Post-Traumatic Stress Disorder (PTSD)

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of Post-Traumatic Stress Disorder (PTSD). In addition, the CPG outlines the organizations that WellCare aligns with regarding PTSD and relevant Measureable Health Outcomes.

OVERVIEW

Although post-traumatic stress disorder (PTSD) is a debilitating anxiety disorder that may cause significant distress and increased use of health resources, the condition often goes undiagnosed. The lifetime prevalence of PTSD in the United States is 8 to 9 percent, and approximately 25 to 30 percent of victims of significant trauma develop PTSD. The emotional and physical symptoms of PTSD occur in three clusters: re-experiencing the trauma, marked avoidance of usual activities, and increased symptoms of arousal. Before a diagnosis of PTSD can be made, the patient's symptoms must significantly disrupt normal activities and last for more than one month.[1] It is estimated that 50 to 90 percent of the population may be exposed to traumatic events during their lifetime most exposed individuals do not develop PTSD. The lifetime prevalence of PTSD is also higher in women than in men and is higher in the presence of underlying vulnerabilities such as adverse childhood experiences or comorbid diagnoses.[2]

Diagnosis of PTSD can occur at any age and includes war veterans, children, and people who have been through a physical or sexual assault, abuse, accident, disaster, or many other serious events. Women are more likely to develop PTSD than men. Some factors that increase risk for PTSD include:[3]

- Living through dangerous events and traumas
- Getting hurt
- Seeing another person hurt, or seeing a dead body
- Childhood trauma
- Feeling horror, helplessness, or extreme fear
- Having little or no social support after the event
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home
- Having a history of mental illness or substance abuse

DSM-V Criteria [4]

The criteria for PTSD include specifying qualifying experiences of traumatic events, four sets of symptom clusters, and two subtypes. The DSM-V also now applies to children over age 6.

Criterion A: Traumatic event. Trauma survivors must have been exposed to actual or threatened death, serious injury, or sexual violence. This can include traumas such as complicated grief, divorce, non-professional media exposure to trauma, or childhood emotional abuse. The exposure can be:

- Direct
- Witnessed
- Indirect, by hearing of a relative or close friend who has experienced the event—indirectly experienced death must be accidental or violent

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- Repeated or extreme indirect exposure to qualifying events, usually by professionals—non-professional exposure by media does not count

Criterion B: Intrusion or Re-experiencing. This includes any of the following:

- Intrusive thoughts or memories
- Nightmares related to the traumatic event
- Flashbacks, feeling like the event is happening again
- Psychological and physical reactivity to reminders of the traumatic event, such as an anniversary

Criterion C: Avoidant symptoms. This includes the way in which an individual may try to avoid any memory of the event, and must include one of the following:

- Avoiding thoughts or feelings connected to the traumatic event; OR
- Avoiding people or situations connected to the traumatic event

Criterion D: Negative alterations in mood or cognitions. This includes many symptoms that have long been observed by clinicians and individuals with PTSD. A decline in someone's mood or though patterns that include:

- Memory problems that are exclusive to the event
- Negative thoughts or beliefs about one's self or the world
- Distorted sense of blame for one's self or others, related to the event
- Being stuck in severe emotions related to the trauma (e.g. horror, shame, sadness)
- Severely reduced interest in pre-trauma activities
- Feeling detached, isolated or disconnected from other people

Criterion E: Increased arousal symptoms. Increased arousal symptoms are used to describe the ways that the brain remains "on edge," wary and watchful of further threats. Symptoms include:

- Difficulty concentrating
- Irritability, increased temper or anger
- Difficulty falling or staying asleep
- Hypervigilance
- Being easily startled

Criteria F: Duration. Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

Criteria G: Functional Significance. Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criteria H. Disturbance is not due to medication, substance use, or other illness.

