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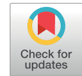
Factors associated with the receipt of documented evidence-based psychotherapy for PTSD in VA☆



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ABSTRACT

Objectives: The VA has mandated that evidence-based psychotherapies (EBPs) be offered to patients with PTSD, but only a small minority of the psychotherapy delivered to VA patients with PTSD is a documented EBP. It is unknown what factors are associated with receiving a documented EBP.

Method: Patients who received an EBP in FY2015 that was documented using a templated progress note ($N = 21{,}808$) were compared with patients who received psychotherapy for PTSD that was not documented using a template ($N = 251{,}886$).

Results: Among psychotherapy recipients, VA patients with markers of clinical complexity such as service connection for PTSD, comorbid bipolar or psychotic disorder, longer duration of PTSD diagnosis, and a benzodiazepine prescription for PTSD had lower odds of receiving a documented EBP.

Conclusions: Recipients of documented EBPs differed from those who did not receive documented EBPs on several sociodemographic characteristics and indicators of treatment need. A limitation of our study is that some individuals in the group without EBP documentation may still have received an EBP, but did not receive EBP documentation in the electronic health record. Nevertheless, our results suggest that high-need or complex VA patients with PTSD may be less likely to receive documented EBPs.

1. Introduction

Posttraumatic stress disorder (PTSD) is a distressing and disabling mental health condition that may affect almost a quarter of returning veterans in the Department of Veterans Affairs (VA) Healthcare System [1]. Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) are evidence-based psychotherapies (EBPs) with demonstrated efficacy [2, 3]. VA treatment guidelines recommend these psychotherapies as first-line interventions for PTSD [4–7] and mandate that they be offered to VA patients with PTSD. However, few patients receive EBPs, and only a small minority of the psychotherapy delivered to VA patients is an EBP [8–12]. For example, follow-up data from the national VA EBP rollout suggests that 18 months after training, most PE-trained therapists delivered PE to only 1–2 patients at a time [8, 9]. Similarly, following CPT rollout training, 69% of CPT-trained providers were using CPT "rarely" or "less than half the time" [13]. Machine learning-based analysis of free text notes in the electronic health record estimated that only 6.3% of New England VA patients received PE or CPT in 2010 [11]. Given that PE and CPT are first-line treatments for PTSD, yet are delivered with such low frequency, it is important to determine which individuals receive these treatments and which individuals potentially receive lower quality care. Thus, the current study was designed to investigate the factors associated with receiving a documented EBP for PTSD.

To date, there are few national studies of EBP usage. However, two studies have assessed systems-level factors associated with EBP. Sayer and colleagues [14] conducted interviews at nine sites across the country with various rates of EBP uptake. They found that the following

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factors were related to EBP uptake: clinic mission, clinic leader and staff engagement, clinic operations, staff perceptions, and practice environment. Notably, all teams with high uptake considered it their primary mission to deliver EBPs. From national medical records data, Sripada et al. [12] found that facilities with higher rates of diagnostic assessment administration and greater rates of psychotherapy adequacy delivered documented EBPs to a greater proportion of their PTSD-diagnosed patients. Shiner and colleagues investigated factors associated with EBP delivery across 38 residential PTSD treatment programs and found that several patient-level characteristics were associated with EBP delivery, including gender, cooccurring conditions, and length of stay [15]. No other study to date has examined the individual or person-level factors associated with documented EBP delivery on a national scale.

Although no national studies exist, several single-site analyses have been conducted to analyze individual-level factors associated with receipt of outpatient EBP. These reports suggest that patients may not be provided with EBPs for PTSD if they are not considered "ready" for EBP treatment [16–19], are considered to have low motivation [20], or have other comorbid conditions such as depression [21], substance use disorders, personality disorders [19, 22, 23], or recent hospitalization [24]. Other studies suggest that veterans of the recent wars in Iraq and Afghanistan (Operation Enduring Freedom and Operation Iraqi Freedom; OEF/OIF) are less likely to receive a full course of EBP [24, 25]. However, no national study has been conducted among outpatients. Given this lack of data, leaders in the field of PTSD implementation research recently issued a call for empirical research on the association between clinically relevant patient-level factors and receipt of EBP [26].

