Body System: Psychogenic

Session Topic: Returning Veterans with PTSD

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Physicians have knowledge and practice gaps with regard to appropriate screening and assessment; effective use of cognitive behavioral therapy; evidence-based pharmacotherapy practices; and providing consultative and coordinated referral services • Mental health professionals in the Veterans Health Administration (VHA) system frequently treat U.S. veterans suffering from posttraumatic stress disorder (PTSD) with medications that are inconsistent with evidence-based guidelines. • Soldiers returning from Iraq and Afghanistan who have mental health diagnoses, especially those with posttraumatic stress disorder (PTSD), are at an "increased risk of receiving opioids for pain, high-risk opioid use	1. Screen all new patients for symptoms of PTSD initially and then on an annual basis, or more frequently, if clinically indicated due to clinical suspicion, recent trauma exposure (e.g., major disaster), or history of PTSD. 2. Assess for co-morbid physical and psychiatric conditions 3. Develop a multidisciplinary treatment plan and initiate trauma-focused psychotherapy and/or pharmacotherapy. 4. Assist patients in connecting with mental health resources, including medication and different types of therapy, to manage and understand symptoms and aid in recovery from PTSD.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

and adverse clinical outcomes."		

ACGME Core Competencies Addressed (select all that apply)			
X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for screening all new patients for symptoms of PTSD initially and then on an annual basis, or more frequently, if clinically indicated due to clinical suspicion, recent trauma exposure (e.g., major disaster), or history of PTSD.
- Provide recommendations for assessing for co-morbid physical and psychiatric conditions
- Provide recommendations and strategies for developing a multidisciplinary treatment plan and initiate trauma-focused psychotherapy and/or pharmacotherapy.
- Provide recommendations and resources for assisting patients in connecting with mental health resources, including medication and different types of therapy, to manage and understand symptoms and aid in recovery from PTSD.
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of PTSD.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.

Needs Assessment

More than 300,000 U.S. veterans returning from combat in Iraq and Afghanistan -- nearly 20 percent of the total number of troops deployed at that time -- reported symptoms of post-traumatic stress disorder (PTSD) or major depression. Moreover, about one in three returning veterans experiences signs or symptoms of combat stress, depression, PTSD or traumatic brain

injury (TBI).[1] In addition, data from the Armed Forces Health Surveillance Center (AFHSC), show that more than 30,000 soldiers were treated in 2010 for TBI. The AFHSC also reported in the October 2011 issue of Medical Surveillance Monthly Report that alcohol abuse in soldiers is increasing sharply.[2,3]

It is these discouraging numbers, in part, that have prompted the AAFP to unite with first lady Michelle Obama and Jill Biden, M.D., in the Joining Forces campaign, which launched in April 2011. The initiative is intended to call attention to the critical issues facing veterans and military families and to expand access to wellness programs and other resources for this population. Through the Veterans Choice Program, many family physicians are in a position to manage returning veterans with post-traumatic stress disorder (PTSD).[4]

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful knowledge and practice gaps with regard to managing PTSD.[5] More specifically, CME outcomes data from 2012 AAFP Assembly (currently FMX) *Post-traumatic Stress Disorder* sessions and 2015 Family Medicine Update National Course *Post-traumatic Stress Disorder* sessions, indicate that physicians have knowledge and practice gaps with regard to appropriate screening and assessment, including screening tools; awareness and understanding of DSM V criteria; assessing for comorbidities; effective use of cognitive behavioral therapy; evidence-based pharmacotherapy practices; and providing consultative and coordinated referral services.[6,7]

A review of the literature validates these gaps, along with other gaps in care:[8-11]

- A study in JAMA: the Journal of the American Medical Association, indicates soldiers returning from Iraq and Afghanistan who have mental health diagnoses, especially those with posttraumatic stress disorder (PTSD), are at an "increased risk of receiving opioids for pain, high-risk opioid use and adverse clinical outcomes."
- With returning combat veterans presenting to primary care physicians in large numbers, extra care should be taken when prescribing opioids to relieve physical symptoms.
- According to one FP expert, however, when opioid therapy is administered to service members shortly after acute injury during combat, it can actually reduce their risk of developing PTSD.
- Mental health professionals in the Veterans Health Administration (VHA) system frequently treat U.S. veterans suffering from posttraumatic stress disorder (PTSD) with medications that are inconsistent with evidence-based guidelines.

Physicians may improve their care of patients with PTSD by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[12-16]

- New patients with a history of trauma exposure should be screened for symptoms of PTSD initially, and then on an annual basis or more frequently if clinically indicated.
- Consider the Startle, Physiological arousal, Anger, and Numbness (SPAN), the four-item primary care PTSD (PC-PTSD) screening instrument, or Breslau screening instruments.
- Trauma-focused psychotherapy and pharmacotherapy with selective serotonin reuptake inhibitors or serotonin–norepinephrine reuptake inhibitors are first-line treatment options for PTSD.

- Trauma-focused cognitive behavior therapy (CBT) and eye movement desensitization and reprocessing (EMDR) are more effective than other therapies in reducing PTSD symptom severity up to four months after treatment, but more robust studies are needed to evaluate the long-term effectiveness.
- Monotherapy for PTSD should be optimized before prescribing additional agents.
- CBT is an effective treatment for mild to moderate depression, anxiety disorders, posttraumatic stress disorder, obsessive-compulsive and tic disorders, autism, eating disorders, personality disorders, insomnia, and attention-deficit/hyperactivity disorder.
- For many psychiatric conditions, CBT provides similar outcomes or additional benefits compared with psychiatric medications alone.
- Adjunctive treatment with prazosin (Minipress) is recommended for patients with PTSD who have sleep disturbance.
- Benzodiazepines should be avoided in the treatment of PTSD.
- Atypical antipsychotics should generally be avoided in the treatment of PTSD.

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.[17,18]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Identifying and managing posttraumatic stress disorder[15]
- VA/DoD: Management of Post-Traumatic Stress Disorder and Acute Stress Reaction[19]
- Psychological therapies for chronic posttraumatic stress disorder[13]
- Common Questions About Cognitive Behavior Therapy for Psychiatric Disorders[12]
- Adding health education specialists to your practice[20]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[21]
- The benefits of using care coordinators in primary care: a case study[22]
- Engaging Patients in Collaborative Care Plans[23]
- The Use of Symptom Diaries in Outpatient Care[24]
- Health Coaching: Teaching Patients to Fish[25]
- Medication adherence: we didn't ask and they didn't tell[26]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[27]
- Integrating a behavioral health specialist into your practice[28]

- Simple tools to increase patient satisfaction with the referral process[17]
- FamilyDoctor.org. Post-traumatic Stress Disorder | Overview (patient education)[29]

References

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