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Ensuring Active Duty Service Members with PTSD Receive Evidence-Based Treatment

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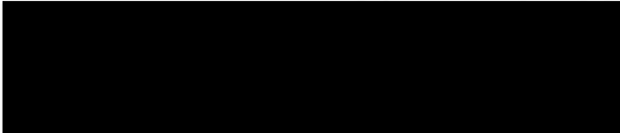

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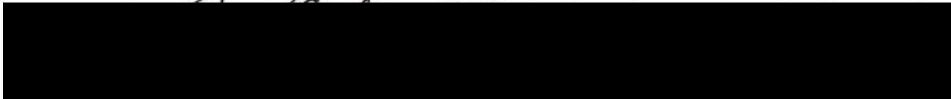

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Abstract

Posttraumatic Stress Disorder (PTSD) is a mental health disorder affecting as many as 20% of veterans who have deployed to Iraq and Afghanistan. The Department of Veterans Affairs and the Department of Defense have issued an evidence-based clinical practice guideline for the management of PTSD; however, some literature suggests that adherence to the treatment guidelines are low and do not meet evidence-based standards. This paper describes a program evaluation project, examining current PTSD treatment practices for active duty Soldiers diagnosed with PTSD at Fort Bliss, Texas.

Introduction

Posttraumatic Stress Disorder (PTSD) is a debilitating mental health disorder that is often comorbid with other physical, cognitive, emotional, and behavioral impairments (VA/DOD, 2010). Patients with PTSD present with a variety of symptoms that cause functional impairments to include relationship and occupational dysfunction, reduced quality of life and, if untreated, can contribute to lifelong mental health dysfunction or incapacitation (Steenkamp & Litz, 2013). Military service members are at a heightened risk for traumatic exposures and subsequent PTSD given the nature of their occupation and current global conflicts (Stahl, 2010). It is imperative that behavioral health providers use effective, evidence-based treatment modalities to achieve positive care outcomes, including symptom remission, and to minimize functional impairment for PTSD patients. The 2010 Department of Veterans Affairs and Department of Defense Clinical Practice Guideline for the Management of Posttraumatic Stress (VA/DOD CPG) gives evidence-based treatment recommendations; therefore, providers should adhere to the VA/DOD CPG treatment recommendations when caring for service members with PTSD.

Posttraumatic Stress Disorder

Posttraumatic Stress Disorder falls under the umbrella of the Trauma- and Stressor-Related Disorders in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM-5) (APA, 2013). Individuals with PTSD experience prolonged psychological distress, typically related to fear and anxiety, following a traumatic exposure (Stahl, 2010). When individuals are faced with an actual or potential threat, the sympathetic nervous system activates and assists the individual to physiologically survive that threat; additionally, the brain processes and conditions responses to future threats (Stahl, 2010). Prolonged autonomic activation in response to actual or potential threats perpetuate fear and anxiety, which can limit an individual’s ability to function

effectively on a daily basis when the anticipation of a threat exists in the absence of threatening stimuli (Stahl, 2010).

Diagnostic criteria for PTSD include: (a) traumatic exposure; (b) re-experiencing of the trauma; (c) avoidance of trauma-associated stimuli; (d) negative alterations of mood and cognitions; and (e) increased arousal and reactivity. Additionally, the distress must be present at least one month and be clinically significant enough to cause functional impairment for the individual (DSM-5, 2013). Common symptoms of PTSD include worry, re-experiencing the event through flashbacks or in nightmares, hypervigilence in anticipation of threatening stimuli, depressive symptoms, and avoidance or numbing (DSM-5, 2013). These symptoms affect Veterans' ability to function daily in relationships, social situations, and occupationally, and are often associated with other psychiatric symptoms, substance abuse, and suicidality (Stahl, 2010).

Significance of the Problem

As many as 20% of veterans who have deployed in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) meet criteria for a diagnosis of PTSD after combat-related exposures and trauma (Steenkamp & Litz, 2013). The Institute of Medicine (IOM) (2014) issued a report brief regarding PTSD treatment in military and veteran populations, addressing the magnitude of PTSD:

> In 2012, 13.5 percent of U.S. Army service members had PTSD, as did 10 percent of Marines, 4.5 percent of Navy personnel, and 4 percent of Air Force personnel. The same year, more than half a million veterans of all eras sought care for PTSD through VA health care services—making up 9.2 percent of all VA users. Almost 24 percent of these veterans (119,500) had served in the Afghanistan and Iraq conflicts. (p. 2)

In addition to being at a higher risk of occupationally- related traumatic exposures, Soldiers often have confounding factors that contribute to an elevated risk of developing PTSD (Stahl, 2010). Soldiers often have multiple combat deployments, which increase the likelihood of personal threats or exposures and witnessed events, and can prolong the fear and anxiety responses. Family separation and strained support systems during deployment, as well as reintegration and readjustment following a deployment, can further complicate recovery. Additional concerns related to Soldiers and PTSD include risk for mild traumatic brain injuries, comorbid substance use and pain, suicidality with access and knowledge of lethal means, and barriers to seeking care related to behavioral health stigma and career implications (Stahl, 2010).

The high volume of service members requiring behavioral health care since 2001, combined with the negative implications of untreated PTSD, led the VA and the DOD healthcare systems to develop the evidence-based guidelines to ensure more standardized and effective PTSD treatments (VA/DOD, 2010).

Evidence for Use of the Clinical Practice Guideline

During the review of literature, the quantity of information to inform the treatment of PTSD was overwhelming and made more manageable by limiting the search to systematic reviews based on active duty and veteran populations and by narrowing the focus to combat related PTSD treatment. Full-text articles were evaluated for their level and quality of evidence using the Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool and the Johns Hopkins Nursing Evidence-Based Practice Evidence Level and Quality Guide. The articles consisted of Level I to Level III evidence with variable quality. The evidence is generally consistent across modalities and treatment recommendations are aligned with the 2010 VA/DOD

CPG for the management of PTSD, as evidence by the Literature Synthesis Summary illustrated in Table 1.

