TRAUMA-INFORMED CARE QUALITY OUTCOMES CROSSWALK

When implementing trauma-informed care throughout your organization, combine or attach your new approaches to initiatives your organization is already focusing on. This approach not only helps expedite adaption and implementation, but it also reinforces that trauma-informed care is not a separate initiative. It fits into your organizations' chosen strategic and/or regulatory requirements.

As an example, many health care organizations around the country are striving to become top tiered patient centered medical homes recognized by the National Center for Quality Improvement (NCQA) or Joint Commission (JCO), centers of excellence or advanced primary care certified or meet the new Medicare quality measures. These efforts align nicely with trauma-informed care approaches through identification and recognition of patients with mental health diagnosis, seamless referral tracking, team-based patient centered care with the patient input into care plans and care trajectories. Below, please find some examples of where your trauma-informed care work may align with these initiatives. Additionally, consider connecting existing teams or committees promoting these initiatives with your trauma-informed care Core Implementation Team (CIT) to discuss how the initiatives align.

Mental Health Screening PHQ2/9

Many patients with a history of trauma experience depression. Implementing a system-wide screening program can not only help identify patients with depression but patients with other mental health diagnoses as well.

APC	NCQA	MIPS
Use PHQ2/PHQ9 for screening of depression and use of a validated screening tool for substance and alcohol abuse	KM 03 (Core) Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool	Depression Utilization of the PHQ-9 tool: Patients age 18 and older with the diagnosis of major depression or dysthymia who have a Patient Health Questionnaire (PHQ-9) tool administered at least once during a 4-month period in which there was a qualifying visit
	KM 20 (Core) Clinical Decision Support: Implements clinical decision support following evidence-based guidelines for care of the following: Depression Screening	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

SBIRT

Given that many patients with a history of trauma tend to use alcohol or substances, a key component to assisting patients is to screen, provide brief interventions and referrals. Be sure to work with your behavioral health care partners to ensure patients entered care following a referral.

APC	NCQA	MIPS
Demonstrate follow-up after substance and alcohol abuse screening at regular intervals and referral tracking	KM 04 (1 Credit) BH Screenings (2+): Anxiety, Alcohol Use, Substance Use, Postpartum Depression, Pediatric BH	Closing the Referral Loop: Receipt of Specialist Report. Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred
Use PHQ2/PHQ9 for screening of depression and use of a validated screening tool for substance and alcohol abuse	KM 20 (Core) Clinical Decision Support: Implements clinical decision support following evidence-based guidelines for care of the following: Substance Use	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling. Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Core Measure) (HEDIS)	DBHI Practice has 1+ clinician who can support MAT	

Warm Handoffs

Introduction to a behavioral health provider is a key component for engaging patients with a history of trauma in care. Receiving a warm handoff as part of a shared care plan for patients with a trauma history could be very empowering and assist patients in meeting regulatory requirements.

APC	NCQA	MIPS
Collaborative Care Agreement with BH provider which has required elements of communication and description of process on how patients are seen, treated and tracked	TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs	Closing the Referral Loop: Receipt of Specialist Report. Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

APC	NCQA	MIPS
Capability of sharing the Care Plan with other health care providers in electronic form and track patient progress	KM 28 (2 Credits) Case Conferences: Has regular "case conferences" involving parties outside the practice team (e.g., community supports, specialists). Uses case conferences to share information and discuss care plans for high-risk patients with clinicians and others outside its usual care team	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen
	CC 09 (2 Credits) Behavioral Health Referral Expectations: Works with behavioral health-care providers to whom the practice frequently refers to set expectations for information sharing and patient care	
	CC 10 Behavioral Health Integration: Integrates Behavioral Health providers into the care delivery system of the practice site	
	DBHI Practice has formal agreement with a BH licensed provider/group	
	DBHI Practice tracks referrals for patient compliance and monitors referral response	
	DBHI: Practice has 1+ clinician to provide BI to patients with BH conditions	

Patient Monitoring, Improvement, Stepped Care

Determining how an organization identifies and monitors the population of patients with trauma and choosing ways to track their care is key for both positive patient outcomes and regulatory success.

APC	NCQA	MIPS
Collaborative Care Agreement with BH provider which has required elements of communication and description of process on how patients are seen, treated and tracked	DBHI Monitors and assesses symptoms over time for patients identified with a Mental Health or SU condition	HP Depression remission at 6 months: Adult patients age 18 years and older with major depression or dysthymia and an initial PHQ-9 score; 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator
Demonstrate follow-up after depression and substance and alcohol abuse screening at regular intervals and referral tracking	DBHI Monitors and assesses symptoms over time for patients identified with a BH condition	HP Depression Remission at 12 months Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score greater than nine who demonstrate remission at twelve months (+/- 30 days after an index visit) defined as a PHQ-9 score less than five. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

Shared Treatment/ Care Plans

Developing patient centered care plans across the care team in collaboration with the patient can help patients achieve established goals and assist the organization in improving the numbers of patients with successful goal completion.

APC	NCQA	MIPS
Capability of sharing the Care Plan with other health care providers and team members in electronic form and track patient progress	KM 01 (Core) Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen
	TC 06 (Core) Individual Patient Care Meetings/ Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.	
	DBHI Practice has a single record for patient's physical BH health OR has protocol for exchanging information	
	DBHI Care plan is integrated and accessible by all of care team	

Quality Improvement		
APC	NCQA	MIPS
Engage/participate in training for behavioral health integration in primary care settings that broadens team-based care and clinical treatment of depression	QI 01 (Core) Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories (must monitor at least one measure of each type): Behavioral Health Measures	
Site must define process of adherence to behavioral health quality measures (common score card)	QI 02 (Core) Resource Stewardship Measures: Monitors at least two measures of resource stewardship (must monitor at least 1 measure of each type): A. Measures related to care coordination.	
	QI 08 (Core) Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories: Behavioral Health Measures	
	DBHI Monitors performance using 2+ BH clinical quality measures	
	Sets goals and acts to improve on 2+ BH clinical quality measures	
	DBHI: Behavioral Health Workforce Training including: Skill Development, Screening and BI for Depression, SBIRT, access to consulting specialist, MAT, CME opportunities	
	TC 07 (Core) Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities	