National Rural Health Association Policy Brief

Morbidity and mortality related to intimate partner violence in the perinatal period

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Introduction

Intimate partner violence (IPV) encompasses various abusive actions or behaviors by a current or former romantic partner.[1] These behaviors include physical violence, sexual violence, stalking, psychological aggression, emotional abuse, and financial and economic abuse.[1] IPV is common, with approximately 41 percent of women and 26 percent of men reporting impacts from IPV during their lifetime.[2] IPV impacts the well-being of victims and survivors, as well as their families. Impacts include physical, mental, and sexual health such as increased risk of injury, fear, post-traumatic stress disorder, missed work, substance use, and depressive symptoms.[1,3] The economic and societal costs of IPV are estimated at over $3.6 trillion, with a lifetime cost per female victim of $103,767.[4]

IPV during the perinatal period poses significant risks to maternal and child health, especially in rural communities[5–7] due to limited access to employment, housing, transportation, health care, and support services.[5,6,8] These factors are further compounded by structural racism and disparities within health care and labor markets,[2,3] which contribute to disproportionately high rates of IPV among certain rural populations.[5–7,9,10] Further, the intersection of these factors may compound the risk of IPV and hinder effective screening and intervention.[5,11]

Analysis

The perinatal period, which includes conception, pregnancy, and the year following delivery, is a particularly vulnerable time for IPV, placing both the birthing individual and baby at significant risk of harm. Recent data indicate that approximately 4.6 percent of individuals in rural communities and 3.2 percent in urban communities report experiencing physical IPV during pregnancy or the 12 months prior.[5] Younger individuals, individuals without private insurance,[5] Black and Indigenous individuals, and people of color,[11] particularly those identifying as American Indian/Alaskan Native and multiple/other races, have higher rates of reported IPV during this time,[5,11] with a pronounced disparity in rural communities.[5]

During the perinatal period, individuals are particularly vulnerable to financial, emotional, and physical abuse from partners. For example, homicide is a leading cause of death among individuals within one year of pregnancy[13,14] and is often linked to IPV.[13] Perpetrators of IPV commonly use guns to both threaten[15] and enact violence,[14] and recent estimates suggest guns were used in more than 69 percent of pregnancy-associated homicides.[14,16] Barriers around employment, housing, access to health services, and transportation, which are more common in rural communities, may increase the risks of experiencing IPV and decrease opportunities to be screened for IPV or escape from an unsafe environment.[5]

Screening for IPV is recommended during the perinatal period but not universally practiced, particularly among rural residents. From 2016 to 2020, the likelihood of not receiving IPV screening during prenatal care was higher among pregnant people in rural areas (21.3 percent) compared to those in urban areas (16.5 percent).[5] These figures are likely underestimates as a function of underreporting due to stigma and privacy concerns, especially in rural communities. Leading barriers to screening individuals with Medicaid coverage include limited time, concerns about the privacy and safety of the patient, and inadequate training of providers.[17] Even when

training occurs, additional barriers exist to support individuals that screen positive for IPV with referrals to appropriate resources.[17] Many of these barriers to both screening and referrals are often particularly pronounced in rural settings and among populations who are at disproportionate risk for IPV.[18] Overall, this pathway from accessing perinatal care to receiving screening and being referred to support services is filled with potential barriers, particularly among individuals that are at highest risk. However, there are promising policy opportunities to improve screening and response to IPV, particularly in rural settings.[18–22]

Policy recommendations

Due to the diverse drivers of IPV, a broad range of social, economic, and health policies are needed to support victims, improve screening rates, and prevent violence before it begins. Policies that address IPV must be survivor-centric and co-created by individuals with lived experiences.[18] The following recommendations apply current evidence and best practices to specifically address IPV experienced by perinatal people living in rural areas, focusing on prevention, screening, and resources for survivors.

1. **Increase prevention:** Prevention of IPV includes reducing environmental, economic, and social risks that increase the likelihood of IPV.
    - **Address financial vulnerability** through policies that support the social and economic well-being of people living in rural areas. For more information, see NRHA's policy briefs on benefits of economic development[23] and social service programs[24] for health outcomes in rural areas.
    - **Firearm safety,** particularly policies that require individuals who have been convicted of IPV to relinquish firearms, have been shown to reduce perinatal homicide.[25] For more information on education, training, and community action to improve rural firearm safety, see NRHA's 2022 rural firearm safety policy brief.[27]
    - **Focus on restorative justice and prevention** for people who have been perpetrators of IPV or those at risk of becoming abusers. The Centers for Disease Control and Prevention recommends teaching safe and healthy relationship skills and engaging influential adults and peers, with a focus on boys and men.[28] Relatedly, there is a need for policies to improve access mental health services in rural areas. For more information, see NRHA's 2022 brief on mental health in rural areas.[29]

2. **Improve screening and treatment during the perinatal period**
    - **Enhance provider education and training,** exploring opportunities to leverage primary care providers, obstetricians, midwives, public health nurses, home-visiting nurses, community health workers, doulas, and other members of the care team.[30–33] As an example, the Domestic Violence Enhanced Home Visitation program reduced reported violence among pregnant women in rural and urban areas who had experienced violence within the year prior.[32,33]
    - **Develop value-based care and alternative payment models** that incentivize quality care for IPV and wraparound services through models that center equity so safety net, rural, and small providers can participate.[34] Since screening for IPV was initially recommended by the US Preventive Services Task Force more than a decade ago, there have been recommendations to incorporate IPV screening and care within quality measures, value-based care, and alternative payment models.[31,35] Specific recommendations for how to define essential services for IPV have also been proposed, which may provide guidance for payers and payment models.[31] Existing mechanisms broadly supporting health-related

social needs screening and care are already in place through Medicaid 1115 demonstration waivers; however, these supports are often focused on other health-related social needs without specific considerations for IPV.[36] The Centers of Medicare & Medicaid's new Transforming Maternal Health Model includes health-related social needs screening as a monitoring and evaluation criteria but not a performance payment metric, as of the writing of this brief.[37]

