Prepared for:

The Office of the National Coordinator for Health Information Technology (ONC) and The Substance Abuse and Mental Health Services Administration (SAMHSA)

ONC-SAMHSA Behavioral Health Clinical Quality Measure Initiative

Technical Expert Panel Results for Behavioral Health Domain – *Trauma*

September 26, 2012

by The MITRE Corporation

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Executive Summary

Background

The Office of the National Coordinator for Health Information Technology (ONC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) engaged The MITRE Corporation to support the development of a portfolio of Behavioral Health (BH) Clinical Quality Measures (CQMs). This portfolio of BH CQMs are under consideration for future stages of the Centers for Medicare & Medicaid Services (CMS) Incentive Program for the Meaningful Use of Health Information Technology ("Meaningful Use"), which is part of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. This engagement was comprised of two phases:

1. Electronic specification (eSpecification) of prioritized BH CQMs under consideration for future stages of the Meaningful Use (MU) program
2. Development and facilitation of a Technical Expert Panel (TEP) of public and private BH specialists for the purpose of identifying and prioritizing recommendations for future development of BH related CQMs

This report presents results of the BH CQM Project Phase 2 (TEP Phase 1) effort for the Trauma BH domain.

Process

A TEP composed of public and private sector BH experts, representing the clinical domains of Alcohol Use, Autism, Depression, Drug Use, Suicide, and Trauma, was recruited, assembled, and facilitated over a 4-month period named "TEP Phase 1" from April through July 2012. Through the course of deliberations, the TEP was briefed on the MU program requirements and informed of the CQM development process, including clinical research, measure logic development, National Quality Forum (NQF) endorsement, and eSpecification creation. In a three-meeting weekly rotating cycle, each clinical domain was evaluated for the existence of CQMs included in the MU Stage 1 Final Rule, the MU Stage 2 Notice of Proposed Rulemaking (NPRM) and MU Stage 2 Final Rule, and those eSpecified as part of Project Phase 1. Additionally, the TEP reviewed results of environmental scans for the existence of measures not endorsed by the NQF and clinical literature searches for evidence warranting new measure development.

A "TEP Phase 2" focused for an additional three months from July through September 2012 on the topics of Depression Trended Outcome measurement and Drug Use/Prescription Drug Misuse measures.

Results

Table 1 provides an overview of the ONC-SAMHSA BH TEP's research activities and recommendations related to developing a BH CQM for the Trauma domain.

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Table 1. Behavioral Health Domain*: Trauma*

Source	Result
Domain specific NQF endorsed measures	No measures prioritized from Phase 1 of the BH CQM project
Meaningful Use Stage 1—Final Rule	No measures related to this clinical domain
Meaningful Use Stage 2 –Final Rule	No measures related to this clinical domain
NQF endorsed measures – future consideration	No measures related to this clinical domain
Non-endorsed Measures (Agency for Healthcare Research and Quality [AHRQ] Database)	22 measures related to this clinical domain were reviewed by TEP, three measures recommended for further development
Clinical Evidence	48 articlescovering three broad areas:* • Post-Traumatic Stress Syndrome (PTSD) Trauma Exposure (Non-Veteran-Specific) • Interpersonal Violence • Childhood Violence/PTSD

* Citations were repeated when findings applied to more than one topic area.

Recommendations

Based on these activities, the Trauma subgroup recommends:

Further development to support retooling and NQF endorsement of the measures below:

- NQMC: 006054 (Veterans Health Administration [VHA])
- NQMC: 006052 (VHA)
- NQMC: 001734 Family Violence Prevention Fund

Future research and development for CQMs for:

- PTSD - Adult/Childhood
- Interpersonal Violence

The following report provides details concerning the ONC-SAMHSA BH TEP activities and recommendations for the Trauma BH clinical domain.

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1 Background

Through the American Recovery and Reinvestment Act of 2009 (ARRA) Health Information Technology for Economic and Clinical Health (HITECH) Act, the Centers for Medicare & Medicaid Services (CMS) is authorized to provide reimbursement incentives for eligible professionals and hospitals for the Meaningful Use (MU) of certified Electronic Health Record (EHR) technology. The Office of the National Coordinator for Health Information Technology (ONC), through an agreement with CMS, has been tasked with developing a portfolio of Clinical Quality Measures (CQM) that capitalizes on the clinical data captured through EHRs for inclusion in the CMS EHR MU Incentive Program.

The Behavioral Health Coordinating Committee at the U.S. Department of Health and Human Services (DHHS), with support from the Office of National Drug Control Policy (ONDCP) Demand Reduction Interagency Workgroup EHR subcommittee, submitted consensus recommendations to the ONC, for behavioral health-relevant clinical quality measures to be included in Stage 2 of the MU incentive program. In July 2011, the ONC Federal Advisory Health Information Technology Policy Committee (HITPC) recommended to ONC that these measures be further developed.

SAMHSA and ONC jointly sponsored this project to follow up on these recommendations by developing and electronically specifying (eSpecification) BH CQMs to be added to the current EHR CQM portfolio of measures. The principal audience for these measures is primary care MU Eligible Professionals and Eligible Hospitals, although they may also be applicable to a broader range of BH professionals. The scope of the resulting BH eMeasure (BHeM) effort included strategic, technical, facilitation, coordination, clinical, and project management support for the development of a portfolio of electronically specified BH CQMs for potential inclusion in future stages of the CMS EHR MU Incentive Program.

BH CQMs for this project are focused in the clinical domains of:

- Alcohol Use
- Autism
- Depression
- Drug Use
- Suicide
- Trauma

This report presents results of the BH CQM Project Phase 2 Technical Expert Panel (TEP) for the Trauma BH domain.

2 Project Overview

The ONC and SAMHSA engaged The MITRE Corporation to support the development of a portfolio of BH CQMs suitable for inclusion in future stages of the CMS Incentive Program for the Meaningful Use of Health Information Technology (“Meaningful Use”), which is part of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). This engagement included two phases:

Phase 1 - eSpecification of BH CQMs suitable for future stages of the MU program. Ten BH CQMs were eSpecified through this project and include:

- National Committee for Quality Assurance (NCQA)
  1. NQF #0576, Follow-Up After Hospitalization for Mental Illness
  2. NQF #1401, Maternal Depression Screening
  3. NQF #1406, Risky Behavior Assessment or Counseling by Age 13
  4. NQF #1507, Risky Behavior Assessment or Counseling by Age 18
- The Joint Commission (TJC):
  5. NQF #1661, SUB-1 Alcohol Use Screening
  6. NQF #1663, SUB-2 Alcohol Use Brief Intervention Provided
- Center for Quality Assessment and Improvement in Mental Health (CQAIMH):
  7. NQF #0109, Bipolar Disorder and Major Depression: Assessment for Manic or Hypomanic Behaviors
  8. NQF#0110, Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use
  9. NQF #0111, Bipolar Disorder: Appraisal for Risk of Suicide
- Resolution Health, Inc. (RHI)
  10. NQF # 0580, Bipolar Antimanic Agent

Note: CQMs NQF #0110 and #1401 were included in MU Stage 2 Final Rule

Phase 2 - Development and facilitation of a TEP of public and pri vate BH specialists for the purpose of identifying and prioritizing recommendations for potential new measures for future development.

2.1 Technical Expert Panel

A TEP composed of public and private sector BH experts, representing the clinical domains of Alcohol Use, Autism, Depression, Drug Use, Suicide, and Trauma, was recruited, assembled, and facilitated over a 4-month period named “TEP Phase 1” from April through July 2012. Through the course of deliberations, the TEP was briefed on the MU program requirements and informed of the CQM development process, including clinical research, measure logic development, National Quality Forum (NQF) endorsement, and eSpecification creation. In a three-meeting weekly rotating cycle, each clinical domain was evaluated for the existence of CQMs included in the MU Stage 1 Final Rule, the MU Stage 2 Notice of Proposed Rulemaking (NPRM), and those eSpecified as part of Project Phase 1. Additionally, the TEP reviewed results of environmental scans for the existence of measures not endorsed by the NQF and clinical literature searches for evidence warranting measure development.

A “TEP Phase 2” focused for an additional three months from July through September 2012 on the topics of Depression Trended Outcome and Drug Use/Prescription Drug Misuse measures.

A list of all TEP members is included in Appendix A.

2.2 Purpose and Activities of the TEP

The purpose of the ONC-SAMHSA BH TEP was to:

- Recommend BH clinical quality measures for widespread adoption and use in future stages of the EHR MU Incentive Program
- Recommend future measure development needs by evaluating available clinical research
- Provide private sector input regarding the feasibility of measure implementation

Over the course of the project the TEP completed a comprehensive review of existing BH-relevant CQMs including measures that are NQF endorsed, community measures in the Agency for Healthcare Research and Quality measure clearinghouse, and measures that were under development through similar federal initiatives. In addition, for each domain, the TEP reviewed the clinical literature to evaluate the state of the field of measure development and to make recommendations on the next steps for measure development.

A listing of all scheduled meetings and topics is included in Appendix B.

Copies of the environmental scans are included in Appendix C.

SAMHSA is currently developing a National Behavioral Health Quality Framework. The framework is aligned with the National Quality Strategy and will prioritize six goals; (1) evidence-based prevention, treatment and recovery, (2) person and family-centered care, (3) coordination of behavioral health and other health care, (4) health living, (5) safe care, and (6) accessible and affordable care. The recommendations from the Technical Expert Panel are focused on measure recommendations for the Meaningful Use EHR incentive program and are primarily applicable to primary care and general hospital settings. These recommendations will be considered in the broad portfolio of SAMHSA quality work, including development of the framework and future measure development activities.

2.3 Common Themes in CQM Development for Behavioral Health

Many common themes emerged in the TEP discussions across the six domains. The United States (U.S.) healthcare system is evolving rapidly. The widespread use of standardized data captured in EHRs has profound potential to improve quality measurement in both research and healthcare contexts. Our discussions highlighted some principles related to BH quality measures development for consideration in efforts to realize this potential.

