV were less likely to receive adequately skilled maternity care, further endangering the health of survivors and their infants (Chojenta, et al., 2019).

Addressing IPV for diverse populations

Populations with marginalized identities are at increased risk of experiencing IPV and facing adverse health outcomes as a result. Populations which experience IPV at disproportionate rates include individuals with disabilities, Indigenous populations, Black and Hispanic populations, Asian populations, Immigrant populations, and the LGBTQ community—especially trans individuals.

Intersection of disability status and IPV: Both mental and physical disabilities are associated with increased risk of IPV (Hahn et al., 2014). A systematic review of articles regarding the frequency of IPV in women with disabilities compared to those without found that most studies identified a statistically significant association between disability and various forms of violence, including psychological, physical, sexual, and particularly financial violence (Garcia-Cueller et al., 2021). One study examining perinatal health in women with disabilities found that women with disabilities were around 2.5 times more likely to experience IPV before or during pregnancy (Alhusen et al., 2022). Another article examining both men and women with disabilities found that women with disabilities were more likely to report experiencing rape, other sexual violence, physical violence, stalking, psychological aggression, and control of reproductive health (Breiding, 2015). Men with disabilities were more likely to experience stalking and psychological aggression than men without disabilities. Overall, individuals with disabilities are at increased risk of all forms of IPV, and targeted interventions to support this population could reduce the disparate prevalence.

Intersection of queer and trans identities and IPV: Violence amongst and against the LGBTQ community is disproportionately prevalent compared to heterosexual and cisgendered populations. One study of screening results for IPV in ED settings found that the prevalence of IPV in LGBTQ populations was significantly higher—with the highest prevalence amongst bisexuals and gay men (Harland et al., 2021). Results from the NISVS show that bisexual women experience more sexual violence, IPV, and stalking than heterosexual women and lesbians; gay and bisexual men also experienced more sexual violence and stalking than heterosexual men (Chen et al., 2021). Nuances exist in the extent of disparities for different forms of IPV experienced by various identified groups within the LGBTQ community. A body of literature focuses on the prevalence and impact of IPV on trans and gender diverse (TGD) populations. A systematic review of 85 articles found that compared to cisgender individuals, trans individuals experienced a dramatically higher prevalence of IPV regardless of trans sub-identity (trans male, trans female, non-binary, etc.) (Peitzmeier et al., 2020). TGD identity had a significant association with survey outcomes for physical violence and forced sex; unique forms of emotional abuse for TGD

individuals, such as threatened to be outed by a partner and had their gender belittled by a partner, were also reported (Kattari et al., 2022). Additionally, TGD populations who experienced homelessness were more likely to experience various forms of IPV (Jackson et al., 2022). Interestingly, TGD individuals were more likely to seek help than cisgender counterparts (Kurdyla et al., 2021) (Heron et al., 2021). Instances of heterosexist microaggressions and racial discrimination were confounding factors in IPV victimization amongst assigned-female-at-birth sexual minority youth of color; this suggests that there is a confounded effect of intersectional identities on risk of IPV (Swann, 2021).

IPV amongst Indigenous and Native Populations: IPV amongst Native populations is high compared to other racial/ethnic groups in the US, particularly difficult to characterize given data availability, and perpetuated in a context of cultural and historical oppression. Data from the 2010 NISVS found that 46 percent of Indigenous women experienced rape, physical violence, or stalking (Jock et al., 2022). This prevalence estimate is 10 percentage points higher than for women in the general population. Furthermore, advocates from groups such as Missing and Murdered Indigenous Women (MMIW) highlight the absence and misrepresentation of data for Indigenous women as a barrier to understanding the full scope of the violence experienced (Urban Indian Health Institute, 2018). Qualitative studies with Indigenous women on their experiences with IPV describe how patterns of violence are grounded in a history of oppression, disruption, dehumanization, and loss (Burnette, 2015). Furthermore, survivors describe a reluctance to seek assistance and barriers with the service system when they do (Finfgeld-Connett, 2015).