- **Improve coverage of services and supports for IPV screening and care in Medicaid programs.** As of August, 2024, 46 states and D.C. had implemented 12-month continued Medicaid coverage for improved access to health services during the perinatal period,[38] which facilitates access to IPV screening. The remaining states should consider expanding full Medicaid coverage,[17] as IPV screening and referral is covered by Medicaid. This is particularly important for rural birthing people, who are more likely to be insured by Medicaid and those covered by Medicaid are at increased risk of IPV.[39]
- **Incentivize provider screening** through the creation of specific billing codes, increased reimbursement, and specific quality measures for IPV screening, as suggested by the Department of Health and Human Services Office of Inspector General's report.[17] Such policies should be survivor-centric and ensure they do not inadvertently charge patients, many of whom may be experiencing financial hardship associated with IPV or may be on the insurance of perpetrators.[39] Several existing health-related social needs screening tools[40–43] and diagnostic Z-codes[44–46] include specific items for identifying and documenting IPV. Further, there are efforts for payers including Medicare and Medicaid to cover screening and support for health-related social needs.[47]
- **Reduce the risk of disclosure of service provision by insurance providers or health systems.** Survivors who share insurance with their abuser may be deterred from seeking health care out of fear that an explanation of benefits may be mailed to their abuser with an indication of IPV screening. Even among those who are able to seek care, there is concern that clinical encounter notes shared via the patient medical portal may disclose victim-reported abuse to anyone who has access to the portal, including abusers.[48] Communication around IPV screening should be thoughtful and survivor-centric. Further, explicit and specific protections for individuals who experience and seek care related to IPV against unwanted disclosure are needed.[45]
- **Ensure availability of telehealth screening and follow-up through legislation that extends telehealth reimbursement and supports connectivity.** These policies are particularly important to expanding care options in rural areas with limited local resources or lack of anonymity in close communities. For more information, see NRHA's recent brief on importance of broadband for improving health outcomes in rural areas.[23]

3. **Resources for survivors:** Expanding resources for survivors across various domains including employment, housing, food, childcare, transportation, and banking is essential.[18] This will require flexible funding for organizations that provide support and/or resources to survivors.
   - **States can expand financial support for survivors through existing programs** such as Temporary Assistance for Needy Families (TANF) and Earned Income Tax Credits (EITC), by eliminating barriers to access.[18] The Family Violence Option grants waivers to individuals experiencing family violence to receive TANF benefits without certain requirements such as work and training so they can set up safe, alternative living arrangements, open a bank account, and seek care for themselves and any children.[49] This waiver is particularly important in rural areas where accessing these resources may take more time. However, very few families are awarded this waiver,[50] despite high rates of IPV

among families that receive TANF.[51] EITC, which has fewer requirements, has been shown to decrease IPV incidence.[52]

- **Policies for strong employer-based paid safe leave** or **paid sick leave** such as Oregon's policies,[53] which allow workers to accrue paid time off that can be used for absences related to IPV.[54] This protected time can help reduce financial instability and the risk of employment loss, which can perpetuate the risk and exacerbate the impact of IPV.[54,55] Importantly, rural residents are less likely to have access to any general paid sick leave, highlighting the need for specific considerations for rural residents and others who do not already have access to any paid sick leave.[56]
- **Invest in taskforces or state offices** that collect data on and allocate resources to address IPV. Examples include Minnesota's Missing and Murdered Indigenous Relatives Office[57] and Missing and Murdered African American Women Task Force.[58]

Recommended actions

Addressing IPV among rural individuals in the perinatal period necessitates a holistic range of actions, for which several opportunities are currently available. The overarching recommendation is that all policy actions should prioritize the needs of survivors, with survivor-centric policies developed through engagement of those with lived experience.[18] Specific actions include:

- **Expand Medicaid coverage during the perinatal period in all states:** Encourage all states to extend postpartum Medicaid coverage through 12 months.
- **Support telehealth flexibility extenders** to enable private screening and care options.
  - Pass S.3967/H.R. 7623 – Telehealth Modernization Act[59, 60]
- **Support the Healthy Families Act** to allow individuals to accrue paid sick leave.
  - Pass S.1664/H.R. 3409 – Healthy Families Act[61,62]
- **Expand temporary financial assistance programs for survivors of IPV,** as modeled by the Oregon Department of Human Services Temporary Assistance for Domestic Violence Survivors program.[63,64] Existing funds such as TANF may be used. Additional federal dollars could be sought from the Family Violence Prevention and Services Act, Violence Against Women Act, and Victims of Crime Act.[63]
- **Support programs that prevent IPV**, such as those recommended by the CDC.[28]
- **Leverage Section 1115 Medicaid Demonstration Waivers**[65] to provide holistic support for IPV survivors, such as North Carolina's Health Opportunities Pilots.[66]

Conclusion

IPV is a leading non-clinical cause of injury and death during the perinatal period, with rural individuals experiencing higher rates than their urban counterparts.[5,14] NRHA supports policies that address common catalysts of IPV and improve access to screening and resources for rural individuals during the perinatal period. Addressing IPV will improve the health, well-being, and economic stability of rural individuals in the perinatal period, as well as that of their children and communities.

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