Standardized, Validated Screening and Assessment Tools

Significant discussion focused on the use of valid tools for screening, assessment, and outcome monitoring for BH diagnoses. Many standardized assessment tools exist for any given BH condition. There is often no ‘gold standard’ assessment tool for a given purpose. As a result, measure developers often specify the use of ‘a valid instrument’. This can create complications for the e-specification of the measure and for data comparison across sites. However, while standards may be useful for exchanging data, mandating the use of a specific instrument may limit a provider’s ability to select tools that they prefer, or develop new, innovative approaches to screening and assessment. Development of standards for the endorsement of validated tools, as well as standard processes for calibrating tools to a standard scale would be incredibly

valuable for improving the quality and interoperability of data while allowing the field to evolve with the state of the science.

Comprehensive Measure Sets

For each of the six domains TEP members discussed the long range goal of developing measure sets that support evidence based practices across the full continuum of care. For most BH disorders addressed in primary care settings this includes prevention, screening, follow up assessments, screening for co-morbid conditions, primary care based intervention, referral management, care coordination, and outcome tracking. For many of the domains addressed in this project the state of the research does not yet support the development of CQMs for each of these purposes. However, it was useful to consider the current state of measure development within this context to make recommendations for the next stages of measure development.

Implementation in Real World Settings

TEP discussions also highlighted the need to consider measure development in the context of real world healthcare settings. Our national healthcare system is rapidly evolving and health reform is putting significant pressure on primary care providers. The efficacy of primary care based interventions for behavioral disorders is highly dependent on implementation which can be influenced by acceptability to providers, ability to integrate best practices into their workflow, provider attitudes and comfort level with the intervention, etc. The TEP highlighted the need for additional research to address the implementation barriers that exist in busy practices, including technologies that reduce patient and provider burden, to identify methods for addressing patients with multiple BH co-morbidities, and to determine how clinical decision support can be tied to CQMs in EHR systems.

3 Domain-Specific Results: *Trauma*

3.1 Environmental Scan Results

MITRE engaged The Cloudburst Group as the subcontractor for the clinical literature review process due to their expertise in completing and analyzing clinical literature research in the six key domains of Alcohol, Substance Abuse, Depression, Suicide, Trauma and Autism. The Cloudburst Group deliverables were aligned with the goals of each TEP meeting (see Table 2).

Table 2. TEP Goals and Literature Reviews

TEP Phase 1 – Goal (All 6 Domains)	Literature Review Deliverables
Meeting 1 - Orientation and Familiarity with Current Measures	TEP participation and orientation if available
Meeting 2 - Non-Endorsed Measures Recommendations/Lit Search Question Formation	Delivery of Phase 1 environmental scan literature review domain-specific search questions for all 6 domains and participation in weekly TEPs
Meeting 3 - Select Promising Clinical Research	Delivery of final results from Phase 1 environmental scan of all 6 domains and participation in weekly TEPs

The Cloudburst Group provided literature search questions for review with the TEP at each Phase 1, Meeting 2 discussion. These questions were based on a preliminary review of ongoing research that could inform the development or retooling of each proposed measure or the creation of new measures. The answers to these questions and additional comments from the TEP members in the Meeting 2 discussions were used to generate the search criteria for the environmental scans. The results of these scans were then summarized and presented to each TEP in an executive summary (Table 3). The most appropriate articles were then collated for each domain and presented in a literature matrix (see Appendix C).

Recommended Search Terms for Trauma Literature Scan:

- Trauma Exposure and screening, primary care (PC)
- Post-Traumatic Stress Disorder (PTSD) screening tools
- Interpersonal violence screenings
- Childhood Violence screening
- Trauma screening treatment primary care
- Trauma screening clinical guideline
- Primary care trauma screen
- Traumatic brain injury screen
- Trauma measures primary care
- National Center for PTSD
- Trauma assessment
- Trauma exposure measures
- Trauma symptom inventory
- Screen interpersonal violence primary care
- Screen/measure adverse childhood event
- Screen child trauma primary care
- Clinical decision rules [trauma screening; PTSD screening; and trauma]

Below is a high-level summary of the 48 total results divided under 3 broad areas. The full matrix including summaries of each of the citations is available in Appendix C of this paper.

Table 3. Literature Search Results and Findings

Topics / Search Focus Area	Summary of Findings
PTSD/Trauma Exposure (non-Vet)	• PTSD is diagnosed only about 50% of the time – and less for those with co-occurring disorders. • Gold standard assessment tools include the Clinician-Administered PTSD Scale and the Structured Clinical Interview for DSM-IV, PTSD module. Use of these in clinical practice is limited by length and need for administration by a trained clinician. • There are a wide range of self-report PTSD assessments though there is no "gold standard" among them. The Impact Events Scale (IES), PTSD Checklist – Civilian Version, Trauma Screening Questionnaire (TSQ), and Self-Report Inventory of PTSD have the best diagnostic properties.

Topics / Search Focus Area	Summary of Findings
Interpersonal Violence (IPV)	• Many professional organizations recommend universal screening for IPV (especially for women), there is no consensus that this is appropriate and/or that there is sufficient evidence to warrant universal screening. • There is no "gold standard" screener – all have limitations on psychometric properties but for healthcare settings the Hurts, Insults, Threatens, and Screams (HITS) Scale screener may be the best current option.
Childhood Violence/PTSD (physical or sexual)	• Studies show large proportion of adults in primary care settings (20-50%) have histories of child physical or sexual abuse. • No agreed upon guidelines for screening and no "gold standard" screener.

3.2 Measure Recommendations

Table 4 provides an overview of current trauma related measures included in the MU program. Table 5 includes an overview of the ONC-SAMHSA BH TEP's recommendations related to developing a BH CQM for the Trauma domain.

Table 4. Behavioral Health Domain: Trauma - *CURRENT POLICY*

Source	Result
Meaningful Use Stage -Final Rule	No measures related to this clinical domain
Meaningful Use Stage 2-Final Rule	No proposed measures related to this clinical domain

Table 5. Behavioral Health Domain: Trauma - *FUTURE RECOMMENDATIONS*

Source	Recommendations
NQF endorsed measures – future consideration	No measures related to this clinical domain
Non-endorsed Measures (Agency for Healthcare Research and Quality [AHRQ] Database)	Three measures related to this clinical domain recommended for further development • NQMC: 006054 (Veterans Health Administration [VHA])- Percent of patients screened positive for PTSD symptoms with the PC-PTSD with timely disposition • NQMC: 006052 (VHA)- Percent of eligible patients screened at required intervals for PTSD and, if positive PC-PTSD result, who have suicide risk evaluation completed within 24 hours • NQMC: 001734 (Family Violence Prevention Fund)- Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) and who answered yes to initial danger assessment questions for whom records indicate that a suicide and homicide assessment was conducted
Clinical Evidence	Recommendations for additional research focused on:* • High risk populations • Symptoms of trauma and comorbidities • Screening and assessment tools for primary care • Identification of childhood trauma • Effective implementation

* Citations were repeated when findings applied to more than one topic area.

The Trauma domain is in its infancy in terms of overall CQM development appropriate for the MU program. There are currently no NQF endorsed measures developed and/or included in the Stage 1 or Stage 2 Final Rules for MU. The outcome goals of the TEP discussions for this domain were to:

- Identify the state of evidence to support trauma screening in the PC setting and the state of available CQMs related to Trauma.
- Determine whether there is clear research and data to support the development of a CQM for Trauma.
- Determine priority next steps for measure development in this domain.

Significant early TEP discussions focused on the definition of trauma. However, for the purposes of this process, the TEP chose to focus on PTSD and interpersonal violence (IPV), since the majority of research is focused on these areas.

Screening for Trauma

In 2004, the United States Preventive Services Task Force (USPSTF) reviewed the evidence and found insufficient evidence to recommend routine screening for trauma. The TEP noted that the American Academy of Pediatrics has stated that screening for IPV is critical due to its effects on children. However, after reviewing the current state of the field there was no consensus among TEP members on the utility of a population based screening for trauma. There was, however, strong support for trauma informed care of patients in treatment of BH disorders. In addition, the TEP suggested that measures targeting high-risk groups for screening including criminal justice and court-involved, patients with mental health and substance abuse disorders, homeless, veterans, and patients with HIV may be valuable.

The Veterans Health Administration (VHA) and the Indian Health Service (IHS) currently regularly screen for both PTSD and IPV due to the prevalence of trauma in their respective populations and could provide evidence to support the development and endorsement of CQMs for this domain. The VHA and the Family Violence Prevention Fund have created suites of measures to address screening and intervention for PTSD and IPV respectively. These measures could be used as a foundation for creating new measures that target high risk populations.

TEP members suggested that research on primary care based screening and interventions focused on specific diagnoses or conditions for which it is important to know of a history of trauma would add great value to the development of future measures targeting high risk populations.

4 Future Recommendations

While the focus of this project is to recommend CQMs for the HITECH MU program, the TEP was also asked to make recommendations for additional research and development needed to support the next phases of measure development for this domain.

Additional Research Recommendations

While there was clear TEP consensus on the relevance of trauma to health and risk for BH disorders, there was not consensus on the sufficiency of evidence to support universal screening. Some TEP members cited the prevalence of trauma to support universal screening however

others emphasized that the trauma-health relationship is significantly mediated by mental health symptoms such as PTSD, other anxiety symptoms, and depression. Screening for these conditions could provide the same potential points of intervention as screening for trauma. Future research should evaluate the percentage of patients who would be identified and treated for trauma using a population based screen versus a screen to identify trauma in targeted high risk populations as described above (i.e., would the population based screening capture or identify more patients?).