Table 1: Literature Synthesis Summary

AUTHOR (YEAR)	STUDY DESIGN (AIM)	MODALITIES	STRENGTHS	WEAKNESSES	AGREE WITH VA/DOD CPG
Bisson, et al (2013)	SR Cochrane (PTSD SX)	CBT (TFCBT, non TFCBT, group) Wait list/ Usual Care, other (supportive)	RCTs 70, 4761 subjects; outcome measure consistent	Authors assessed high or unclear risk of bias, determined low quality studies	Y TFCBT, EDMR effective
Dinnen, et al (2015)	SR (PTSD SX)	CBT (PE); CPT; EMDR	2 RCTs	1 non random CT; 3 uncontrolled pilot studies; small samples, method limitations, lack of comparison conditions Impaired cognition?	Y PE, CPT, EMDR
Mello, et al (2013)	SR (PTSD SX)	CBT, PE, CPT compared to each other or EMDR, wait list or usual care	29 RCTs, low quality scoring and removal of study; outcome measures	More exposure based THx studies; attrition; manualized techniques (essential components)	Y CBT, PE, CPT equally effective; EMDR > CBT
Metcalf, et al (2016)	SR (Emerging THx-CAM)	15 interventions Mind-body: acupuncture, emotional freedom tech., mantra, yoga	19 studies- Moderate quality RCTs for mind-body Tx with active Tx showing efficacy	Non-randomized included, Most with method limitations, small samples	M Adjunctive Tx Acupuncture promising
Steenkamp, et al (2015)	SR (THx in veteran pops)	CPT, PE vs wait list or usual care, EMDR trials	9 RCTs, 883 subjects, active or veteran inclusion except EMDR studies	Limited # studies, Small sample sizes, attrition, EMDR trials CIV and pre 2003	Y Marginally superior to wait list
Tawa & Murphy (2013)	SR Integrative (Pharm)	SSRI as 1st line vs propranolol	5 RCTs well designed, studies support resistant PTSD in veterans and highlight need for alternative/ adjunctive RX	Ethical considerations with propranolol and preventative focus with reduction of multiple physical Sx, small pool of studies	Y SSRI as 1st line
Cusack, et al (2016)	SR/MA (THx)	CT/CPT, CBT-Exp, SIT, EMDR vs each other, wait list, usual care	64 RCTs; detailed, discriminate; PE- high strength of evidence (SOE)	SOE less for other modalities, poor generalizability	Y-CPT, CBT M-EMDR, SIT
Goodson, et al (2011)	SR/MA (VA Tx-CPG)	Exposure therapies (broad), Cognitive Thx	10 RCT, comparative effect sizes; overall large sample, combat r/t	14 Open trials, broad category of exposure (PE, EMDR)	Y Med ES: PE, CPT, CBT
Haagen et al (2015)	SR/MA (CPG)	EMDR, CBT, CPT, PE, SIT Individual & group	69 treated samples well designed, combat r/t; Strong pre, post data	Type I errors- exploratory, may fail to ID predictors; lack of follow-up data	Y ET, CPT> EMDR, SIT
Hoskins, et al (2015)	SR/MA (Pharm-monothx)	SSRI, TCA, MAOI, others	51 RCTs, excluded trials, trauma focused THx and experimental meds	Heterogeneity- generalizability; Attrition, Rx w THx?	Y SSRI Sml ES
Lenz, et al (2014)	SR/MA (THx)	CPT, PE, present centered, wait list	11 studies	Small sample-non RCT, Sample 69% Caucasian, > women, CIV	Y CPT
Powers, et all (2010)	SR/MA (THx)	PE, CPT, EMDR, CT, SIT vs wait list, usual care	13 RCTs, 675 subjects	Similar research groups publishing, Poor comparison data, not with RX	Y PE, CPT, EMDR, SIT
Puetz, et al (2015)	SR/MA (Pharm)	SSRI, TCA, AntiPsych, AntiConv, other	18 DB RCTs, combat pops, validated measures	Small samples, compliance and concomitant med use	Y SSRI
Watts, et al (2013)	SR/MA All Tx	Psychotherapy and Psychopharmacy Tx vs wait list or active control	112 studies, large sample	1980-2012, “any Tx”; difficult to compare designs, methods	Y CT, PE, EMDR; SSRI

Adherence to the Practice Guideline

The 2010 VA/DOD CPG for PTSD acknowledges that CPG recommendations aim to assist clinicians with clinical decision-making by providing the latest evidence and are not a substitute for clinical judgment or patient preference. The evidence-based psychotherapeutic interventions use manualized or packaged techniques to ensure fidelity of treatment, making it crucial for behavioral health providers to adhere to the modality protocols, such as scripting and sequencing. Research suggests that therapy provided to a significant number of service members did not meet the manualized standards (Levin, 2012) and, according to Wilk et al. (2013), many providers self-report using the evidence-based modalities, but also self-report deviation from the manualized core techniques of the treatment modality. The same article points out that, on average, clinicians only used about half of the manualized or packaged evidence-based techniques that they were trained in (Wilk et al., 2013). Although it is unclear how deviations from the manualized techniques of therapy affect treatment outcomes, providers should strictly adhere to the manualized techniques of each modality in order to ensure the fidelity of the evidence-based care provided to patients.

Literature also indicated that providers use different metrics for assessing treatment effectiveness, which implies that treatment outcomes and symptom improvement outcomes are not being measured equivalently (IOM, 2014). Furthermore, a majority of the measurement tools (metrics) only assess process measures and do not report the impact of treatment on measures of patient symptom severity (IOM, 2014). Shin, Greenbaum, Jain, & Rosen (2014) discuss how the use of process metrics, instead of symptom severity measures, can be misleading in assessing the efficacy of both psychotherapy and psychopharmacology. Therefore, they suggested that all providers use a standardized evidence-based assessment tool such as the PTSD Checklist (PCL-

5) for the Diagnostic and Statistical Manual of Mental Disorders (5th Edition) (DSM- 5) in order to compare treatment efficacy in a standardized format and drive positive clinical outcomes (Shin, Greenbaum, Jain, & Rosen, 2014).

Local Treatment Policy

The Department of Behavioral Health encompasses all behavioral health services at Fort Bliss, Texas, and falls under clinical services at William Beaumont Army Medical Center (WBAMC). Local policy at WBAMC is directed by regulations and policy from the Office of The Surgeon General (OTSG) at United States Army Medical Command (MEDCOM). Policy memo14-094, signed December 18, 2014, from OTSG/MEDCOM delineates guidance on the assessment and treatment of service members who present with symptoms consistent with PTSD. This policy memo specifically instructs anyone who provides or directs behavioral health treatment to comply with recommendations from the 2010 VA/DOD CPG (Department of the Army, 2014). This policy memo addresses screening, diagnosis, and treatment, as well as co-occurring mental health diagnoses and adjunctive treatment modalities. Additionally, the memo specifies that individual patient preferences and clinical judgment may serve as rationale for deviation from the CPG, although it is the expectation and standard of care.

Practice Guideline Summary of PTSD Treatment

The VA/DOD CPG (2010) endorses specific evidence-based pharmacologic and psychotherapeutic treatment modalities for PTSD based on comprehensive research by their working group. The VA/DOD CPG (2010) identifies psychotherapy and psychopharmacologic agents that have shown benefit for patients with PTSD and makes algorithm-based recommendations for first-line treatment interventions, either used alone or concurrently.

Psychopharmacologic agents are classified and either recommended or discouraged based on evidence of known benefit, or possible harm, to patients with PTSD (VA/DOD CPG, 2010). Clinical judgment and provider or patient preference may dictate the use of pharmacologic agents that differ from the treatment guidelines.

According to the VA/DOD CPG (2010), when a service member screens positive for trauma exposure and PTSD symptoms, the provider and patient collaboratively form a treatment plan. Primary care managers (PCMs) can assess and diagnose PTSD however; they should refer to behavioral health if the patient prefers it, if comorbid mental health disorders are present, or if the severity is beyond the training, experience, or comfort level of the primary care provider. Both the PCM and behavioral health provider are able to initiate first-line treatments.