IPV and Race/Ethnicity: There is some variation in IPV rates between racial and ethnic groups in the US. A study found that Black populations were most at risk of experiencing IPV, followed by White and Latino groups, and Asian population had the lowest risk (Cho, 2012). Forty-five percent of Black women experience IPV compared to 25 percent of the general population, and Black women are three times more likely to be killed by an intimate partner than White women (Kelly et al., 2022). Variation in help-seeking behavior by race/ethnicity exists; White women were more likely to utilize mental health and social services, whereas Black and Latina women were more likely to utilize formal supports through hospitals or law enforcement (Satyen et al., 2019). In Latino men, it was found that discrimination was linked to poorer mental health and drug dependence, which in turn was associated with IPV perpetration (Maldonado et al., 2020). A variety of articles discussed the importance of cultural sensitivity in the development of interventions and support services for IPV (Ravi et al., 2022) (Alvarez et al., 2016).

IPV amongst Immigrant Communities: A systematic review found significant variation in the prevalence of IPV amongst immigrants. Estimates ranged from 3.8 percent to 46.9 percent for past-year IPV and 13.9 percent to 93 percent for lifetime IPV victimization rates (Morrison et al., 2023). It is difficult to determine actual rates of IPV in this population, but it is known that ethnic minority and immigrant women experience barriers to seeking help. Such barriers include institutional racism, immigration laws, religion and culture, and lack of diversity or cultural competence of frontline services (Hulley, 2022). A comprehensive report by Futures Without Violence discusses IPV in immigrant and refugee communities and describes several programs within the US which provide IPV services to immigrant and refugee populations, provide recommendations for program funders, and evaluate the small

evidence base of published IPV interventions for this population. The report stresses the importance of documentation of program activities and of impact for research and evaluation purposes (Runner et al., 2009).

Supporting Evidence for Measurement of IPV

The United States Preventive Task Force (USPTF) recommends that clinicians screen all women of reproductive age, including those who are pregnant or postpartum, for intimate partner violence (IPV) (USPTF, 2025). The recommendation received a B grade, due to moderate certainty of benefit. However, for older or vulnerable adults, the USPTF issues an "I" grade, citing insufficient evidence to assess the balance of benefits and harms of screening for abuse or neglect by caregivers. The USPTF is considering an update to the IPV recommendation and held a Public Comment period in November 2024. Their proposed updated recommendation states that pregnant and postpartum persons, as well as women of reproductive age, get screened by clinicians for IPV; this update reflects the robust evidence base focused on pregnant and postpartum persons. There is not sufficient evidence for the USPTF to recommend screening or interventions for IPV in men. Furthermore, there is insufficient evidence for the USPTF to recommend screening for abuse or neglect of elders by a caregiver or child maltreatment.

The Women's Preventive Services Initiative (WPSI) also recommends annual screening of adolescents and women for physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both (WPSI, 2024). Included in their recommendation is providing referrals to initial services and suggest that appropriate interventions include, but are not limited to, counseling, education, harm reduction strategies and referral to appropriate supportive services.

The National Academies of Sciences conducted a report, in collaboration with the US Health and Human Services Department, to determine guidelines for delivering essential IPV services during public health emergencies (NASEM, 2024). The formal recommendation determined that universal screening for IPV should be included as an essential health care service. They also recommended that providers pair IPV screening with education on IPV and, for individuals who screen positive for IPV, to refer them to support services regardless of steady state or public health emergency conditions. Further recommendations include providing culturally and linguistically relevant IPV resources.

Addressing IPV in Health Settings

IPV screening tools

A variety of screening tools have been developed and validated for identifying cases of IPV. Widely implemented tools are summarized in Table 1 and their association to Logical Observation Identifiers Names and Codes (LOINC) terminology is indicated. Screening tools exist that were developed for more specific populations, such as adolescents and trans individuals. For example, the Relationship Behavior Survey was designed to measure denigrating, controlling, and intrusive behaviors, as well as perpetrator intent, in adolescent relationships (Cascardi, 2023). There are nine existing screening tools specifically for trans populations and IPV, but they have not been validated (Maclin, 2024). Interviews with a diverse study population of trans survivors of IPV determined that the four crucial domains to include in transphobia-driven IPV questionnaires were pressure to perform, disrupting gender affirmation, belittling gender identity, and intentional misgendering (Maclin, 2024). While tools tailored for specific populations are crucial for identifying unique forms of IPV, they are often less standardized and not as widely implemented compared to standardized questionnaires that are embedded in toolkits and research initiatives worldwide.