Symptoms of Trauma and Co-morbidities

Questions were also raised regarding the value of primary care based intervention for individuals who screen positive for trauma but show no clinical symptoms. TEP members recommended additional research to evaluate the value of screening for trauma in the absence of clinically significant symptoms. Is primary care based intervention valuable for patients without co-morbid BH issues? The primary care system is already overburdened such that any additional screening requirements must be actionable in a way that improves patient outcomes.

In addition, TEP members highlighted the need for additional research on the factors that influence response to trauma and resilience. How do symptomatology and resilience differ with age, gender, and culture? TEP members pointed out that not all those who experience trauma are negatively impacted by it; therefore, targeting symptomology could aid in more accurately identifying patients likely to benefit from specific interventions including early intervention efforts to improve resiliency.

Screening and Assessment Tools

One of the challenges in developing measures for PTSD and IPV is the lack of a clear "gold standard" for screening methods. A summary of screeners and treatment protocols was provided in a clinical literature scan and is attached in Appendix C.3. The TEP recommended additional research focused on identifying valid and reliable screening and assessment tools that are practical for implementation in a primary care setting. Research should also assess unanticipated harms associated with repeated or poorly implemented screening.

The TEP also recommended evaluating the value of treating individuals with subclinical PTSD (i.e., those signs/symptoms of trauma exposure that may impact functioning but that don't meet the clinical criteria for the disorder). Some data suggest that the majority of individuals with false negative PC-PTSD screens have partial PTSD; these individuals could be captured by adjusting thresholds in the PTSD screening protocol.

The TEP also recommended additional studies regarding the most relevant time frames to target screening and assessments (e.g., past year vs. lifetime). The sequelae of trauma can be lifelong, though often hidden from detection due to shame, secrecy, and social taboos against exploring certain realms of human experience. However, targeted research should help to define the time frames that are most clinically relevant for a given population.

Childhood Trauma

A review of the longitudinal research on adverse childhood experiences by Dr. Vincent Felitti (see appendix C.5.2) was shared and discussed with the TEP. This research highlights the long-term impacts on physical and psychological health from adverse experiences in childhood. The American Academy of Pediatrics has stated that screening for IPV is critical due to its effects on

children. However, the USPSTF, in its recent report to Congress, highlighted the need for additional research into interventions to prevent child abuse and neglect in primary care and acute care settings. The TEP recommends more research into child abuse screening in primary care and hospital settings, where this issue frequently goes unrecognized.

Implementation

The TEP also recommended additional research regarding implementation of trauma screening in real world settings. This should include trauma screening feasibility and acceptability to providers, adherence to screening and intervention best practices, unanticipated harms of repeat or poorly administered screening, screening efficiency, and long term outcomes. In addition, it is important to address whether the information best gathered by interpersonal interview or by computer/self-administered, and whether this differs across populations (culture, age, sex, type of trauma, etc.).

Provider Attitudes

Provider attitudes and comfort level with discussing trauma dramatically influence the efficacy of screening and primary care based intervention. Repeated screening for trauma can re-traumatize the victim so it is very important how these systems are implemented. The TEP highlighted the complexity of trauma screening and the need for training and ongoing support to be in place if screenings are conducted. Additional research is needed on the best ways to administer this type of screening in real world settings with physicians who may not be familiar or comfortable with addressing trauma and/or related topics. Future study is also recommended to determine how trauma screening and intervention can be implemented to improve provider attitudes or reduce the influence of the provider on the effectiveness of the process.

5 Conclusion

The ONC-SAMHSA Behavioral Health CQM TEP, Trauma domain subgroup, in its quest to recommend CQMs suited for the HITECH Meaningful Use of Health IT Incentive program, determined that while there are currently no NQF endorsed CQMs in the Trauma domain, there are a number of measures that are currently in use in healthcare systems across the country that could be retooled to improve quality in this domain. In addition, significant research is needed to better understand what opportunities exist to advance healthcare quality through addressing trauma in real world ambulatory care settings.

Appendix A TEP Member List

COMMUNITY MEMBERS

Gavin Bart, MD FACP FASAM, Director, Division of Addiction Medicine, Hennepin County Medical Center

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* delineates member with specific expertise in domain of Trauma

** ad hoc

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Appendix B Meeting Schedule

BH CQM TEP Schedule and Topics – Revised 7/6/12		
Week #	**Week of:**	**Topic**
1	4/9-4/13	KICK-OFF – OPTION 1: 4/9: 1:00P-3:00P OPTION 2: 4/12: 12:30P–2:30P
2	4/16 3-4:30pm Eastern	Suicide/Trauma – Week 1
3	4/23 3-4:30pm Eastern	Autism – Week 1
4	4/30 3-4:30pm Eastern	Depression – Week 1
5	5/7 3-4:30pm Eastern	Drugs/Alcohol – Week 1
6	5/14 3-4:30pm Eastern	Suicide/Trauma – Week 2
7	5/21 3-4:30pm Eastern	Autism – Week 2
8	5/29 3-4:30pm Eastern	Depression – Week 2
9	6/4 3-4:30pm Eastern	Drugs/Alcohol – Week 2
10	6/11 3-4:30pm Eastern	Suicide/Trauma – Week 3
11	6/22 3-4:30pm Eastern	Autism – Week 3
12	6/25 3-4:30pm Eastern	Depression – Week 3
13	7/2 3-4:30pm Eastern	CANCELLED
14	7/9 3-4:30pm Eastern	Drugs/Alcohol – Week 3
TEP PHASE II		
15	7/16 3-4:30pm Eastern	Depression – Week 1
16	7/23 3-4:30pm Eastern	Drug Use/PDM – Week 1
17	7/30 3-4:30pm Eastern	Depression – Week 2 *
18	8/6 3-4:30pm Eastern	Drug Use/PDM – Week 2 *
ADDED	8/9 All day event	In person and Webinar
19	8/13 3-4:30pm Eastern	Depression – Week 3 *
20	8/20 3-4:30pm Eastern	Drug Use/PDM – Week 3 *
21	8/27 3-4:30pm Eastern	Depression – Week 4 *
22	9/3 3-4:30pm Eastern	Drug Use/PDM – Week 4 *
23	9/10 3-4:30pm Eastern	Depression – Week 5 *
24	9/17 3-4:30pm Eastern	Drug Use/PDM – Week 5 *
		*if needed

Appendix C Environmental Scans

C.1 NQF-Endorsed Measures - *None for the Trauma Domain*

C.2 AHRQ Measures (Non-NQF-Endorsed)

C.3 Clinical Literature Search Matrix

C.4 Clinical Literature Search Summary Document

Domain: Trauma (Trauma Screening) – Environmental Scan

Search Criteria: Trauma Screening

- **19 results initially identified**
  - 5 removed (NQF endorsed)
- **Final pool = 14 results for review**

Full List of Original Results*

(*includes NQF endorsed measures)

Click Here

Domain: Trauma Screening – Top Results

	Measure Review (M= maybe, X=No, Y = yes)	Prioritized Result Summary
1	M	Hospital-based inpatient psychiatric services: the percentage of patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths. 2010 Dec. **[NQMC Update Pending]** NQMC:006322 The Joint Commission - Health Care Accreditation Organization
2		Behavioral health: percent of eligible patients screened at required intervals for PTSD. 2010 Oct. NQMC:006012 Veterans Health Administration - Federal Government Agency [U.S.]
3		Post-traumatic stress disorder (PTSD): percent of Veterans screened positive for PTSD symptoms with the PC-PTSD with disposition. 2010 Oct. NQMC:006055 Veterans Health Administration - Federal Government Agency [U.S.]
4	Y	Post traumatic stress disorder (PTSD): percent of patients screened positive for PTSD symptoms with the PC-PTSD with timely disposition. 2010 Oct. NQMC:006054 Veterans Health Administration - Federal Government Agency [U.S.]
5	Y	Post-traumatic stress disorder (PTSD): percent of eligible patients screened at required intervals for PTSD and, if positive PC-PTSD result, who have suicide risk evaluation completed within 24 hours. 2010 Oct. NQMC:006052 Veterans Health Administration - Federal Government Agency [U.S.]

Domain: Trauma (PTSD) – Environmental Scan

Search Criteria: Post Traumatic Stress Disorder and Ambulatory

- 15 results initially identified
  - 0 removed (NQF endorsed)
- Final pool = 15 results for review

Full List of Original Results*

(*includes NQF endorsed measures)

Click Here

Domain: Trauma (PTSD) – Top Results

	Measure Review (M= maybe, X=No, Y = yes)	Prioritized Result Summary
1	☐	**Behavioral health: percent of eligible patients screened annually for depression AND if positive PHQ-2 or PHQ-9 result or affirmative response to Q9 of the PHQ-9 and percent of eligible patients screened at required intervals for PTSD AND if positive PC-PTSD result, have suicide risk evaluation completed within 24 hours.** 2010 Oct. NQMC:006013 Veterans Health Administration - Federal Government Agency
2	☐	**Domestic violence: percent of adult and adolescent patients assessed who disclosed that they were victims of abuse.** 2004 Feb. NQMC:001435 Family Violence Prevention Fund - Nonprofit Organization
3	☐	**Domestic violence: percent of adult and adolescent patients seen by a provider who were assessed for intimate partner violence (IPV) during the last year.** 2004 Feb. NQMC:001434 Family Violence Prevention Fund - Nonprofit Organization
4	☐	**Domestic violence: percent of adult and adolescent patients who screened negative for current or past intimate partner violence (IPV) but whom the provider is still concerned may be a victim of IPV who were offered information about IPV and referrals.** 2004 Feb. NQMC:001736 Family Violence Prevention Fund - Nonprofit Organization
5	☐	**Domestic violence: percent of adult and adolescent patients who screened negative for current or past intimate partner violence (IPV) but whom the provider is still concerned may be a victim of IPV whose records include prompts for specific follow-up questions about IPV to occur at the patient's next visit.** 2004 Feb. NQMC:001737 Family Violence Prevention Fund - Nonprofit Organization
6	☒ Y	**Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) and who answered yes to initial danger assessment questions for whom records indicate that a suicide and homicide assessment was conducted.** 2004 Feb. NQMC:001734 Family Violence Prevention Fund - Nonprofit Organization

(Continued)

Domain: Trauma (PTSD) – Top Results Cont.