Building on these preliminary findings, the current study was designed to answer two questions. First, among treatment-seeking patients receiving psychotherapy for PTSD, what is the percentage that receives a documented EBP? Second, what are the patient-level characteristics associated with receipt of a documented EBP? Based on previous studies [16–19, 21–23], we hypothesized that lower rates of comorbidities and lower levels of clinical complexity would be associated with greater likelihood of receiving a documented EBP.

2. Methods

2.1. Study population

The full study cohort consisted of all VA patients with a primary PTSD diagnosis (identified using ICD-9-CM codes) and at least one psychotherapy visit (identified using current procedural terminology codes) in Fiscal Year 2015 (n = 273,694). We compared individuals who received at least one EBP template (PE or CPT) for PTSD in 2015 (hereafter referred to as "documented EBP") with those who did not receive any EBP templates.

2.2. Data source

Documented EBP provision was measured using EBP Note Templates. The VA EBP templates are structured note templates that can be inserted into progress notes in the VA's electronic health record. In recognition of the important role that EBP documentation plays, EBP templates have been mandated for those using EBPs in VA since October 2014 [27, 28]. Recently, EBP template use has been incentivized so that encounters using an EBP template receive "extra credit" toward a facility's mental health composite score on VA's quality improvement metrics (Strategic Analytics for Improvement and Learning Mental Health Domain Composite). In order to train providers to use the templates, the VA EBP office uses a "train the trainer" model in which local EBP coordinators are trained to use the templates and then train local clinicians. In addition, VA EBP training programs introduce the documentation templates in training workshops so that clinicians learn to use the templates contemporaneously with learning to deliver the EBP. In order to be certified as an EBP provider, clinicians must use the EBP templates during the consultation phase of EBP training. Recent data suggests that EBP templates are a reasonable estimate of VA EBP utilization. For example, Shiner and colleagues utilized EBP note templates to assess EBP provision in residential PTSD treatment settings and found adequate correlations between EBP note template provision and self-report data on EBP provision gathered from provider surveys [15].

EBP templates list the essential components of each EBP session according to the EBP treatment manual. To use the templates, treatment providers click on boxes corresponding to session content elements. The selection of a content element creates a corresponding data tag in the encounter information of the visit, making the content element accessible via the VA Corporate Data Warehouse. To assess PTSD EBP template usage, we included all notes with a data tag that indicated provision of PE or CPT.

The VA Corporate Data Warehouse also provided data on patient demographic characteristics, medications, and mental health service utilization. The local Institutional Review Board approved this study and granted a waiver of informed consent for access to protected health information.

2.3. Variables

The dependent variable was receipt of a documented EBP in FY15. Independent variables were potential predictors of EBP receipt and were selected based on previous studies suggesting that demographic variables [15, 24, 25], comorbid mental health diagnoses [15, 19, 21–23], psychiatric medications [16], and VA service utilization [15, 24] are associated with EBP receipt. The demographic variables included age (< 35, 35–55, > 55 years), period of service, sex, race, ethnicity, and service connected-disability level, including PTSD and non-PTSD conditions. We created a dichotomous variable indicating the presence or absence of PTSD service-connected disability and another variable that represented the average rating of an individual's non-PTSD service-connected conditions. Comorbid mental health diagnoses were identified from ICD-9 codes in the encounter information from any visit during the year prior to the EBP and consisted of depressive disorders, serious mental illness (bipolar and psychotic disorders), other anxiety disorders, and substance use disorders. We also created a variable enumerating years since receipt of a PTSD diagnosis at a VA encounter dating back to FY2000. We included past-year prescriptions for benzodiazepines or antipsychotics, which are not first line medications for PTSD [4, 7]. Past-year service utilization variables included mental health visits (indicated by a 500 series stop code), missed mental health visits (defined as visits that were not attended and not cancelled), emergency department visits, psychiatric hospitalizations, and total non-mental health visits. We also adjusted for past-year documented EBP use as indicated by the presence or absence of at least one EBP template in FY14.

2.4. Analyses

We used a stepwise modeling approach. For bivariate analyses, we conducted a series of Generalized Estimating Equation (GEE) models, which took into account potential clustering by facility, with documented EBP receipt as the outcome and each independent variable entered individually in its own model. For adjusted analyses, we estimated a GEE model with all the variables that were significant in bivariate analyses entered as covariates.

2.5. Sensitivity analyses

We conducted several sensitivity analyses to address the possibility that individuals in the non-EBP group could have received an EBP

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