Interventions for IPV in health settings

Healthcare setting interventions help identify IPV cases and provide information, resources and support to survivors. The intervention literature supports the importance of identifying cases of IPV and connecting survivors to resources and additional care. For example, a study conducted with

Spanish-speaking pregnant women found that screening for abuse was the most effective intervention for preventing IPV while studying briefings, counseling, and outreach strategies (McFarlane et al., 2000). Addressing mental health, fostering empowerment, and attending group sessions are all methods to help mitigate IPV and its effects. Psychosocial therapy for survivors likely reduces depression and may reduce anxiety (Hameed et al., 2020). One article focused on immigrant women experiencing IPV reported that empowerment interventions were able to reduce suicidality rates (Butter et al., 2024).

Partnerships between healthcare settings and community organizations to address domestic violence are shown to improve screening rates of IPV and support of survivors. For example, the Domestic Violence and Health Care Partnership initiative in California was a concerted effort in California health settings to train providers and domestic violence advocates to screen patients and refer them to support services (Blue Shield CA Foundation, n.d.). Evaluation of the program showed that providers doubled their rate of assessments for domestic violence, patients were more likely to report domestic violence, and there was an increased confidence in and comfort with helping patients connect to services (Blue Shield CA Foundation, 2016). Similarly, Kaiser Permanente Northern California has implemented an IPV identification and response effort since 2001. Their approach includes messaging regarding healthy relationships for patients, routine screening and referrals, safety planning services delivered by mental health clinicians, partnerships with advocacy organizations to connect survivors with crisis response or legal services, and embedded fields in electronic health record (EHR) systems to facilitate documentation and ensure patient privacy (Young-Wolff et al., 2016). Activities from the health system level, including partnerships and programming in health settings to identify IPV and support survivors, have the potential to effectively address the prevalence and impacts of IPV.

Another example of health systems implementing interventions for IPV includes the Intimate Partner Violence Assistance Program (IPVAP) at the Veterans Health Administration—an initiative developed with a person-centered, veteran-centric, and trauma-centric approach. Their programming is led by coordinators who connect survivors or partners to community-based support groups, advocacy or legal services, domestic violence shelters, or interventions for those who use violence (US Department of Veteran Affairs, 2024). The initiative developed toolkits and resources with relevant hotlines/call centers and safety planning tips to raise awareness. Furthermore, their plan integrates routine screenings and appropriate intervention planning for individuals experiencing IPV as well as those who use IPV.

Studies which aimed to identify key features of effective programs around the world concluded that well-trained staff responsible for screening and supporting, working with men and women, attunement to local context and target populations, gender and social empowerment activities, connection with mental health care, developing safety plans, improving economic and law literacy, and enhancing social support systems were all important factors and forms of intervention for successful support of IPV survivors (Jewkes, 2021) (Periyasamy et al., 2024). Interventions tailored to certain populations can help target the disparities experienced by marginalized communities and promote an intersectional, equitable approach.

Public policies related to health plans play an important role in addressing health coverage accessibility and clinician screenings. Federal marketplace plans allow survivors of IPV to enroll in health plans separately from their abusers, state on their applications that they are unmarried, and request special enrollment periods (Futures Without Violence, 2022). Additionally, the Affordable Care Act requires private insurers and Medicaid expansion programs to reimburse clinicians for IPV screening and brief intervention services to women (Ramaswamy et al., 2019).

Barriers to survivors of IPV seeking help include minimal awareness, fears around disclosure, and lack of materials resources (Robinson et al., 2020). Interactions with healthcare settings can be a key moment for connecting with individuals, facilitating a safe and confidential environment, and asking directly about abuse—all factors proven to encourage disclosure (Heron et al., 2021). IPV disclosure in healthcare settings can be supported through standardized protocol and having specialists available in medical facilities who are available to support survivors (Cheng et al., 2020).

Gaps in care

Overall, literature suggests that a performance gap in screening and intervening for IPV in healthcare settings exists. Addressing this gap would improve guideline adherence and connect survivors to interventions for addressing IPV.