	Measure Review (M= maybe, X=No, Y = yes)	Prioritized Result Summary
7	☐	**Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) for whom records indicate that specified assessments were conducted.** 2004 Feb. NQMC:001733 Family Violence Prevention Fund - Nonprofit Organization
8	☐	**Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) for whom records indicate that specified intervention and treatment plans were offered.** 2004 Feb. NQMC:001735 Family Violence Prevention Fund - Nonprofit Organization
9	☐	**Domestic violence: percent of providers of health care services to adult and adolescent patients in the clinical setting who documented that they complied with assessment protocols.** 2004 Feb. NQMC:001436 Family Violence Prevention Fund - Nonprofit Organization

Domain: Trauma (Adverse Childhood Experiences) – Environmental Scan

Search Criteria: Adverse Childhood Experiences

- 9 results initially identified
  - 0 removed (NQF endorsed)
- Final pool = 9 results for review

Full List of Original Results*

(*includes NQF endorsed measures)

Click Here

Domain: Trauma (Adverse Childhood Experience) – Top Results

	Measure Review (M= maybe, X=No, Y = yes)	Prioritized Result Summary
1	☐	**Domestic violence: percent of adult and adolescent patients assessed who disclosed that they were victims of abuse.** 2004 Feb. NQMC:001435 Family Violence Prevention Fund - Nonprofit Organization
2	☐	**Domestic violence: percent of adult and adolescent patients seen by a provider who were assessed for intimate partner violence (IPV) during the last year.** 2004 Feb. NQMC:001434 Family Violence Prevention Fund - Nonprofit Organization
3	☐	**Domestic violence: percent of adult and adolescent patients who screened negative for current or past intimate partner violence (IPV) but whom the provider is still concerned may be a victim of IPV who were offered information about IPV and referrals.** 2004 Feb. NQMC:001736 Family Violence Prevention Fund - Nonprofit Organization
4	☐	**Domestic violence: percent of adult and adolescent patients who screened negative for current or past intimate partner violence (IPV) but whom the provider is still concerned may be a victim of IPV whose records include prompts for specific follow-up questions about IPV to occur at the patient's next visit.** 2004 Feb. NQMC:001737 Family Violence Prevention Fund - Nonprofit Organization
5	☒ Y	**Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) and who answered yes to initial danger assessment questions for whom records indicate that a suicide and homicide assessment was conducted.** 2004 Feb. NQMC:001734 Family Violence Prevention Fund - Nonprofit Organization
6	☐	**Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) for whom records indicate that specified assessments were conducted.** 2004 Feb. NQMC:001733 Family Violence Prevention Fund - Nonprofit Organization

(Continued)

Domain: Trauma (Adverse Childhood Experiences) – Top Results Cont.

	Measure Review (M= maybe, X=No, Y = yes)	Prioritized Result Summary
7	☐	Domestic violence: percent of adult and adolescent patients who screened positive for current or past intimate partner violence (IPV) for whom records indicate that specified intervention and treatment plans were offered. 2004 Feb. NQMC:001735 Family Violence Prevention Fund - Nonprofit Organization
8	☐	Domestic violence: percent of providers of health care services to adult and adolescent patients in the clinical setting who documented that they complied with assessment protocols. 2004 Feb. NQMC:001436 Family Violence Prevention Fund - Nonprofit Organization

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
	Assessments of Trauma Screeners in Primary Care Settings												
Trauma Exposure and PTSD Screeners used in Clinical Settings													
Review Studies													
1	Brewin, C. R. (2005). "Systematic Review of Screening Instruments for Adults at Risk of PTSD." Journal of Traumatic Stress 18(1): 53-62.	2005	Systematic Review of PTSD Screeners	13 PTSD Screeners reviewed	Adults	varied	varied	Universal		IES, TSQ performed consistently well; small # of core symptoms as effective as longer lists; measures with fewer items perform as well as those with more items		M1	
2	del Vecchio, N., A. R. Elwy, et al. (2011). "Enhancing Self-Report Assessment of PTSD: Development of an Item Bank." Journal of Traumatic Stress 24(2): 191-199.	2011	Self-Report Assessments of PTSD	SysReview of 41 Self-Report PTSD Screeners	Adults	varied	varied	Pressing need to develop quality screener to ensure people with PTSD are not missed - especially those masked by co-occurring disorder, and to ensure those who do not are not misdiagnosed.		Developed item bank of 104 measures in interest of developing a CAT (computer adapted test) for PTSD - builds on previous systematic reviews (Brewin, Norris). Only reviewed tools that identified multiple types of trauma. No "gold standard" among self-report screeners, but named IES, PTSD Checklist - Civilian Version, TSQ, and Self-Report Inventory of PTSD to have best credentials.	H1		
3	Deady, M. (2009). A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings, Network of Alcohol and Other Drug Agencies.	2009	Review of Screening and Outcomes Measures for Alcohol/Drug Settings	Review includes 6 trauma-specific measures: Impact of Events Scale (IES); Primary Care - PTSD Screener (PC-PTSD); PTSD Checklist; PTSD Symptom Self Report; Traumatic Life Event Questionnaire (TLEQ); Trauma Screening Questionnaire (TSQ)	Adults	varied	varied			PTSD Checklist has excellent psychometrics and has been used in variety of settings; IES has been tested extensively and has good psychometrics; PC PTSD is very brief and limited empirical testing; PTSD Symptom Self Report has good psychometrics and used in range of pops; TLEQ Adequate reliability and validity - used in adolescents, D&A user, and prison pops - limited empirical testing; TSQ is simple, limited empirical testing, adequate psychometrics in preliminary studies		M1	
4	Norris, F. H. and J. L. Hamblen (2004). Standardized self-report measures of civilian trauma and PTSD. Assessing psychological trauma and PTSD. J. Wilson and T. M. Keane. New York, NY, Guilford Press: 63-102.	2004	Self-report measures of civilian trauma and PTSD	SysReview of 24 PTSD Self-Report Screeners		varied	varied			(have not yet acquired the book, but above reviews cite - and build upon - this work)		M1	
Individual Studies													
5	Carlson, E. B., P. A. Palmieri, et al. (2011). "Development and Validation of a Brief Self-Report Measure of Trauma Exposure: The Trauma History Screen." Psychological Assessment 23(2): 463-477.	2011	Self-report measure of trauma exposure	Trauma History Screen (THS)	4 samples: mean ages=45 (homeless vets); 43 (hospital trauma center); 18.5 (university females); 20 years (community college)	4 samples: residential rehab ctr for vets; university hospital trauma center; university; small community college	Homeless Veterans; Non-clinical community sample in hospital; Non-clinical community sample (female university students);	Universal	n/a	Validation of brief self-report measure of trauma exposure - assesses frequency of HMS and PPD, + detail on PPD events	H2		
6	Carlson, E. B. (2001). "Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events." Assessment 8: 431-441.	2001	Psychometric study of brief screen for PTSD	Screen for Posttraumatic Stress Symptoms	Adults (30-45)	lg, private, nonprofit psychiatric hospital	inpatient admissions to psych hospital	Universal		SPTSS found to be valid and reliable brief screener for PTSD symptoms - epecially for those who may have experienced multiple traumatic events, who report no traumatic events, or who have not been asked about traumatic events		M2	

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
7	Goodman, L. A., C. Corcoran, et al. (1998). "Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire." Journal of Traumatic Stress 11: 521-542.	1998	Assessing traumatic event exposure	Stressful Life Events Screening Questionnaire	Adults					Reviews the psychometric properties of the Life Events Screening Questionnaire, and discusses the complexities of assessing trauma exposure. Good discussion of general challenges/issues related to asessment.			L2
8	Kubany, E. S., M. B. Leisen, et al. (2000). "Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire." Psychological Assessment 12: 210-224.	2000	validation of broad-spectrum measure of trauma exposure	Traumatic Life Events Questionnaire	4 samples: mean ages=males 31& females 29 (SA program residents); 51 (Vietnam vets); males 24& females 21 (undergraduates); 20-54 ("battered women")	4 samples: SA residential program; VA vocational rehab program; university; support group for battered women	4 samples: SA residential program residents; Vietnam vets; undergraduates; "battered women"	Universal	n/a	Brief screener intended for use in clinical settings - assess exposure to broad range of traumatic events		M2	
9	Lang, A. J., C. Laffaye, et al. (2003). "Sensitivity and specificity of the PTSD Checklist in detecting PTSD in femal veterans in primary care." Journal of Traumatic Stress 16: 257-264.	2003	PTSD Checklist sensitivity	PTSD Checklist- Civilian version	Adults (avg. 48.9 years)	VA Primary Care Clinic	Female veterans			found qualitfied support for use of the PTSD-Civilian version with female veterans in primary care setting - but urged further research to find optimal tool for general clinical settings		M2	
10	Yeager, D. E., K. M. Magruder, et al. (2007). "Performance characteristics of the Posttraumatic Stress Disorder Checklist and SPAN in Veterans Affairs primary care settings." General Hospital Psychiatry 29: 294-301.	2007	PTSD Checklist and SPAN in VA primary care settings	PTSD Checklist and SPAN	Adults (Males avg. 62 years; Females 50 years)	VA Primary Care clinic	Patients in four VA medical centers			Found PTSD Checklist the preferred diagnostic tool, unless brevity is an issue. Suggests clinicians consider a lower cutoff score for the PTSD Checklist when used in primary care settings - but did not recommend different cutoffs by gender or race.		M2	
11	Boscarino, J. A., H. L. Kirchner, et al. (2011). "A brief screening tool for assessing psychological trauma in clinical practice: development and validation of the New York PTSD Risk Score." General Hospital Psychiatry 33: 189-500.	2011	Brief screening tool for assessing psychological trauma in clinical care	New York PTSD Risk Score	Adults		Trauma patients		n/a	Validation of brief screening tool for psychological trauma in clinical care setting that incorporates Primary Care PTSD Screen, depression symptoms, access to care, sleep disturbance, trauma history and demographic variables symptoms, access to care, sleep disturbance, trauma history and demographic variable	H2		
12	Gerlach, L. B., E. M. Datner, et al. (2007). "Does sex matter? Effect of screener sex in intimate partner violence screening." American Journal of Emergency Medicine 25: 1047-1050.	2007	Screener sex for IPV	4-items from Abuse Assessment Scale	Adults	ED	Emergency Dept patients			Screener sex does not affect disclosure of IPV			L2