Psychopharmacology. While clinical judgment should always be utilized in determining which medication is right for the patient, the VA/DOD CPG (2010) specifically identifies monotherapy with either a Selective Serotonin Reuptake Inhibitor (SSRI) or a Serotonin Norepinephrine Reuptake Inhibitor (SNRI) as first-line pharmacotherapy for patients with PTSD. These pharmacologic agents target serotonin and norepinephrine and aim to reduce anxiety and depressive symptoms in patients with PTSD. The VA/DOD CPG (2010) identifies SSRIs and SNRIs as having the most significant benefit for reducing PTSD symptom severity and insufficient evidence supports the use of other medications as a first-line or monotherapy for PTSD treatment. Some benefit has been shown to reduce PTSD symptoms with the use of Tricyclic Antidepressants (TCAs), Monoamine Oxidase Inhibitors (MAOIs), Mirtazapine, and Nefazodone. Other medications and classes of medications have been listed specifically as having “unknown benefit” or “no benefit”, with benzodiazepines listed as harmful for patients

who are treated for PTSD. Adjunctive medications may also be used to treat specific symptoms such as Prazosin to reduce nightmares, which has shown some benefit. (VA/DOD, 2010)

Psychotherapy. Psychotherapies aim to reduce symptom severity and functional impairment as well as to improve quality of life for the patient (VA/DOD, 2010). Evidence-based therapies recommended for the treatment of PTSD are trauma-focused psychotherapies and stress inoculation training (SIT), both of which show significant benefit for patients with PTSD. Trauma-focused therapy covers a range of specific modalities with components of cognitive and emotional processing with consideration for learning and fear-conditioning theories (VA/DOD, 2010). These modalities help the patient to process the trauma exposure and use cognitive restructuring to reduce the emotional response to the trauma, and alleviate PTSD symptoms (VA/DOD, 2010). Examples of trauma-focused modalities are Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR). Stress Inoculation Training helps to reduce functional impairments uses various relaxation techniques in order to reduce trauma-related avoidance, anxiety, and cognitions without focusing on specific traumatic memories (VA/DOD, 2010). Components of cognitive and exposure therapy may be included in SIT but are not the focus. Other treatment modalities or services are appropriate during treatment and can include: (a) psychoeducation for symptom-specific management (sleep, pain, anger, etc.); (b) psychosocial therapy for co-existing conditions such as substance use disorders or, for marital and family therapy; (c) case management; (d) social and spiritual support services; and (e) acupuncture or other Complimentary and Alternative Medicine (CAM) modalities; however, these modalities should be used adjunctively and not as monotherapy (VA/DOD, 2010).

Symptom reassessment. As part of comprehensive and individualized treatment planning, the VA/DOD CPG (2010) suggests reassessment of PTSD treatment efficacy and patient compliance at least every 90 days using a measure of PTSD symptom severity such as the PCL-5. A measure of depressive symptom severity, such as the PHQ-9, is also strongly encouraged. The VA/DOD CPG (2010) suggests that other measures, such as anxiety scales and substance use or suicide screening tools, should be considered based on individual patient needs, used to plan treatment, and assess treatment progress.

Military Relevance of the Problem

The military invests large amounts of time and money into training service members in their specialized job, as a means to accomplish a global defense mission. By treating PTSD with safe, efficacious, evidence-based psychotherapy and psychopharmacology, the military can potentially return these service members back to full duty. In addition to caring for service members, underlying aims exist to retain well-trained service members who wish to remain in service and to decrease healthcare spending. The IOM (2014) reports that the DOD spent 294 million dollars on PTSD care, while the VA spent 3 billion dollars on PTSD care. Mentally healthy and functional service members, that are returned to duty, benefit the military by lowering the financial burden on the military healthcare system and increasing overall combat readiness of the fighting force.

Nursing Relevance of the Problem

Patients with PTSD are treated across the spectrum of healthcare services and are seen in a variety of care settings where nurses are integral to care and, therefore, are likely to care for patients with PTSD during their career. Advance Practice Registered Nurses (APRNs) are primary care practitioners and may be the first to screen and identify PTSD symptoms in their

patients, playing a key role in the clinical decision-making and management of patients with PTSD (VA/DOD, 2010). Psychiatric Mental Health APRNs provide direct care for patients with PTSD and work collaboratively with other healthcare team members. Considering the prevalence of PTSD in the military population, it is important for nurses working in the DOD to understand the PTSD treatment guidelines outlined in the VA/DOD CPG (2010) and implications for their particular nursing role.

Clinical Question

Are active duty service members with PTSD receiving evidence-based treatment from Behavioral Health Providers at Fort Bliss, Texas, according to the 2010 VA/DOD CPG for PTSD?

Focus Areas

This program evaluation project team will: (a) conduct a staff inquiry regarding provider knowledge and perception of adherence to the 2010 VA/DOD CPG for the management of PTSD; (b) examine current provider practices in comparison to the 2010 VA/DOD CPG recommendations; (c) identify any discrepancies in the delivery of evidence-based clinical care for Soldiers with PTSD; (d) attempt to understand any knowledge or practice gaps and provide interventions to bridge treatment practices with current evidence; and (e) conclude with recommendations for future program implementation and practice improvements at Fort Bliss. Short-term goals of this project include increasing awareness and knowledge of the 2010 VA/DOD CPG for the Management of PTSD with emphasis on treatment algorithms, evidence-based treatment modalities, and patient reassessment at a minimum of every 90 days. By increasing this knowledge and highlighting the evidence-based efficacy of the 2010 VA/DOD CPG, the team hopes to increase the adherence to the treatment recommendations for PTSD.

Long-term goals of this project include the standardization of CPG training as well as program implementation and assessment.

Organizing Framework

Since this project is a program evaluation of CPG treatment adherence, current practices of behavioral health providers at Fort Bliss will be evaluated. Rosswurm and Larrabee's Model for Evidence-Based Practice Change will serve as the framework of the project (White & Dudley-Brown, 2012). The six-step model serves as a guide for organizations to make the shift from traditional and institutional practices to evidence-driven practices. Since the Fort Bliss project is a program evaluation of evidence-based practice guidelines that should already be in place, the team will focus on applicable steps of the implementation model: steps one, five, and six.

Project Design

General Approach

This project is a program evaluation of treatment practices for active duty patients with PTSD, cared for by behavioral health providers at Fort Bliss, Texas. The specific aim of the project is to assess adherence to the 2010 VA/DOD CPG treatment recommendations for PTSD. For the purposes of this project, provider adherence to the 2010 VA/DOD CPG for management of PTSD means: (a) a licensed mental health provider; (b) provided treatment to an active duty service member diagnosed with PTSD; and (c) the patient received an evidence-based treatment modality supported by the 2010 VA/DOD CPG for management of PTSD. The team reviewed the Fort Bliss behavioral health clinics' electronic records for patients diagnosed with PTSD and compared the treatment modality used by the provider to the recommended treatment modalities found in the VA/DOD CPG for management of PTSD. Findings and recommendations will be

made based on information gathered and synthesized from a behavioral health staff inquiry as well as a retrospective chart review of treatment practices.

Setting

The objective data for this program evaluation was collected from three outpatient behavioral health clinics at Fort Bliss, Texas. These clinics are embedded in the garrison commands of the 1st, 2nd, and 3rd Brigades of the 1st Armored Division, referred to as 1-1, 2-1, and 3-1 respectively. Each Embedded Behavioral Health (EBH) Clinic serves one Brigade Combat Team (BCT) with an empanelment of approximately 4000 Soldiers. The team members conducted a retrospective, longitudinal chart review at each clinic, reviewing electronic medical records (EMR) in the Armed Forces Longitudinal Health Technology Application (AHLTA), of patients diagnosed and treated for PTSD from January 2017 to December 2017.