Evidence suggests that screening for IPV in healthcare settings is an effective method for identifying survivors and delivering interventions, which can enhance quality of life. A study aimed at informing the USPTF found that while screening tools are reasonably effective at identifying IPV, screening alone was not associated with reductions in IPV or improvements in quality of life over a period of 3 to 18 months. However, some evidence suggests that addressing multiple risk factors through home visits and behavioral counseling may reduce IPV amongst pregnant or postpartum individuals (Feltner et al., 2018). A study conducted in EDs found that cases of identified IPV were helpful for providing legal documentation and connecting to police if needed; however, only 33 percent received safety assessments and were referred to survivor services 25 percent of the time (Kothari et al., 2012). Of a cohort of women who had a documented IPV incident and eventually visited the ED, only 72 percent were identified as survivors of abuse (Kothari et al., 2012). Findings from this study indicate that routine screenings and referrals for IPV in ED settings could help identify and support the large percentage of survivors whose survivor status is currently overlooked in this care setting.

Literature suggests that there is variability amongst providers regarding IPV screening practices, a lack of standardized protocols in healthcare settings, and some existing barriers for IPV disclosure and connection to interventions. A systematic review of studies regarding provider screening practices for IPV demonstrated that variability exists in provider screening practices, which may be due to a lack of system-level guidance (Alvarez, 2017). This finding suggests there is room for quality improvement activities to reduce such variability. A qualitative study of IPV screenings with healthcare workers found that none of the interviewed clinical sites had a protocol guiding screening for IPV and responding to disclosures (Alvarez et al., 2018). Healthcare workers felt that the clinical and community resources available for IPV were limited. Referral to a social worker or providing information on resources (e.g., safe houses and hotlines) were the most common forms of intervention. Furthermore, studies demonstrate that a

central barrier to survivors disclosing their experiences with IPV in healthcare settings is the reactions and attitudes of healthcare professionals (Heron et al., 2021). Survivors reported fear of being judged negatively and encountering unsympathetic, disinterested, or minimizing attitudes from their providers. Facilitators of disclosure included positive relationships, directly asking survivors about the abuse, and ensuring a safe and confidential environment. Implementation of protocols which facilitate and foster appropriate environments for IPV disclosure and support referrals can help address the screening performance gap, mitigate fears around disclosure, and improve intervention delivery.

Digital Considerations

PVS-E will be developed as an ECDS measure, meaning reporting will be supported using clinical data. Likewise, NCQA has found several screening tools for IPV that can be documented in clinical data. The screening tools and their associated LOINC codes can be found below in Table 1.

As part of NCQA's strategic transition to a fully digital quality measurement portfolio, we also conducted a feasibility assessment to inform eventual digital measure implementation. The assessment evaluates the measure's intent and associated clinical concepts within a digital framework. Refer to Appendix B for details on the overall measure digital feasibility.

Table 1. Screening Tools for Identifying IPV in Health Settings

Screening Tool	Tool Summary	Positive Screen Threshold (Range)	Validation findings	Associated LOINC Codes
Hurt, Insult, Threaten, Scream (HITS)	4 items, asks respondents how often their partner physically hurt, insulted, threatened with harm, or screamed at them	≥10 Points (4-20)	Good construct validity and internal consistency (Sherin et al., 1998).	95619-3
Extended–Hurt, Insult, Threaten, Scream (E-HITS)	5 items, modified version of the original HITS tool to include sexual violence	≥7 Points (5-25)	Specificity and accuracy of HITS with clinical benefit of sexual IPV item (Iverson et al., 2015).	None for sexual IPV item, awaiting
Humiliation, Afraid, Rape, Kick (HARK)	4 items, screens for emotional, sexual, and physical abuse	≥1 Yes (0-4)	Accurately identified women compared to 30 item composite abuse scale (Sohal, 2007).	76499-3
Intimate Partner Violence-4 (IPV-4)	4 items, asks about control and feeling trapped, feeling afraid, pressure or forcing something sexual, and physical abuse	≥1 Yes (0-4)	Development and integration of IPV-4, a patient-reported screening instrument of intimate partner violence for primary and HIV care (Fredericksen et al., 2022).	106925-1
Relationship Assessment Tool (RAT), previously Women's Experiences with Battering (WEB)	10 items, asks about behaviors of partners and assigned 6-point scale(1-disagree strongly to 6-agree strongly)	≥20 Points (10-60)	Reliability and construct validity demonstrated in previous version. (Smith et al, 1995). Recommended by	None