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
13	Bahraini, N. H., L. A. Brenner, et al. (2009). "Utility of the Trauma Symptom Inventory for the Assessment of Post-Traumatic Stress Symptoms in Veterans with a History of Pscyhological Trauma and/or Brain Injury." Military Medicine 174(10): 1005-1009.	2009	Assessing PTSD Symptoms in Veterans	Trauma Symptom Inventory	Adults		Veterans with TBI and/or PTSD			TSI is useful measure of trauma symptoms in vets who also have TBI		M2	
14	Gore, K. L., C. C. Engel, et al. (2008). "Test of a single-item posttraumatic stress disorder screener in a military primary care setting." General Hospital Psychiatry 30: 391-397.	2008	Test of single-item PTSD screener	1-item PTSD screener (compared with 4-item PC-PTSD)	Adults	Military Health Primary Care Clinic	Patients in military health primary care clinics			compared single-item PTSD screener with 4-item PC-PTSD - it failed to offer sound test characteristics	H2		
15	Schild, S. and C. J. Dalenberg (2012). "Trauma Exposure and Traumatic Symptoms in Deaf Adults." Psychological Trauma: Theory, Research, Practice, and Policy 4(1): 117-127.	2012	Trauma exposure and symptoms in deaf pop.	Life Event Checklist, Clinician Administered PTSD Scale, Peritraumatic Distress Scale, Trauma Symptom Inventory, Somatoform Diissociation Questionnaire, Peabody Individual Achievement Test - Revised, Interpersonal Support Evaluation list	Adults		Deaf persons			CAPS more effective screener for PTSD in deaf population than TSI		M2	
16	van Dam, D., T. Ehring, et al. (2010). "Validation of the Primary Care Posttraumatic Stress Disorder (PC-PTSD) screening questionnaire in civilian substance use disorder patients." Journal of Substance Abuse Treatment 39: 105-113.	2010	Validation of PC-PTSD screener in civilian SA patients	PC-PTSD Screener	Adults		Persons with Substance Use Disorders			original PCD-PTSD useful screener for civilians with SUD		M2	
17	Richmond, T. S., J. Ruzek, et al. (2011). "Predicting the future development of depression or PTSD after injury." General Hospital Psychiatry 33: 327-335.	2011	Predicting PTSD after injury	Predictive screener based on STEPP (validated for children) - adapted for adults, and adding depression prediction	Adults	Urban ED	Urban ER - presenting with minor injury	Universal		easily implemented in clinical care setting - used to risk-stratify injury patients to predict potential PTSD	H2		
18	Neria, Y., M. Olfson, et al. (2008). "Trauma exposure and posttraumatic stress disorder among primary care patients with bipolar spectrum disorder." Bipolar Disorders 10: 503-510.	2008	Trauma exposure and PTSD in Bipolar Patients	PTSD Checklist - Civilian Version, Life Events Scale (trauma screeners only)	Adults (18-70)	Primary Care - General Medicine Practice	Patients screening positive for Bipolar Disorder		comorbidity of lifetime bipolar disorder and current PTSD sign associated with impairment and poor social functioning	Pts screening postive for BD were 2.6 x more likely to report physical assault and 2.9 x more likely to screen positive for current PTSD		M2	

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
19	Wrenn, G. L., A. P. Wingo, et al. (2011). "The Effect of Resilience on Posttraumatic Stress Disorder in Trauma-Exposed Inner-City Primary Care Patients." Journal of the National Medical Association 103(7): 560-566.	2011	Effect of Resilience	Childhood Trauma Questionnaire; Traumatic Events Inventory	Adults (18-75)	Primary Care or OB-GYN at urban general hospital	urban, low-income, highly traumatized, predominantly AA men and women,			Use of 10-item CD-RISC self-report scale for resilience can help clinicians better understand within-group differences in those with PTSD, and identify those with low-resilience who may benefit from interventions designed to increase resilience	H2		
20	Barry, D. T., M. Beitel, et al. (2011). "Exploring Relations Among Traumatic, Posttraumatic, and Physical Pain Experiences in Methadone-Maintained Patients." The Journal of Pain 12(1): 22-28.	2011	Relations among Traumatic, Post-Traumatic and Physical Pain Experiences	Life Experiences Checklist; Primary Care PTSD Screen	Adults	Methadone clinic	Methadone-maintenance treatment patients		found higher levels of lifetime trauma experiences among those with chronic severe pain	supports clinical standard of assessing for trauma and PTSD among those in SA treatment		M2	
21	Norman, S. B., A. J. Means-Christensen, et al. (2006). "Associations Between Psychological Trauma and Physical Illness in Primary Care." Journal of Traumatic Stress 19(4): 461-470.	2006	Associations between psychological trauma and physical illness	PTSD Module of the Composite International Diagnostic Interview	Adults (18-79)	university-affiliated primary care clinics	patients with panic disorder		possible gender differences in treatment compliance depending on trauma history	examines types of pschological trauma and specific physical illnesses assocaited with each. For example, sexual trauma was associated with arthritis in men and with cancer and digestive problems in women.	H3		
22	Wohlfarth, T., F. W. Winkel, et al. (2003). "Screening for Posttraumatic Stress Disorder: An Evaluation of Two Self-Report Scales among Crime Victims." Psychological Assessment 15(1): 101-109.	2003	Evaluating 2 self-report PTSD screeners	Impact of Events Scale; Posttraumatic Stress Disorder (PTSD) Symptom Scale, Self-Report version (PSS-SR)	Adults (mean age 48)	Police stations	Victims of crime			both screeners found especially suitable because of ease of administration - esp important in situations in which no professional personnel is available		M2	
Sexual Trauma/DV/IPV													
Review Studies													
23	Nelson, H. D., C. Bougatsos, et al. (2012). "Screening Women for Intimate Partner Violence: A Systematic Review to Update the 2004 U.S. Preventive Services Task Force Recommendation." Annals of Internal Medicine 156(11): 1-13.	2012	Screening Women for IPV - Systematic Review	Review of 14 Screeners	Adults	primary care, acute care, OB-GYN clinics	Women	Universal	effectievness of IPV screening assessed in RCT -reduced IPV recurrence, PTSD reduced IPV recurrence, PTSD symptoms, and alcohol problems and improved scores for quality of life, depression, and mental health, differences were not statistically significant between groups (39).	More women in the screened group initiated discussions about IPV with their clinicians, indicating at least a change in the clinic visit related to screening. Screening instruments designed for healthcare settings can accurately identify women experiencing IPV. Screening..can reduce IPV and improve health outcomes depending on population screened and outcomes measured (though effectiveness trials have important limitations). Screening has minimal adverse effects.	H1		

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
24	Haggerty, L. A., J. W. Hawkins, et al. (2011). "Tools for Screening for Interpersonal Violence: State of the Science." Violence and Victims 26(6): 725-737.	2011	Screening for IPV: State of the Science	HITS; WAST; ISA-P; PVS; AAS; WEBS	Adults			Ensure before implementing a universal screener that the benefits outweigh the risks - many screeners are not emprically sound. Author says limitations related to the psychometric properties of available screening tools warrant caution and additional evidence is needed to confirm or negate the value of universal screening in low-risk populations.		Reviews these commonly used screeners and urges clinicians to understand their limitations - though they have some utility in identifying maltreatment, none of the screeners have been validated with IPV reports (e.g. police reports). The CTS is often used in comparative studies, but it was not developed with an IPV focus. There is no "gold standard".	H1		
25	O'Reilly, R., B. Beale, et al. (2010). "Screening and Intervention for Domestic Violence During Pregnancy Care: A Systematic Review." Trauma, Violence, and Abuse 11(4): 190-201.	2010	Screening for DV during pregnancy	Abuse Assessment Screen (AAS); Conflicts Tactics Scale; Violence Against Women Screen	Varied: Adolescents; Adults	Pre-Natal Clinic	Pre-natal clinic patients			identification of DV increased with use of screener - especially repeated use throughout pregnancy & in questionnaire format		M1	
26	Feder, G., J. Ramsay, et al. (2009). "How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria." Health Technology Assessment 13(16): i-136.	2009	Sys Review of Screening Critiera (UK National Committee)	Review of 18 Tools	Adults	Varied (general practice, Eds, urgent care, DV refuges, women's healthcare centers, women's homes, ante-natal clinics)	Women	insufficient evidence	limited evidence from "weak" studies	found HITS scale the best of several short screening tools for use in health-care settings		M1	
Individual Studies													
27	Kimerling, R., A. E. Street, et al. (2008). "Evaluation of Universal Screening for Military-Related Sexual Trauma." Psychiatric Services 59(6): 635-640.	2008	Evaluation of Universal Screening	VA screener for sexual trauma (clinical reminder)	Adults	data extracted from VA clinical reminders	VA patients screened for sexual trauma		increase in use of mh services by those screened for sexual trauma	Prospective study assessing whether universal screening for military-related sexual trauma had an impact on subsequent use of mh services		M2	
28	Thombs, B. D., D. P. Bernstein, et al. (2007). "A brief two-item screener for detecting a history of physical or sexual abuse in childhood." General Hospital Psychiatry 29: 8-13.	2007	2-item screener for childhood physical/sexual abuse	2 items from the Childhood Trauma Questionnaire - Short Form (CTQ-SF)	Adults	HMO	Women			2-item screener found effective for detecting history of physical or sexual abuse in childhood - developed for primary care setting	H2		
29	Todahl, J. and E. Walters (2011). "Universal Screening for Intimate Partner Violence: A Systematic Review." Journal of Marital and Family Therapy 37(3): 355-369.	2011	Systematic Review of Universal Screening for IPV	not named	Adults	varied	Women (primarily)	Both sides of the argument are presented	insufficient evidence of health outcomes as a result of universal screening for women	reviews literature on universal screening for IPV	H2		