Additionally, subjective data was collected through a short, anonymous staff inquiry disseminated to behavioral health providers at Fort Bliss who treat adult patients. The Department of Behavioral Health includes 90 providers however; those providers who work primarily in the Child and Family Behavioral Health Services (CAFBHS) and Substance Use Disorder Care (SUDC) Clinics were not surveyed. The purpose of the inquiry is to obtain a broad picture of CPG knowledge and PTSD treatment practices among the department by asking behavioral health providers about their general knowledge and practices related to PTSD management and the 2010 VA/DOD CPG. Similar to the chart audit tool, the inquiry questions are aligned with the PTSD treatment recommendations provided in the 2010 VA/DOD CPG.

Procedural Steps

Essential tasks of the Fort Bliss project include: (a) identify key leaders and stakeholders and conduct meetings; (b) obtain IRB approval; (c) administer inquiries to behavioral health

providers at Fort Bliss in November 2017; (d) review electronic patient records in AHLTA during the months of January and February 2018; (e) conduct a data analysis and synthesis of information from record review and inquiry findings by March 2018; and (f) engage clinical experts to develop appropriate interventions for staff education and practice standards aligned with the 2010 VA/DOD CPG recommendations for the management of PTSD. The findings and recommendations for this program evaluation will be presented to behavioral health leadership at Fort Bliss as well as in academic forums at WBAMC and the Uniformed Services University.

HIPAA Concerns (IRB)

The Institutional Review Board (IRB) at WBAMC approved this project. Although patient data was collected and studied for this project, the data was recorded using a unique patient identifier and patient identifiable information (PII) was not recorded nor stored for this project. Therefore, the DNP project was submitted to the IRB as exempted status since the risks are considered as everyday risks.

Project Results

Longitudinal Retrospective Chart Review

The Fort Bliss project team conducted a retrospective longitudinal chart review of service members diagnosed and treated for PTSD at Ft. Bliss between January and December 2017. In order to prevent this chart review from becoming focused on a provider's documentation ability, three EMR encounters from each eligible service member were reviewed. The first encounter reviewed was that of the initial diagnosis, the second was a follow-up visit within 90 days, and the third, or ninety-day follow-up, visit was reviewed in order to capture the provider's intended treatment goals, interventions, and re-assessment. This longitudinal approach intended to prevent categorizing treatment as non-adherent due to documentation (e.g. no documented intervention,

no documented PCL-5 reassessment) and to increase the accuracy of determining if the service member received evidence-based treatment in accordance with the 2010 VA/DOD CPG for management of PTSD.

From January to December 2017 the three EBH clinics at Fort Bliss reported 127 service members as being treated for PTSD. The project team collaborated with the EBH nurse case managers and clinical officers-in-charge in order to identify those service members diagnosed with PTSD at each respective EBH clinic. No PII was recorded nor stored by the project team during the course of the chart review. Furthermore, the data findings do not identify or separate individual providers and does not stratify findings per individual clinics.

The project team excluded any service members diagnosed with PTSD prior to arriving at Fort Bliss, as this was a program evaluation of this location specifically. The team excluded service members with PTSD who were concurrently being treated for substance use disorders. The also team excluded service members with PTSD who were currently attending intensive outpatient treatment for any co-occurring psychiatric disorder. The team excluded service members who did not have at least 90 days of outpatient visits documented in AHLTA. The purpose of the aforementioned exclusionary criteria was to create a sample population of service members with PTSD, whose treatment could accurately determined to be in accordance with the 2010 VA/DOD CPG. After all exclusionary criteria were applied, 65 service members were included into the retrospective chart review.

The chart audit tool consisted of three clinical components: (a) current pharmacological treatment modalities; (b) current psychotherapeutic modalities; and (c) PCL-5 reassessed with 90 days of initial diagnosis. In order for a patient’s treatment to be considered compliant with the 2010 VA/DOD CPG, the EMR must have included a recommended pharmacological agent

and/or a recommended trauma-focused psychotherapy, documented in at least one of the three reviewed encounters, and have a documented reassessment within 90 days using a PCL-5 or PTSD checklist. In order for a patient's treatment to be categorized as non-compliant, the EMR did not include documentation of a recommended pharmacotherapy, and/or a recommended trauma-focused psychotherapy, and did not have a documented PTSD symptom reassessment during the course of 90 days.

Findings. The primary aim of this project was to determine if service members diagnosed with PTSD are receiving evidence-based treatment according to the 2010 VA/DOD CPG for the management of PTSD. Of the 65 service members included in the retrospective longitudinal chart review, 77 percent received evidence-based treatment in accordance with the CPG. Twenty-three percent of the service members did not receive evidence-based treatment in accordance with the 2010 VA/DOD CPG. Of the 15 service members who did not receive evidence-based treatment in accordance with the CPG, 10 were due to failure of PTSD symptom reassessment within 90 days of their PTSD diagnosis. In other words, only 5 service members (less than 1 percent) did not receive evidence-based pharmacotherapy or psychotherapy treatment interventions.

Of the compliant charts reviewed, the data demonstrates that 30 percent of the documented psychotherapy interventions were trauma-focused therapies recommended by the 2010 VA/DOD CPG. However, that 30 percent is a combined percentage, which includes both psychotherapy alone and psychotherapy in combination with pharmacotherapy. Service members receiving pharmacotherapy alone was calculated at 18 percent, psychotherapy alone at 45 percent, and combination therapy at 37 percent.

The project findings indicate that 92 percent of those service members whose EMR was reviewed did receive evidence-based treatment for PTSD according to the 2010 VA/DOD CPG, when the data is controlled for symptom reassessment with the PCL-5. The project team can confidently make this assertion because the PCL-5 is required to be completed in BHDP prior to an appointment, however the provider may not have documented it in AHLTA.

Subjective Provider Inquiry

The purpose of the staff inquiry was to gain a subjective understanding of the current knowledge and provider perceptions of adherence to the 2010 VA/DOD CPG for the management of PTSD. The inquiry was voluntary and anonymous, and disseminated during staff meetings to licensed behavioral health providers and did not include non-credentialed nursing or ancillary staff members. Questions were aimed at the individual providers, specifically their treatment practices and first-line treatment interventions and reassessment practices for managing patients with PTSD. The inquiry did not ask for personally identifying or clinic specific information in order to maintain confidentiality and reduce the perception or worry of punitive or corrective action aimed at individuals or specific clinics, as this is a program-wide program evaluation and maximum participation was encouraged.

Findings. As previously mentioned the Fort Bliss Department of Behavioral Health consists of 90 providers. For the purposes of this project, only those providers who manage the treatment of active duty Soldiers with PTSD, and excluding those who primarily manage patients within the Substance Use Disorder Care Clinic (SUDCC) treatment, were asked to participate in this anonymous staff survey. Of the 47 eligible providers, 34 inquiries were returned, yielding an impressive 72 percent response rate. Interestingly, 91 percent of responders indicated they were aware of the 2010 VA/DOD CPG for the management of PTSD (Item 1). Twenty-seven

responders, or 79 percent, indicated that they generally followed the CPG recommendations (Item 2).

Thirteen responders indicated that they were non-prescribing providers and 14 inquiries were left blank for the item regarding first-line pharmacotherapy (item 3), where 7 of the remaining 17 responders reported prescribing SSRI and SNRI as first-line psychopharmacologic agents. All reported medication classes or specific medications were appropriate for the management of PTSD and associated symptoms, such as Prazosin for nightmares. Benzodiazepine use was not reported as a first-line psychopharmacologic agent by any responder.

When asked about first-line psychotherapeutic modalities (Item 4), many responders reported more than one modality with a total of 31 responses congruent with the evidence-based recommendations outlined in the 2010 VA/DOD CPG for the management of PTSD. Thirty-three responders indicated that PTSD symptoms were reassessed at least every 90 days using the PCL-5 (Item 5), again indicating strong compliance in reassessment practices and the use of BHDP.

Synthesis of Findings

Data from the chart review reveals high adherence to evidence-based PTSD treatment recommendations in accordance with the 2010 VA/DOD CPG for the management of PTSD. However, the data also suggests that documentation in the EMR does not accurately reflect this treatment due to inconsistent documentation for each encounter as well as non-specific terminology used. For example, “individual therapy” cited in the treatment plan for psychotherapeutic treatment intervention was not specific in identifying a therapy as trauma focused. Additionally, medications that were consistent with CPG recommendations may have

been associated with a co-occurring diagnosis such as depression, rather than being associated with the PTSD diagnosis.

Discussion

Limitations of this Project

The original aim of this program evaluation project was to determine if service members diagnosed with PTSD at Fort Bliss are receiving evidence-based treatment according to the 2010 VA/DOD CPG recommendations. In order to achieve the aim, a retrospective longitudinal chart review was conducted, which relied on the accurate documentation of care by the behavioral health provider. Therefore, it is possible a service member received evidence-based treatment according to the 2010 VA/DOD CPG, but that treatment was not accurately documented or captured in the EMR.

The chart audit tool examined adherence to the 2010 VA/DOD CPG recommendation to complete a 90-day reassessment of PTSD symptoms with a validated outcome measure tool such as the PCL-5. Service members are required to complete a PCL-5 in the Behavioral Health Data Portal (BHDP) at every appointment or as designated. Therefore, it is possible that the behavioral health provider did not document the PCL-5 reassessment in the EMR even if it was completed in BHDP, a separate database from the MHR, which does not automatically populate to the service members' EMR.

The recommended psychotherapeutic modalities for PTSD are broadly labeled as trauma-focused psychotherapies and include a variety of specific modalities that require specialty training or highly manualized techniques, whereas behavioral health providers may not be trained in trauma-specific modalities. Furthermore, it is possible that the behavioral health

provider was actually using a trauma-focused therapy but documented “Individual therapy” in the treatment plan within the EMR.

Although the project team tried to select PTSD patients diagnosed at Fort Bliss without other co-occurring substance use or other psychiatric diagnoses, documentation did not always associate the medication regimen or psychotherapeutic modality to the PTSD diagnosis specifically. Therefore, it is possible that behavioral health providers met the adherence criteria as outlined for this project, but were actually treating a co-occurring or pre-existing diagnosis.

The subjective provider inquiry aimed to gather information regarding knowledge and perceptions of compliance with the 2010 VA/DOD CPG for the management of PTSD. The response rate was promising. However, many providers left items blank or marked multiple modalities (as was permitted), which diminished he quality of the data and does not provide an accurate picture of the providers’ knowledge or practice perceptions. The syntax of inquiry items was deliberate to prevent items from conducting primary research versus program evaluation. The inquiry as it is presented would require a higher response rate per each items and follow-on questions in order to translate the inquiry findings into meaningful data. Additionally, verbiage should have aimed to limit multiple answers per item.

2017 CPG Update & Policy Guidance

In 2017, the VA and DOD released an updated CPG for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder (ASD). The updated CPG did not alter the aims or process of this Ft. Bliss DNP project. Furthermore, the updated recommendations from the 2010 CPG to the updated 2017 CPG would not have altered the findings of this project without alterations to the provider inquiry and chart audit tools. However, it is important to

briefly describe some of the major differences found in the most current CPG and incorporate these changes in the project interventions to ensure the most current guidelines are disseminated.

The most significant change in the current 2017 VA/DOD CPG for the management of PTSD and ASD is the recommendation for individualized, manualized trauma-focused psychotherapy over other pharmacologic and non-pharmacologic interventions as the first-line treatment of PTSD. While the 2010 VA/DOD CPG recommended either SSRI/SNRIs or trauma-focused psychotherapy as the first-line treatment for PTSD, the 2017 VA/DOD Work Group recognized the potential lack of individual trauma-focused psychotherapy trained providers. The Work Group then recommended pharmacotherapy or individual non-trauma-focused psychotherapy in the absence of trained providers or as patient preference dictates (VA/DOD, 2017). The recommended evidence based trauma-focused psychotherapies have not changed from the 2010 VA/DOD CPG.

In comparison to the 2010 VA/DOD CPG, the 2017 VA/DOD CPG recommends specific SSRI/SNRIs instead of a general drug class recommendation. Specifically, the 2017 VA/DOD CPG recommends Sertraline, Paroxetine, Fluoxetine, and Venlafaxine over other SSRI/SNRIs; however, it does not suggest using other SSRI/SNRIs is inappropriate with the exception of the use of Citalopram as monotherapy for the treatment of PTSD. The last pharmacological change is the downgrading of strength of evidence for the use of Prazosin for PTSD associated nightmares. In the previous CPG, Prazosin was classified as *Some Benefit* for PTSD associated nightmares, but the 2017 VA/DOD CPG classifies Prazosin as *No Recommendation For or Against* its use.

Policy guidance from OTSG and MEDCOM has not been updated to reflect or support the use of the updated 2017 VA/DOD CPG the management of PTSD and ASD. Additionally,

the Military Health System (MHS) is currently transitioning to a service unified command authority under the Defense Health Agency (DHA). Accessing current policy guidance can be a cumbersome process and this transition further complicates the process.

Project Interventions

The Fort Bliss project team will meet with the Department of Behavioral Heath leadership to report the findings of this program evaluation. After discussion and further guidance, the project team will recommend a staff education plan to disseminate full and updated treatment recommendations as presented in the 2017 VA/DOD CPG for the management of PTSD and ASD. Providers may also benefit from a quick reference card for each of the VA/DOD CPGs. Additionally, the team hopes to inspire further standardization within the Department of Behavioral Health as well as a means to access a consolidated repository of clinical and administrative resources to access updated clinical references and to enhance continuity of care among department providers.

Recommendations

Standardization

Based on the findings and challenges of this program evaluation project, the Fort Bliss project team makes several recommendations with the understanding that independent providers make clinical judgments that guide individual treatment. These recommendations do not intend to diminish independent practice; however, they do aim to standardize evidence-based practice and documentation in the context of policy adherence. The first recommendation is to ensure staff education and training regarding behavioral health CPGs and policies are current and consistent across the department. There are existing tools within the EMR and BHDP to standardize charting templates and that recommend evidence-based practices. Second, the

department should maintain a centralized and updated share drive in order for providers to easily access and reference current, local policy, as MEDCOM policies are accessible from the Behavioral Health Service Line website and OTSG. Thirdly, documentation should be standardized across the department where appropriate and consistently evaluated through the current peer-review process and consider incorporating evidence-based treatment evaluations as part of peer-reviews. Finally, as mentioned, behavioral health providers may not be trained in trauma-specific psychotherapeutic modalities; therefore, it is recommended that providers are encouraged and afforded training opportunities to obtain and master such psychotherapeutic skillsets and their scheduling templates allow for utilization.

Future Research

While this project was a program evaluation, the team recommends primary research be conducted to further determine knowledge and practice gaps as well as understand barriers to providing and documenting evidence-based treatment according to CPGs and as directed by policy. As providers become specialized in trauma-specific therapy, it would benefit the department to conduct a program evaluation of referral management practices in order to optimize access to specific treatment modalities within the department and to efficiently manage patients who need network referrals outside of the MHS, providing a fiscal benefit to the MHS.

Conclusion

Service members diagnosed and treated for PTSD at Fort Bliss are receiving evidence-based treatment more than 90 percent of the time. Recommendations were well received by behavioral health leadership at Fort Bliss who have already taken steps to improve standardization of treatment documentation and have named a CPG champion to help disseminate information and educate the department on updated recommendations.

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Appendix A: Provider Inquiry Tool

Fort Bliss PMHNP DNP Project
Management of Patients with PTSD

Behavioral Health Staff Inquiry

1. Are you aware of the VA/DoD Clinical Practice Guideline (CPG) for the Management of Post- Traumatic Stress? YES NO

2. If yes, do you generally follow the CPG recommendations? YES NO N/A

3. If you are a prescriber, please circle YOUR first-line pharmacotherapeutic modalities of choice for the management of patients with PTSD:

SSRI SNRI	MAOI	Mood Stabilizers
Benzodiazepines	Mirtazapine	Prazosin
Stimulants	Antipsychotics	TCA Nefazadone Phenelzine
Non-benzo Hypnotics	Other:	NA: non-prescriber

4. Please circle YOUR first-line psychotherapeutic modalities of choice for the management of patients with PTSD:

Prolonged Exposure (PE)	Group Therapy	Case Management
Collateral treatment: example is marital therapy	Problem solving therapy	Stress Inoculation Training (SIT)
Substance Use Treatment	Eye Movement Desensitization and Reprocessing (EMDR)	Specific management such as sleep, pain, anger
Cognitive Processing Therapy (CPT)	Not applicable	Other:

5. In YOUR practice, are PTSD symptoms/ treatment efficacy evaluated using the PCL-5, at least every 90 days? YES NO

Thank you for taking the time to complete this inquiry.

Appendix B: Chart Audit Tool

Fort Bliss PMHNP DNP Project
PTSD Treatment: Retrospective Chart Audit Tool

1. Date of chart review:

2. Reviewer: MAJ Brzuchalski MAJ Walker

3. EBH Clinic: 1-1 2-1 3-1

4. Unique Subject Identifier: ________________ (Second letter first/last name; FMP; Last 2 SSN)

5. Current Pharmacologic Treatment Modalities:

SSRI SNRI	MAOI	Mood Stabilizers
Benzodiazepines	Mirtazapine	Prazosin
Stimulants	Antipsychotics	TCA Nefazadone Phenelzine
Non-benzo Hypnotics	Other:	No meds started

6. Current Psychotherapy:

Prolonged Exposure (PE)	Group Therapy	Case Management
Collateral treatment: example is marital therapy	Problem solving therapy	Stress Inoculation Training (SIT)
Substance Use Treatment	Eye Movement Desensitization and Reprocessing (EMDR)	Specific management such as sleep, pain, anger
Cognitive Processing Therapy (CPT)	Not applicable	Other:

7. PCL-5 reassessed in the last 90 days? YES NO Not met 90 days of TX

8. Notes/Comments:

Appendix C: CITI Certificates- Brzuchalski

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Amy Brzuchalski (ID: 4988408)
- **Email:** amy.brzuchalski@usuhs.edu
- **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
- **Institution Unit:** GSN
- **Phone:** 901-409-5371

- **Curriculum Group:** OUSD P&R Human Research (Current)
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 16976818
- **Completion Date:** 08/23/2015
- **Expiration Date:** 08/22/2018
- **Minimum Passing:** 80
- **Reported Score*:** 92

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Records-Based Research (ID: 5)	08/23/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/23/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/23/15
FDA-Regulated Research (ID: 12)	08/23/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/23/15
Informed Consent (ID: 3)	08/23/15
History and Ethics of Human Subjects Research (ID: 498)	08/23/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/23/15
Genetic Research in Human Populations (ID: 6)	08/23/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/23/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/23/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/23/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/23/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/23/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/23/15
Cultural Competence in Research (ID: 15166)	08/23/15

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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Collaborative Institutional Training Initiative at the University of Miami

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Amy Brzuchalski (ID: 4988408)
- **Email:** amy.brzuchalski@usuhs.edu
- **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
- **Institution Unit:** GSN
- **Phone:** 901-409-5371

- **Curriculum Group:** OUSD P&R Human Research (Current)
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 16976818
- **Report Date:** 08/23/2015
- **Current Score**:** 92

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT
History and Ethics of Human Subjects Research (ID: 498)	08/23/15
Informed Consent (ID: 3)	08/23/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/23/15
Records-Based Research (ID: 5)	08/23/15
Genetic Research in Human Populations (ID: 6)	08/23/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/23/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/23/15
FDA-Regulated Research (ID: 12)	08/23/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/23/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/23/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/23/15
Cultural Competence in Research (ID: 15166)	08/23/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/23/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/23/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/23/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/23/15

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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Collaborative Institutional Training Initiative at the University of Miami

Appendix D: CITI Certificates- Walker

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Charles Walker (ID: 4990956)
- **Email:** charles.walker@usuhs.edu
- **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
- **Institution Unit:** GSN
- **Phone:** 2515993448

- **Curriculum Group:** OUSD P&R Human Research (Current)
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 16988115
- **Report Date:** 08/24/2015
- **Current Score**:** 90

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT
History and Ethics of Human Subjects Research (ID: 498)	08/23/15
Informed Consent (ID: 3)	08/23/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/23/15
Records-Based Research (ID: 5)	08/23/15
Genetic Research in Human Populations (ID: 6)	08/23/15
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	08/24/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/23/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/23/15
FDA-Regulated Research (ID: 12)	08/23/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/24/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/24/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/24/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/23/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/24/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/24/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/24/15

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Charles Walker (ID: 4990956)
- **Email:** charles.walker@usuhs.edu
- **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
- **Institution Unit:** GSN
- **Phone:** 2515993448

- **Curriculum Group:** OUSD P&R Human Research (Current)
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 16988115
- **Completion Date:** 08/24/2015
- **Expiration Date:** 08/23/2018
- **Minimum Passing:** 80
- **Reported Score*:** 90

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Records-Based Research (ID: 5)	08/23/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/23/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/23/15
FDA-Regulated Research (ID: 12)	08/23/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/23/15
Informed Consent (ID: 3)	08/23/15
History and Ethics of Human Subjects Research (ID: 498)	08/23/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/23/15
Genetic Research in Human Populations (ID: 6)	08/23/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/24/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/24/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/24/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/24/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/24/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/24/15
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	08/24/15

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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Appendix E: USU Form 3202N

USUHS FORM 3202N
DANIEL K. INOUYE GRADUATE SCHOOL OF NURSING
EVIDENCE-BASED PRACTICE/PERFORMANCE IMPROVEMENT PROPOSAL

VPR Date Stamp

Project Number: T06193 41 (VPR will assign)
Project Title: Ensuring Active Duty Service Members with PTSD Receive Evidence-Based Treatment

SECTION A: STUDENT POC INFORMATION

1. Name (Last, First, MI): Brzuchalski, Amy E Student E-mail: amy.brzuchalski@usuhs.edu

SECTION B: COMMITTEE CHAIR / SENIOR MENTOR INFORMATION

3. Name (Last, First, MI): Dillon, Douglas
4. Telephone: 301-295-0742 Fax: E-mail: douglas.dillon@usuhs.edu
5. USUHS Building/ Room No.: GSN

SECTION C: PROJECT INFORMATION

6. Attach the Abstract for the proposal, including the following sections: Site Location of the Project, Title, Authors, Background or Problem/Issue, Clinical Question/Purpose, Project Design, Anticipated Organizational Impact/Implications for Practice and also include the Proposed Timeline. Single space the abstract and use Times New Roman font, size 12.
7. Is this proposal related to an active research project of the Chair/Senior Mentor identified in Section B? ☐Yes ☒No
   If yes, complete below; if no, proceed to Part 8.
   Project Number:
   Project Title:
   Project Start Date: Project End Date:
8. Anticipated period of performance: Project Start Date: 1/1/2017 Project End Date: 4/30/2018
9. Performance Site(s): Fort Bliss, Texas
10. Does this project involve any classified information? (Contact the USUHS Security Office for guidance) ☐Yes ☒No
11. Do you have a funding source for this project? ☐Yes ☒No ☐NA
    If yes, specify the funding agency and the amount provided:

SECTION D: SIGNATURES

The following signatures attest to the validity of the above information:

Chair/Program Director (Signature and Date)

13 Sep 2017 (Signature and Date)

19 Sept 2[illegible] (Signature and Date)

Associate Dean for Research, GSN

In light of the above signatures, the project is approved.

USUHS Vice President for Research Date

USUHS Form 3202N (VPR) - Revised Sep 2015 v1.2
Previous versions are obsolete

OFFICE OF RESEARCH
4301 JONES BRIDGE ROAD
BETHESDA, MAYLAND 20814
PHONE: (301) 295-3303; FAX: (301) 295-6771

NOTICE OF PROJECT APPROVAL

Change Number: Original

VPR Site Number: T0-GSN-61-9341-01
Principal Investigator: Brzuchalski, Amy (GSN-61)
Department: Graduate School of Nursing
Project Type: Student
Project Title: Ensuring Active Duty Service Members with PTSD Receive Evidence-Based Treatment

Project Period: 10/5/2017 to 4/30/2018

Assurance and Progress Report Information:

Name	Sup	Approval Type	Status	Approved On	Forms Received
Progress Report	0			To be Submitted	N/A

Remarks:
This Notice of Project Approval has been reviewed and approved. Please remember that you must submit a final Progress Report (Form 3210) upon completion of this project.

Questions regarding this approval should be directed to the following person in the Office of Research:
Ronda Dudley, (301) 295-9818.

Yvonne T. Maddox, Ph.D. Date
Vice President for Research
Uniformed Services University of the Health Sciences

cc: Brzuchalski, Amy (GSN-61)
Vernell Shaw
File
Douglas Dillon
Linda Wanzer

Appendix F: IRB Letter of Determination

William Beaumont Army Medical Center
Human Research Protections Office

"NOT RESEARCH" DETERMINATION PROJECT APPLICATION

Application Date:	*05 June 2017*
Project Title:	*Ensuring Active Duty Service Members with PTSD Receive Evidence-based Psychotherapy*
Project Lead:	*MAJ Brzuchalski*

DIRECTIONS FOR FORM COMPLETION:

1. Complete all sections of the form. **DO NOT REMOVE ANY OF THE TEMPLATED LANGUAGE OR MODIFY FORM.** Please be as complete and thorough as possible. Insufficient information may result in a delay in completing the determination review.
2. Submit this completed form along with all required supporting documents to the WBAMC Human Protections Administrator by e-mail: larissa.a.schmersal.civ@mail.mil

1. GENERAL INFORMATION

1.1 Project Title: *Ensuring Active Duty Service Members with PTSD Receive Evidence-based Psychotherapy*

1.2 Project Lead
Rank, Name, Corps: Major, Amy Brzuchalski, AN
Title (PGY-[ ]): DNP/PMHNP Student
Service and Department: Psychiatry/ Education
Current Duty Station/Address: WBAMC Fort Bliss, TX/ 5005 N Piedras St., El Paso, TX 79920
Phone Number: (901) 409-5371
E-mail Address: amy.brzuchalski@usuhs.edu

1.3 Other Staff on Project
Rank, Name, Corps: Major, Charles Walker, AN
Title (PGY-[ ]): DNP/PMHNP student
Service and Department: Psychiatry/ Education
Current Duty Station/Address: WBAMC Fort Bliss, TX/ 5005 N Piedras St., El Paso, TX 79920
Phone Number: (251) 599-3448
E-mail Address: charles.walker@usuhs.edu

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2. PARAMETERS

2.1 Are the activities or interventions considered standard of care?

[x] Yes
[ ] No
[ ] N/A

2.2 Will data be collected from living individuals through some type of intervention?

[ ] Yes (Describe in Section 3.3)
[x] No
[ ] N/A

2.3 Will you interact with a living individual?

[ ] Yes (Describe in Section 3.3)
[x] No
[ ] N/A

2.4 Will you access individually identifiable information?

The team will access AHLTA and BHDP databases to collect raw data points. Data points consist of treatment information and personally identifiable information will not be captured; a unique project ID will be given to each patient.

[x] Yes - Check ALL that apply:
[x] 1. Names
[ ] 2. Street address, city, county, 5-digit zip code
[ ] 3. Months, dates (years are OK), ages >89 (unless all persons over 89 years are aggregated into a single category)
[ ] 4. Telephone numbers
[ ] 5. Fax numbers
[ ] 6. E-mail addresses
[x] 7. Social security number
[x] 8. Medical record number
[ ] 9. Health plan beneficiary number
[ ] 10. Account number
[ ] 11. Certificate/license number
[ ] 12. Vehicle identification number (VIN) and/or license plate number
[ ] 13. Device identifiers and serial numbers
[ ] 14. URLs (Uniform Resource Locators)
[ ] 15. Internet protocol address number
[ ] 16. Biometric identifiers, such as finger and voice prints
[ ] 17. Full face photographic images or any comparable images
[x] 18. Any other unique identifying number, characteristic, or code such as patient initials (Provide Unique Identifier):
For team tracking purposes only
Second Letters of First and Last Name, FMP, First and Last Digits of SSN, last four only
Example: (Maj Brzuchalski as subject) MR2004

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[ ] No
[ ] N/A

3. PROJECT DESCRIPTION

3.1 Describe the process, program, or system to be improved or assessed:
This project is a service/program evaluation of adherence to the 2010 Department of Veterans Affairs (VA) and Department of Defense (DOD) Clinical Practice Guidelines (CPG) for the management of Posttraumatic Stress; more specifically, evaluating the treatment of PTSD using evidence-based modalities given by providers at behavioral health clinics only (exclude primary care).

3.2 Describe the purpose and intent of your project:
The purpose of this DNP project is to evaluate the Fort Bliss mental health clinics adherence to evidence-based recommendations in the 2010 Va/DoD CPG for PTSD. The project will include patient data collection and provider self-report surveys, data analysis, as well as recommendations where necessary. The intent of the project is to ensure providers are aware of and adhering to the treatment recommendations; interventions will include education to close knowledge/practice gaps as well as recommendations to service chiefs related to other identified barriers.

3.3 Describe the project methodology (step-by-step description of what you will do):
1. Data Collection via patient record review and provider self-report surveys (Sept-Nov 2017)
2. Data Analysis of patient raw data (Dec 2017)
3. Aggregation of survey results (Dec 2017)
4. Identify gaps in knowledge and/or practice (Jan 2018)
5. Identify barriers to practice (Jan 2018)
6. Make recommendations to psychiatric service leaders (Feb 2018)
7. Education provided to psychiatric providers (Feb-Apr 2018)

3.4 Describe the data to be collected:
The team will access AHLTA and BHDP databases to collect raw data points. Data points consist of treatment information and personally identifiable information will not be captured; a unique project ID will be given to each patient. The team will conduct a record review of patients with a coded diagnosis of PTSD (exclude MST related PTSD) to determine if treatment has followed the recommendations of the 2010 Va/DoD CPG for PTSD. Data points will include: PTSD Dx present (combat related); assessment measures recorded in BHDP and frequency; relevant pharmacotherapy used and dosages; psychotherapy data to include modality, number of sessions, frequency, etc.

The team will also use a service such as Survey Monkey to survey all of the providers assigned to Fort Bliss psychiatric clinics. Data points will include: license type (MD, APRN, LCSW, Psychologist); level of education; training related to modalities; years of practice; average number of patients seen/treated per week with PTSD; regarding the CPG- knowledge based questions/gaps, practice gaps and barriers; and, level of comfort with relevant psychopharmacology and psychotherapeutic modalities.

3.5 Describe how the data will be analyzed:
The patient raw data will be entered into SPSS, a statistical analysis software program, to calculate adherence rates and other statistics as appropriate. The provider survey responses will be aggregated and summarized.

3.6 Describe the anticipated effect on the process, program, or system to be studied:

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The team anticipates greater adherence to evidence-based care by closing knowledge gaps and identifying practice barriers, to which education and recommendations will be provided. The team ultimately anticipates a positive impact on patient care, as adherence to CPG recommendations should equate to more positive patient outcomes. Time and project permitting, the team will recommend a more standardized outcome measurement program.

4. PROJECT INTENT

4.1 Describe the plan to publish and/or present results of this project:
The results of this project will be presented in poster format to staff of WBAMC and psychiatric clinics as well as faculty and students at the Uniformed Services University of the Health Sciences (USUHS).

4.2 Describe the primary intent for the information learned from this project. Indicate whether it is primarily intended to be generalizable beyond the institution or primarily intended to provide immediate and continuous improvement at the institution:
The results of this project are intended for immediate and continued improvement at the behavioral health clinics at FT Bliss, TX. However, there is potential for more generalizable use of findings or interventions.

4.3 Indicate whether any portion of this project is to be used as a student activity (e.g., Capstone, dissertation). If yes, describe what information will be used in this capacity and what information, if any, will be shared with individuals outside of WBAMC (e.g., dissertation committee members, faculty advisor):
Yes; This project is a scholarly inquiry project conducted by DNP students at USUHS, Graduate School of Nursing. The students will present the project to USUHS faculty and students as well as Fort Bliss psychiatric providers and leaders. The presentation will include background information, methods, data summaries and findings, recommendations, and interventions provided.

5. SIGNATURES

The study project lead and the department chief where the project will take place must sign in support of the application. The department chief's signature verifies that the department is responsible for the activities conducted under this project.

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Appendix G: PAO Clearance

DEPARTMENT OF THE ARMY
William Beaumont Army Medical Center
5005 North Piedras Street
El Paso, Texas 79920-5001

MCHM-DCI 4 May 2018

MEMORANDUM FOR MAJ Amy Brzuchalski, MC, Department of Education, William Beaumont Army Medical Center, El Paso, TX 79920

SUBJECT: Approval of the slide deck and poster entitled “Ensuring Active Duty Service Members with PTSD Receive Evidence-Based Treatment,” for presentation at USU Research Days and the manuscript of the same title for archiving at USU.

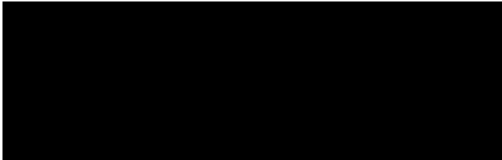
1. Under the provision of AR 360-1 and OTSG/MEDCOM Policy #16-024, The Public Affairs Office, Readiness Division, MEDCOM, and the Department of Clinical Investigation have cleared the subject material for presentation and archiving as above. It is approved with the stipulation that the following disclaimer be reflected on any written or oral presentation prior to submission: “The views expressed in this document are those of the author(s) and do not reflect the official policy of William Beaumont Army Medical Center, the Department of the Army, or the United States Government.”

2. The subject material is cleared for the sole and specified purpose of presentation at USU Research Days and the manuscript for archiving at USU. Any changes to the material submitted will require a subsequent clearance review prior to publication or archiving. Reuse of this approval is not authorized, as review and approval are required for every proposed use of the material.

3. If subject material is to be published, please contact the Department of Clinical Investigation with an additional publication clearance request.

4. POC is the undersigned at (915) 742-7469.

5/4/2018



DEPARTMENT OF THE ARMY
WILLIAM BEAUMONT ARMY MEDICAL CENTER
5005 NORTH PIEDRAS STREET
EL PASO, TEXAS, 79920-5001

MCHM-DCI 29 March 2018

MEMORANUDUM FOR RECORD

SUBJECT: Delegation of Signature Authority

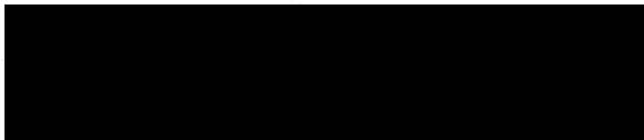
1. The following individual is appointed with delegated authority to sign and initial for the Chief, Department of Clinical Investigation, William Beaumont Army Medical Center, Fort Bliss, Texas for the specified purposes:

   a. CPT Zhenqian Zhu, MS, Ph.D., Department of Clinical Investigation, WBAMC Documents that require signature or concurrence and initials.

2. Authority: AR 25-50, 17 May 2013 Chapter 6, par. 6-1

3. PERIOD: Until officially relieved, released from appointment, or reassigned.

4. Special Instructions: I retain the authority to cancel or withdraw theses appointment at any time. Upon Change of Command, all appointments are subject to review for the purpose of cancellation or review by the incumbent. Appointments are automatically cancelled upon retirement, change of duty, or change of position of the individuals appointed.



Appendix H: Project Completion Verification Form

Appendix J: Daniel K. Inouye Graduate School of Nursing
DNP Project Completion Verification Form

DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form

The DNP Project titled: ***Ensuring Active Duty Service Members with PTSD Receive Evidence-Based Treatment*** was completed at William Beaumont Army Medical Center at Fort Bliss, Texas by the following student(s):

(Type student name)		*(Date)*
Amy E. Brzuchalski, MAJ/AN		01APR18
Charles D. Walker, MAJ/AN		01APR18

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership/stakeholders at the Phase II Site,
- Abstract/Impact Statement (*Appendix F*), and
- DNP Project written report.

Verified by:

(Type name)		*(Date)*	
Joellen Schimmels, LTC/A		01APR18	Senior Mentor
Nikki R. Battle, MAJ/AN Smith		01APR18	Team Mentor & Phase II Site Director

For RNA Students only - add the following additional signature for final verification of project completion:

RNA Project Director *(type name)* *(Signature)* *(Date)*

Form Version: 26 Aug 2017