			Futures Without Violence.	
Partner Violence Screen (PVS)	3 items, asks about physical violence and perceived personal safety	≥1 Yes (0-3)	High sensitivity and specificity compared to 2 standardized measures (Feldhaus et al., 1997).	None
Woman Abuse Screening Tool (WAST)	8 items, screens for verbal, emotional, physical, and sexual abuse	≥4 Points (0-16)	Found reliable and valid in family practice settings (Brown et al., 2000).	None
Ongoing Violence Assessment Tool (OVAT)	4 items, asks if partner threaten, beaten, would like to kill you, shows no respect	≥1 Yes (0-4)	Validated for men and women in ED settings (Ernst, 2004).	None
Slapped, Threatened, and Throw (STaT) Measure	3 items, pushed or slapped; threatened with violence; partner has thrown, broken, or punched things	≥1 Yes (0-3)	High sensitivity and specificity compared to semi structured interviews determining lifetime IPV (Paranjape, 2003).	None
Abuse Assessment Screen (AAS)	5 items including sexual coercion, lifetime abuse, current abuse, abuse during pregnancy	≥1 Yes (0-5)	Reliable and valid instrument for screening for abuse (Soeken, 1998).	None
PErpetrator RaPid Scale (PERPS)	3 items, asks about physical abuse of a partner to identify perpetrators	≥1 Yes (0-3)	Accurate and valid compared to 25-question scale gold standard (Ernst, 2012).	None

Conclusion

Intimate partner violence (IPV) is a prevalent issue with serious consequences on health outcomes, mental health, children exposed to violence, and healthcare costs. Vulnerable communities experience IPV at greater rates and unique forms of IPV—including LGBTQ+ individuals, people with disabilities, Indigenous and Native peoples, and immigrant populations. Evidence-based interventions exist for improving health amongst IPV survivors and reducing IPV through prevention of aggression in relationships. Interventions designed for healthcare settings that promote partnerships, train providers and staff on IPV assessment and referrals, and implement quality improvement activities have proven effective in improving screening and intervention rates. Guidelines exist to support these activities including a variety of validated questionnaires and assessment tools exist to screen for IPV. A quality measure which assesses screenings for intimate partner violence as well as follow-up care for identified survivors would help address the performance gap, improve guideline adherence, and promote the health of people experiencing IPV.

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Appendix B: Digital Feasibility

As part of NCQA's strategic transition to a fully digital quality measurement portfolio, we conduct a feasibility assessment to evaluate the measure's intent and associated clinical concepts within a digital framework. The primary objectives were to determine whether the clinical concepts could be represented using standardized data models and nationally recognized terminologies, and to assess the availability of discrete, structured data necessary to support accurate and reliable digital measurement.

Data and Terminology Standards

NCQA's digital quality measures are built on the Fast Healthcare Interoperability Resources (FHIR®) standard, developed by HL7®, to support interoperable exchange of electronic health data. In the U.S., FHIR US Core profiles provide detailed implementation guidance aligned with the United States Core Data for Interoperability (USCDI), a federal standard maintained by ASTP (formerly ONC). USCDI defines essential data classes and elements, while FHIR US Core specifies how to represent and exchange them. Additionally, NCQA uses nationally recognized clinical terminologies (e.g., ICD-10, CPT, LOINC) to define value sets, ensuring standardized interpretation and representation of clinical data in quality measures.

Digital Feasibility Assessment

The digital feasibility assessment is conducted at two stages during the measure development process, pre-testing phase and post-testing phase, summarized below. This assessment examines each measure concept across three high-level categories:

- **Data Standards and Terminology**. Evaluates the alignment with national standards (FHIR, USCDI) and recognized terminology standards (i.e., LOINC, ICD).
- **Clinical Workflow and Data Accuracy**. Evaluates whether the concept aligns with standard clinical practice and the likelihood that the data will be accurate, complete, and reliable.
- **Data Availability and Structure**. Assesses if the data is likely to be present, in structured fields, and accessible to health plans.

The digital feasibility assessment (shown in Figure A) rates each concept from high to low. High = Feasible with no concerns, Medium = Feasible with some concerns (with a potential mitigation strategy); Low = Low feasibility with concerns (with little to no mitigation strategy for the current development cycle).

Pre-Testing Feasibility Findings.

Overall, a digital version of this measure as currently specified is feasible. Terminology and data standards exist for the clinical concepts in the measure. However, the actual implementation and use of these terminology and data standards, as well as the collection of these clinical concepts in routine clinical workflow, will need to be assessed through testing.

Data Standards & Terminology. As shown in Figure A-1, all clinical concepts can be modeled in the FHIR data standard and represented in nationally recognized standard terminologies, supporting strong alignment with national interoperability requirements.

Clinical Workflow & Data Accuracy. There is uncertainty around the CUES Framework, positive findings for intimate partner violence screening, and gender identity being captured in routine clinical workflow.

Data Availability & Structure. Though diagnosis for intimate partner violence is often documented, it may be found more often in free text than structured fields. For positive findings on a screening, there does not seem to be consistency in how this data is stored across EHRs, as structured fields may exist, but is more likely to be found in free text, if at all. The CUES Framework raises the strongest concerns for data availability as the uncertainty around its collection in clinical workflow also makes it hard to find in the ideal format for data exchange. As a result of these clinical concepts being rated medium and low, their score for data accessibility, by extension, is also medium (i.e. uncertainty about being in discrete, structured fields leads to uncertainty about ability to exchange/access the data).

Figure A-1: Pre-Testing Digital Concept Feasibility Assessment

Score key: H-high, M-medium, L-low						
	Data Standards & Terminology		**Clinical Workflow & Data Accuracy**		**Data Availability & Structure**	
Clinical Concept	**Data Standards**	**Terminology Standards**	**Workflow**	**Data Accuracy**	**Data Availability**	**Data Accessibility**
Age	H	H	H	H	H	H
Positive finding or diagnosis for intimate partner violence	H	H	H	H	M	M
Documented finding for intimate partner violence pre-screening procedure (CUES Framework)	H	H	M	H	L/M	M
Positive finding for intimate partner violence screening	H	H	M	H	M	M
F/u on positive screen	H	H	H	H	H	H
Administrative gender	H	H	H	H	H	H
Gender identity	H	H	M	H	H	H

Post-Testing Feasibility Findings.

Overall, a digital version of this measure as currently specified is feasible, as all the clinical concepts used in the measure, except for the CUES Framework, demonstrate medium to high digital feasibility.

Data Standards & Terminology. As shown in Figure A-2, all clinical concepts can be modeled in the FHIR data standard and represented in nationally recognized standard terminologies, supporting strong alignment with national interoperability requirements.

Clinical Workflow & Data Accuracy. Based on preliminary testing results, the screening for intimate partner violence is limited to a few clinical settings. Additionally, gender identity is typically updated by a patient in their portal but could also be edited by a provider, which would suggest that its incorporation into the clinical workflow is not standardized.

Data Availability & Structure. Testing results did confirm data accessibility issues with the CUES Framework concept, as the test site was unable to pull SNOMED codes. Even if the test site had the ability to pull SNOMED codes, there is still reasonable uncertainty about the collection of this data in a structured field. However, the testing site did show successful, robust extraction of codes for diagnosis for intimate partner violence, elevating its score for data availability to an “H.”

Figure A-2: Post-Testing Digital Concept Feasibility Assessment

Score key: H-high, M-medium, L-low						
	Data Standards & Terminology		**Clinical Workflow & Data Accuracy**		**Data Availability & Structure**	
Clinical Concept	**Data Standards**	**Terminology Standards**	**Workflow**	**Data Accuracy**	**Data Availability**	**Data Accessibility**
Age	H	H	H	H	H	H
Positive finding or diagnosis for intimate partner violence	H	H	H	H	H	M
Documented finding for intimate partner violence pre-screening procedure (CUES Framework)	H	H	M	H	L/M	M
Positive finding for intimate partner violence screening	H	H	M	H	M	M
F/u on positive screen	H	H	H	H	H	H
Administrative gender	H	H	H	H	H	H
Gender identity	H	H	M	H	H	H