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
30	Friend, D. J., R. P. Cleary Bradley, et al. (2011). "Typologies of Intimate Partner Violence: Evaluation of a Screening Instrument for Differentiation." Journal of Family Violence 26: 551-563.	2011	Screener for Typologies of IPV	a modified version of the Revised Conflict Tactics scale CTS-2 (+screeners for alcohol and drug abuse & antisocial personalities)	Adults (18+)	comparison sample recruited from community-based organizations, govt agencies, ads	Couples experiencing situational violence			Screening instrument useful for distinguishing characterological and situational violence. (Part of a larger study to assess efficacy of a workshop designed to reduce couple violence.)		M2	
31	Jory, B. (2004). "The Intimate Justice Scale: An Instrument to Screen for Psychological Abuse and Physical Violence in Clinical Practice." Journal of Marital and Family Therapy 30(1): 29-44.	2004	Intimate Justice Scale	Danger Assessment Scale (DAS); Revised Conflict Tactics Scale (CTS-2); Intimate Justice Scale	Adults (19-59, mean 34)	community mental health centers, medical center, private mental health practices, counseling centers, DV center	women seeking treatment for any presenting problem (not limited to DV)	Universal		Argues drawbacks associated with both DAS and CTS-2. Intimate Justice Scale addresses these drawbacks - focuses on ethical dynamics in relationships, not specific abuse. Not intended to replace questionnaires that directly assess violence, but in conjunction.		M3	
32	MacMillan, H. L., C. N. Wathen, et al. (2006). "Approaches to Screening for Intimate Partner Violence in Health Care Settings." JAMA Journal of the American Medical Association 296(5): 530-536.	2006	Screening for IPV in Health Care Settings	Woman Abuse Screening Tool (WAST); Partner Violence Screen (PVS)	18-64	Emergency Department, Family Practices, Women's Health Clinic	Women		n/a	RCT on screening methods - sample assigned written, computer-based, and verbal methods (PVS and WAST randomized within these groups) Women preferred self-completed approaches (over face-to-face); computer screening did not increase prevalence; written screens had fewest missing data. PVS and WAST highly comparable.	H2		
33	Kapur, N. A. and D. M. Windish (2011). "Optimal Methods to Screen Men and Women for Intimate Partner Violence: Results from an Internal Medicine Residency Continuity Clinic." Journal of Interpersonal Violence 26(2): 2335-2352.	2011	Optimal Methods and Screeners for IPV	Partner Violence Screen (PVS); Hurts, Insults, Threatens and Screams (HITS)	Adults (mean age 43.9)	Urban, Academic, Internal Medicine Residency Continuity Clinic	Men and Women			PVS and HITS chosen for practicality in a busy internal medicine practice, validation in similar study populations, and correlation with the previously validated 19-item Conflict Tactics Scale. Study found prevalence higher for self-report (over face-to-face) for women, but methods ns for men; PVS had higher prevalence than HITS but HITS has potential to capture greater variety of IPV	H2		
Childhood Violence/ Adverse Childhood Events													
	Review Studies												
34	Stover, C. S. and S. Berkowitz (2005). "Assessing Violence Exposure and Trauma Symptoms in Young Children: A Critical Review of Measures." Journal of Traumatic Stress 18(6): 707-717.	2005	Review of Measures assessing violence exposure and trauma symptoms in young children	multiple screeners/ measures	0-6	varied	young children			Assessment measures of trauma symptoms and PTSD in young children lack a measure that includes are critical components. Some of the parent checklist measures show promise.		M1	

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
35	Makley, A. T. and R. A. J. Falcone (2010). "Posttraumatic Stress Disorder in the Pediatric Trauma Patient." Seminars in Pediatric Surgery 19: 292-299.	2010	PTSD in Pediatric Trauma Patient	UCLA PTSD Reaction Index (UCLA PTSD RI); Child Trauma Screening Questionnaire (CTSQ); Children's Impact of Events Scale (CIES); Screening Tool for Early Predictors of PTSD (STEPP); Pediatric Symptoms Checklist (PSC)	0-18	Primary Care (general)	children/youth	"a move towards universal screening of some sort should be the primary goal"		UCLA PTSD RI is most common, but not used universally - there is an abbreviated version (9 items); CTSQ outperformed CIES in predicting PTSD; STEPP developed specifically for use in acute trauma settings (feasibility tested for brevity and simplicity in administering and scoring). Authors suggest continued evaluation and research is needed to determine which screening tool is the most reliable, but say even with adequate screening children are not accessing the follow-up treatment they need. And, Even with an ideal screening tool, determining which group of health care workers are best suited to screen children is not clear.	H1		
Individual Studies													
36	Loeb, J., E. M. Stettler, et al. (2011). "The Child Behavior Checklist PTSD Scale: Screening for PTSD in Young Children with High Exposure to Trauma." Journal of Traumatic Stress 24(4): 430-434.	2011	Screening for PTSD in young children	Child Behavior Checklist - PTSD subscale	Children 1.5-5 years	MH Center	children attending Mental Health center			CBCL-PTSD subscale is not useful in screening for PTSD as it failes to adequately discriminate between young children with PTSD and children with other psychiatric and behavioral symptoms	H2		
37	Scheeringa, M. S., M. J. Wright, et al. (2006). "Factors Affecting the Diagnosis and Prediction of PTSD Symptomatology in Children and Adolescents." The American Journal of Psychiatry 163(4): 644-651.	2006	Prediction of PTSD in Children and Adolescents	Child Behavior Checklist; DSM-IV	Children (avg. 10.4 years)	Level I Trauma Center	Children and their parents seeking services in a Level I trauma center			discusses DSM-IV algorithm threshold differences for criteria B, C, D for various age groups. suggests possible underreporting of symptoms when child or parent is interviewed, but not both. General discussion of inherent challenges of assessing trauma in younger children.		M2	
38	Waite, R., P. Gerrity, et al. (2010). "Assessment for and Response to Adverse Childhood Experiences." Journal of Psychosocial Nursing 48(12): 51-61.	2010	Assessment and Response to ACEs	Stressful Life Events Screening Questionnaire; Primary Care PTSD Screen; Impact of Event Scale-Revised; Life Stressor Checklist - Revised; Short Form of the PTSD Checklist Civilian Version; Childhood Trauma Questionnaire Short Form	Adults	n/a	n/a	"ethical imperative for nurses to ask about ACE"	n/a	authors suggest screeners (listed under "screening tools/measures) can and should be used by clinicians to assess for ACEs at varied entry points into health services; should be used for men and women regardless of demographic or relational circumstances	H2		
39	Conradi, L., J. Wherry, et al. (2011). "Linking Child Welfare and Mental Health Using Trauma-Informed Screening and Assessment Practices." Child Welfare 90(6): 129-147.	2011	Linking Child Welfare and MH using Trauma Screening and Assessment	Traumatic Events Screening Inventory - Parent Report (TESI-PFR-R); UCLA Child PTSD Reaction Index (CPTSD-RI); Trauma Symptom Checklist for Children (TSCC); Trauma Symptom Checklist for Young Children (TSCYC)	0-6 (TESI-PRR); 0-18 (CPTSD-RI); 0-18 (TSCC); 3-12 (TSCYC)	none specified	Children experiencing trauma	Screeners intended to be universal		purpose of the paper is to provide guidance to Child Welfare workers to integrate trauma screening, assessment, and evaluation into child welfare and MH services - reviews commonly used tools for each		M2	

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
Screening Behaviors of Primary Care Providers: Associated Factors													
40	Weinreb, L., J. A. Savageau, et al. (2010). "Screening for Childhood Trauma in Adult Primary Care Patients: A Cross-Sectional Survey." The Primary Care Companion to the Journal of Clinical Psychiatry 12(6).	2010	Screening for Childhood Trauma in Adult PC Patients	n/a	n/a	n/a	n/a	Universal		examines physician knowledge, attitudes, and practices about screening for childhood abuse histories - most rarely or never screened	H3		
41	Waite, R., P. Gerrity, et al. (2010). "Assessment for and Response to Adverse Childhood Experiences." Journal of Psychosocial Nursing 48(12): 51-61.	2010	Assessment and Response to ACEs	multiple						discusses nurses' screening behaviors for child abuse, and guidelines for clinicians for screening for and responding to disclosure of childhood abuse		M3	
42	Prins, A., R. Kimerling, et al. (1999). The Primary Care PTSD Screen (PC-PTSD). 15th Annual Meeting of the International Society for Traumatic Stress Studies. Miami, FL.	1999	PC-PTSD Guidelines	PC-PTSD	Adults	Primary Care (general)	n/a			Provides guidelines for primary care clinicians to use the PC-PTSD screener and respond to positive results	H3		
43	Stover, C. S. and S. Berkowitz (2005). "Assessing Violence Exposure and Trauma Symptoms in Young Children: A Critical Review of Measures." Journal of Traumatic Stress 18(6): 707-717.	2005	Review of Measures assessing violence exposure and trauma symptoms in young children	multiple	Young children (0-6 years)					discusses challenges associated with screening young children for trauma symptoms		M3	
44	Green, B. L., S. Kaltman, et al. (2011). "Primary Care Providers' Experiences with Trauma Patients: A Qualitative Study." Psychological Trauma: Theory, Research, Practice, and Policy 3(1): 37-41.	2011	Primary Care providers' experiences with trauma patients	n/a	Adults	Primary care (general)	n/a			qualitative study on PC providers' experiences and strategies in working with trauma patients			L3
45	Thackeray, J. D., P. V. Scribano, et al. (2010). "Domestic violence assessments in the child advocacy center." Child Abuse and Neglect 34: 172-182.	2010	DV assessments in child advocacy center	non-specific	Adults	Child Advocacy Centers			n/a	assesses frequency, methods and practices of universal DV assessments in CACs - <1/3 do universal assessments, and often inadequately		M3	

	Citation	Year of Pub	Topic	Screening Tool or Measure	Target Population/Setting			Universal vs Targeted Screening	Evidence of Health Outcomes	Key Findings/Implications	Weighted Relevance		
					Age Range	(Clinical) Setting	Risk Group				High	Med	Low
46	Terebelo, S. (2006). "Practical approaches to screening for domestic violence." JAAPA Journal of the American Academy of Physician Assistants 19(9): 30-35.	2006	Practical approaches to screening for IPV	WAST	Adults	Primary care (general)	Women	Universal	acts of disclosure alone is thereapeutic if done correctly	describes how primary care providers can overcome common barriers to screening for IPV - specific strategies provided for screening and response to positive screens	H3		
47	Roark, S. V. (2010). "Intimate Partner Violence: Screening and Intervention in the Health Care Setting." Journal of Continuing Education in Nursing 41(11): 490-495.	2010	Screening for DV in healthcare settings	non-specific	Adults	Primary Care (general)	Women	Universal	general: Appropriate screening and interventions will benefit victims of IPV"	Cites research supporting universal screening; describes training for nurses to assist in IPV screening	H3		
48	MacMillan, H. L., C. N. Wathen, et al. (2006). "Approaches to Screening for Intimate Partner Violence in Health Care Settings." JAMA Journal of the American Medical Association 296(5): 530-536.	2006	Screening for IPV in Health Care Settings	Woman Abuse Screening Tool (WAST); Partner Violence Screen (PVS)	18-64	Emergency Department, Family Practices, Women's Health Clinic	Women		n/a	RCT on screening methods - sample assigned written, computer-based, and verbal methods (PVS and WAST randomized within these groups) Women preferred self-completed approaches (over face-to-face); computer screening did not increase prevalence; written screens had fewest missing data. PVS and WAST highly comparable.	H3		

Screens for PTSD	# of items	Time to Admin. (in min.)	Allows Multiple Trauma	Corresponds to DSM-IV Criteria
BAI-PC	7	3	Yes	N/A
Primary Care PTSD Screen (PC-PTSD)	4	2	Yes	N/A
Short Form of the PTSD Checklist	6	2	Yes	N/A
Short Screening Scale for PTSD	7	3	Yes	N/A
SPAN	4	2	Yes	N/A
SPRINT	8	3	Yes	N/A
Trauma Screening Questionnaire (TSQ)	10	4	Yes	N/A
PTSD Checklist (PCL)	17	5 to 10	Yes	Yes

Trauma Exposure Measures	Target Group	Format	# of items	Time to Administer (minutes)	Assesses DSM-IV Criterion A
Combat Exposure Scale (CES)	Adult	Self-Report	7	5	No
Evaluation of Lifetime Stressors (ELS)	Adult	Self-Report and Interview	56	60-360	Yes
Life Events Checklist (LEC)	Adult	Self-Report	17	5 to 10	No
Life Stressor Checklist-Revised (LSC-R)	Adult	Self-Report	30	15-30	Yes
Potential Stressful Events Interview (PSEI)	Adult	Interview	62	120	Yes
Stressful Life Events Screening Questionnaire (SLESQ)	Adult	Self-Report	13	10 to 15	No
Trauma Assessment for Adults (TAA)	Adult	Self-Report and Interview	17	10 to 15	A-1 only
Trauma History Screen (THS)	Adult	Self-Report	13	2 to 5	Yes
Trauma History Questionnaire (THQ)	Adult	Self-Report	24	10 to 15	A-1 only
Traumatic Events Questionnaire (TEQ)	Adult	Self-Report	13	5	A-1 only
Traumatic Life Events Questionnaire (TLEQ)	Adult	Self-Report	25	10 to 15	A-1 only
Trauma History Questionnaire (THQ)	Adult	Self-Report	24	10 to 15	Yes
Traumatic Stress Schedule (TSS)	Adult	Interview	9	5 to 30	A-1 only

It PTSD Self-Report Measures	# of items	Time to Admin. (in min.)	Allows Multiple Trauma	Corresponds to DSM-IV Criteria
Davidson Trauma Scale (DTS)	17	10 to 15	No	Yes
Distressing Event Questionnaire (DEQ)	35	10 to 15	Yes	Yes
Impact of Event Scale-Revised (IES-R)	22	5 to 10	No	Yes
Los Angeles Symptom Checklist (LASC)	43	10 to 15	Yes	No
Mississippi Scale for Combat-Related PTSD (M-PTSD)	17	10 to 15	Yes	No
Modified PTSD Symptom Scale (MPSS-SR)	17	10 to 15	Yes	Yes
Penn Inventory for Posttraumatic Stress Disorder (Penn Inventory)	26	15-20	Yes	No
Posttraumatic Diagnostic Scale (PDS)	49	10 to 15	No	Yes
PTSD Checklist (PCL) - Civilian, Military, Specific Trauma	17	5 to 10	Yes	Yes
Screen for Posttraumatic Stress Symptoms (SPTSS)	17	10 to 15	Yes	Yes
Trauma Symptom Checklist-40 (TSC-40)	40	10 to 15	Yes	No
Trauma Symptom Inventory (TSI)	100	15-20	Yes	No

Child Measures	Target Age Group	Format	# of items	Time to Admin. (min.)	Allows Multiple Trauma	Corresponds to DSM-IV Criteria
Child PTSD Reaction Index*(CPTS-RI)	6 to 17	Interview	20	15-20	No	No
Child PTSD Symptom Scale (CPSS)	8 to 18	Self-Report	26	10 to 15	Yes	Yes
Childhood PTSD Interview	n.s.	Interview	93/1	15-20	Yes	Yes
Children's Impact of Traumatic Events Scale-Revised (CITES-2)	6 to 18	Interview	78	30-45	Yes	Yes
Children's Posttraumatic Stress Disorder Inventory (CPTSDI)	7 to 18	Interview	43/1	15-20	Yes	Yes
Clinician-Administered PTSD Scale for Children & Adolescents (CAPS-CA)	7 to 18	Interview	33/2	30-120	Yes	Yes
CPTS-RI Revision 2 (aka PTSD Index for DSM-IV)	6 to 17	Interview	20	15-20	No	No
Dimensions of Stressful Events (DOSE)	n.s.*	Interview	24/varies	15-30	Yes	Yes
My Worst Experiences Survey	10 to 18	Self-Report	105	20-30	No	Yes
Parent Report of Child's Reaction to Stress	n.s.	Parent Report	79	30-45	Yes	No
Trauma Symptom Checklist for Children (TSCC)	6 to 17	Interview	54/1	10 to 20	Yes	No
Trauma Symptom Checklist for Young Children (TSCYC)	3 to 12	Caregiver-report	54/1	20-30	Yes	No
Traumatic Events Screening Inventory*(TESI)	4 and up	Interview	18/varies	10 to 30	Yes	Yes
UCLA PTSD Index for DSM-IV	7-12 child, 13+ adol	Self-Report	48	15-20	Yes	Yes
When Bad Things Happen Scale (WBTH)	8 to 13	Self-Report	95/1	10 to 20	No	Yes

Stressful Life Events Screening Questionnaire (Goodman, Corcoran, Turner, Yuan, & Green, 1998).

A 26-question standardized instrument measuring exposure to all possible kinds of traumas, including sexual and physical assault, witnessing violence, combat trauma, illness, accidents, traumatic deaths, and natural disasters; test-retest reliability (median Cronbach's alpha coefficient = 0.73) and convergent validity (median Cronbach's alpha coefficient = 0.64).

Primary Care PTSD Screen (Prins et al., 1999)

A 4-question instrument measuring symptoms of trauma during the past month; sensitivity = 0.91 and specificity = 0.72.

Impact of Event Scale–Revised (Weiss & Marmar, 1997)

A 22-item questionnaire developed and based on DSM-IV criteria; reported internal consistency ranges from 0.79 to 0.92.

Life Stressor Checklist–Revised (Wolfe & Kimmerling, 1997)

A 30-item instrument measuring lifetime exposure to stressful events; Cronbach's alpha coefficient = 0.70.

Short Form of the PTSD Checklist-Civilian Version (Lang & Stein, 2005)

A 6-item instrument empirically derived from the 17-item PTSD Checklist-Civilian Version for use in primary care settings; Cronbach's alpha coefficient = 0.79.

Childhood Trauma Questionnaire-Short Form (Bernstein & Fink, 1998)

A 28-item retrospective self-report questionnaire designed to assess five dimensions of childhood maltreatment; reliability for each of the scales across physical abuse = 0.83 to 0.86, emotional abuse = 0.84 to 0.89, sexual abuse = 0.92 to 0.95, physical neglect = 0.61 to 0.78, and emotional neglect = 0.85 to 0.91.

Measures for Children Under 6 for potential trauma and PTSD symptoms

Trauma Exposure Symptom Inventory - Parent Report (TESI-PR)
TESI-PRR = Traumatic Events Screening Inventory–Parent Report Revised;
VEX-PV = Violence Exposure Scale–Preschool Version;
VEX-PR = Violence Exposure Scale–Parent Report;
CBCL = Child Behavior Checklist
PTE=Potentially Traumatic Event
CBCL = Child Behavior Checklist
CSBI = Child Sexual Behavior Inventory
TSCYC=Trauma Symptom Checklist for Young Children
IBI = Interbeat Interval
PT-SIC = Posttraumatic Symptoms Inventory for Children
PTSD-PAC = Posttraumatic Stress Disorders in Preschool Aged Children
PAPA = Preschool Aged Psychiatric Assessment;
TSCC = Trauma Symptom Checklist
CDC = Child Dissociative Checklist

Interpersonal Violence/Domestic Violence

Hurts, Insults, Threatens, and Screams (HITS) Scale - Sherin, Sinacore, Li, Zitter, & Shakil, 1998 (designed specifically for primary care)
Women's Experience with Battering Scale (WEBS)
Ongoing Violence Assessment Tool (OVAT)
Index of Spouse Abuse - Physical (ISA-P)
Woman Abuse Screening Tool (WAST)
Conflict Tactics Scale (3 versions: CTS, CTS-2, CTS2S) - used primarily for research purposes, not clinical
Danger Assesment Scale (DAS) Campbell, 1995
Partner Violence Screen (PVS) Feldhaus et al., 1997 (developed and validated in ERs)
Abuse Assessment Screen (AAS) Norton, Peiper, Zierler, Lima, & Hume, 1995
Ongoing Abuse Screen (OAS) Weiss, Ernst, Cham, & Nick, 2003
Index of Spouse Abuse (ISA) Hudson & McIntosh, 1981 - designed to monitor IPV over time
GET SAFFEER (Lewis O-Connor 2007)

IPV Screening - Debate over Utility of Universal Screening

Todahl&Walter 2011	A rapidly increasing number of professional associations now recommend universal screening. They include, in part: the American Medical Association (AMA); the American Academy of Pediatrics Committee on Child Abuse and Neglect (1998); the American College of Obstetricians and Gynecologists; the American Academy of Family Physicians; the American College of Nurse Midwives; the American College of Emergency Physicians; and the American Academy of Nurse Practitioners. Among U.S. mental health professional associations, only the National Association of Social Workers (2002) and the American Psychological Association (2002) recommend universal screening. The American Association for Marriage and Family Therapy has not issued a recommendation or practice guidelines specific to IPV universal screening. The specific guidelines and recommendations urged by these organizations vary—though taken together they generally recommend that providers routinely screen all female patients for IPV (Jonassen & Mazor, 2003; McCloskey & Grigsby, 2005). The AMA (1992) encourages physicians to screen universally; their policy equates universal screening with prevention, preferring proactive procedures over a wait-and-see strategy that inquires about IPV only when signs or symptoms of violence emerge (Nelson, Nygren, McInerney, & Klein, 2004). The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings (FVPF, 2004) recommends screening all adult and adolescent female patients; male patients are screened ''when indicated.'' Although many professional associations and organizations now recommend universal screening, others have argued either that universal screening is not appropriate or that existing evidence for the merits of screening is inconclusive. Ramsay, Richardson, Carter, Davidson, and Feder (2002) argued that as insufficient evidence exists to verify whether screening is associated with improved health outcomes for women, it is ''premature to introduce a screening program for domestic violence in health care settings'' (p. 12). Others have argued that it is not known whether screening leads to a decline in abuse and, therefore, screening at this time is not warranted (Nelson et al., 2004). The U.S. Preventive Services Task Force (USPSTF) found that the risks and benefits of screening are yet to be confirmed by rigorously designed clinical studies and, therefore, the USPSTF could not recommend for or against routine screening (Berg, 2004). Others argue that screening should only be conducted when physicians and midwives have received education about abuse and have enough knowledge about local resources to be able to respond appropriately (Webster & Holt, 2004). Ramsay et al. (2002), in their review of the screening outcome literature, ''found little evidence for the effectiveness of interventions in medical settings with women who are identified by screening programs'' (p. 10). Others have drawn similar conclusions (e.g., Nelson et al., 2004; Wathen & MacMillan, 2003).
Nelson et al 2012	Routine screening for IPV in health care settings could identify women at risk and lead to interventions that reduce violence and improve health outcomes. New recommendations from the Institute of Medicine (27), as well as recommendations from professional organizations (28–30), support screening. Screening by health care professionals is generally acceptable to women under conditions that are perceived as private and safe and when women are asked questions in a comfortable manner, although there is no consensus about the optimal screening setting or method (31).
Feder, et al. 2009 (UK)	Currently there is insufficient evidence to implement a screening programme for partner violence against women either in health services generally or in specific clinical settings.
Terebolo 2006	many professional medical organizations endorse and recommend screening, including ACEP, the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Medical Association, American College of Physicians, and American Academy of Pediatrics, actual screening rates by health care providers remain dismal. This is discouraging because prevalence studies suggest that at least 1 in 5 female patients in the primary care setting have been victims of IPV at some point in adulthood.13 Health care providers are uniquely positioned to intervene.
American Academy of Pediatrics 2010	Looking for signs of intimate partner violence between parents of pediatric patients may or may not help the parents, but the effects of that violence on children are so profound that physicians must ask about it, a clinical report from the American Academy of Pediatrics concludes. The lead author of the report, Dr. Jonathan D. Thackeray, highlighted it in a plenary session at the academy's national meeting because the recommendations didn't get the attention they deserved when published earlier this year, he said (Pediatrics 2010; 125:1094-100).

Screening for Childhood Abuse Histories

Waite et al. 2010	no published guidelines exist for how and under what conditions adults should be screened for childhood abuse histories in primary care settings. This is remarkable, considering Springer et al. (2003) reported that 20% to 50% of patients in adult primary care settings have a history of physical or sexual abuse.

Summary Comments: Trauma Domain

- This scan focused on trauma-screeners that fall into three broad categories: Trauma Exposure (general)/PTSD (omits screeners specific to veteran populations and experiences); Interpersonal Violence; and Childhood Violence

PTSD/Trauma Exposure (non-Veteran-specific)

- Studies have shown PTSD is diagnosed only about 50% of the time – and less for those with co-occurring disorders – so there is good consensus that a screener would be useful.
- Gold standards are clinician-administered assessments such as the Clinician-Administered PTSD Scale (Blake et al., 1995) and the Structured Clinical Interview for DSM-IV, PTSD module (First, Spitzer, Gibbon, &Williams, 1996). Use of these in clinical practice is limited by length and need for administration by a trained clinician.
- There are a wide range of self-report PTSD measures (one recent review identified 41) but results vary. Though no "gold standard" among self-report tools, the Impact Events Scale (IES), PTSD Checklist – Civilian Version, Trauma Screening Questionnaire (TSQ), and Self-Report Inventory of PTSD have best diagnostic properties.

Interpersonal Violence

- Though a large (and growing) number of professional organizations recommend universal screening for IPV (especially for women), there is not consensus that this is appropriate and/or that there is sufficient evidence to warrant universal screening. (see third tab in spreadsheet for specific studies/comments) The American Academy of Pediatrics weighed in that IPV screening is critical due to effects on children.
- There is no "gold standard" screener – all have limitations on psychometric properties. In healthcare settings, the HITS screener is considered the best by many researchers.

Childhood Violence/PTSD

- A large proportion (20-50%) of adults in primary care settings have histories of child physical or sexual abuse, but there are no agreed-upon guidelines for screening, nor consensus on which group of healthcare workers would be most appropriate to screen.
- Again, no "gold standard" screener –more research and evaluation needed to determine which screener is most reliable.
- The UCLA PTSD Reaction Index is used most commonly (though by no means universally). Child Trauma Screening Questionnaire (CTSQ) performs better than others in predicting PTSD, but Screening Tool for Early Predictors of PTSD (STEPP) was developed specifically for use in acute trauma settings and offers brevity and simplicity.

Acronyms

AHRQ	Agency for Healthcare Research and Quality
ASPE	Assistant Secretary for Planning and Evaluation
BH	Behavioral Health
BHeM	BH eMeasure
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CQAIMH	Center for Quality Assessment and Improvement in Mental Health
CQM	Clinical Quality Measure
CMS	Centers for Medicare and Medicaid Services
FACP	Fellow, American College of Physicians
FASAM	Fellow, American Society of Addiction Medicine
EDC	Education Development Center
EHR	Electronic Health Record
HITECH	Health Information Technology for Economic and Clinical Health Act of 2009
HITPC	Health Information Technology Policy Committee
HITS	Hurts, Insults, Threatens, and Screams
HRSA	Health Resources and Services Administration
IES	Impact Events Scale
IHS	Indian Health Service
ICSI	Institute for Clinical Systems Improvement
IPV	Interpersonal Violence/ Intimate Partner Violence
IT	Information Technology
MD	Medical Doctor
MPH	Masters in Public Health
MSW	Masters in Social Work
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NICHD	National Institute of Child Health and Health Development
NIDA	National Institute on Drug Abuse

NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NINR	National Institute of Nursing Research
NIST	National Institute of Standards and Technology
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NORC	National Organization for Research at the University of Chicago
NQMC	National Quality Measures Clearinghouse
NPRM	Notice of Proposed Rulemaking
NQF	National Quality Forum
ONC	Office of the National Coordinator for Health Information Technology
ONDIEH	Office of Noncommunicable Disease, Injury and Environmental Health
PC	Primary Care
PhD	Doctorate of Philosophy
PHQ	Patient Health Questionnaire
PRO	Patient Recorded Outcome
PROMIS	Patient Reported Outcomes Measurement Information System
PsyD	Doctor of Psychology
PTSD	Post-Traumatic Stress Syndrome
RHI	Resolution Health, Inc.
SAMHSA	Substance Abuse and Mental Health Services Administration
ScD	Doctor of Science
TEP	Technical Evaluation Panel
TJC	The Joint Commission
TSQ	Trauma Screening Questionnaire
US	United States of America
USPSTF	United Stated Preventative Services Task Force
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VP	Vice President