Subtype: Dissociation. Dissociation has now been set apart from the symptom clusters, and now its presence can be specified. While there are several types of dissociation, only two are included in the DSM:

- Depersonalization, or feeling disconnected from oneself
- De-realization, a sense that one's surroundings aren't real

Co-Morbidity and PTSD

Approximately 80 percent of patients with PTSD have at least one comorbid psychiatric disorder – the most common are depression, alcohol and drug abuse, and other anxiety disorders. In addition, 59 percent of men and 44 percent of women who have PTSD meet the criteria for three or more psychiatric diagnoses. Women who have PTSD are 4 times as likely to develop a major depression and 4.5 times as likely to develop mania as women who do not have PTSD. Men who have PTSD are 7 times as likely to develop depression and 10 times as likely to develop mania as men who do not have PTSD. The rate of attempted suicide in patients who have PTSD is estimated at 20 percent. Treatment relies on a multidimensional approach, including supportive patient education, cognitive behavior therapy, and psychopharmacology. Selective serotonin reuptake inhibitors are the mainstay of pharmacologic treatment.[1]

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the United States Department of Veterans Affairs (VA) American Psychiatric Association (APA). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to PTSD, WellCare defaults (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the VA and the APA on the topic. Highlights from their respective publications are noted below.

UNITED STATES DEPARTMENT OF VETERAN AFFAIRS

The United States Department of Veteran Affairs (VA) and the Department of Defense (DOD) published the *Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* to provide providers with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with posttraumatic stress disorder (PTSD) and acute stress disorder (ASD), to improve clinical outcomes. The guideline includes objective, evidence-based information on the management of PTSD and related conditions. The intention is to assist providers in all aspects of patient care, including, but not limited to, diagnosis, treatment, and follow-up. The VA/DOD also discuss the following:[5] .

- Enhance assessment of the patient's condition and determine the best treatment method in collaboration with the patient and, when possible and desired, the patient's family and caregivers
- Optimize the patient's health outcomes and improve quality of life
- Minimize preventable complications and morbidity
- Emphasize the use of patient-centered care

The VA guideline can be found in its entirety here.[6] In addition, a Pocket Guide is available here.[7]

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

The American Psychiatric Association (APA) published a guideline on acute stress disorder and PTSD in 2004. The guideline covers pharmacotherapies such as antidepressants and adrenergic agents as well as types of psychotherapies (e.g., exposure based cognitive behavioral therapies [CBTs], eye movement desensitization and reprocessing [EMDR], group therapies).[2]

A Guideline Watch was published in 2009 due to a number of well-designed randomized controlled trials of pharmacological and psychotherapeutic interventions for PTSD in various populations exposed to trauma. The Guideline Watch expands on items discussed in the 2004 guideline as well as includes a brief section on the neurobiology of PTSD with respect to the processes of emotional memory and impairment of extinction learning. Finally, the Guideline Watch addresses psychological first aid – a preventive approach for disaster survivors that includes fostering safety, calmness, self- and community efficacy, social connectedness, and optimism in the aftermath of disaster. While psychological first aid is supported by considerable empirical evidence, further research is needed.[8]

The APA guideline can be found here.[2] In addition, the guideline watch published in 2009 can be found here.[8] A useful accompaniment was also published based on the APA guideline covering initial assessment, psychiatric management, principles of treatment selection, and specific treatment strategies – it can be found here.[9]

NOTE: The APA guideline refers to the DSM-IV criteria; since publication however criteria was updated and part of the DSM-V update in 2013.

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) has published the following reports that assess the efficacy, comparative effectiveness, and harms of psychological and pharmacological treatments for adults with PTSD:

- **Interventions for the Prevention of Posttraumatic Stress Disorder (PTSD) in Adults After Exposure to Psychological Trauma**[10] (click here)
- **Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder (PTSD)**[11] (click here)

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement.*

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Care Management

PTSD may occur after a trauma in which the person who experienced the trauma continues to have symptoms of the "fight or flight" response when they are no longer in any danger. Symptoms usually start within 3 months after the traumatic event but sometimes may start years after the event occurred. Symptoms must last over one month and be severe enough to interfere with the member's life; such as affecting relationships or ability to function at work. Treatment includes medications, psychotherapy, or both. Some therapies that have been shown to be helpful to people with PTSD include Cognitive Behavioral Therapy (CBT), Exposure therapy, Cognitive Restructuring, Cognitive Processing Therapy and EMDR.[3] Veterans with PTSD may also suffer survivor's guilt making them feel that recovering from PTSD would be a betrayal to those who died around them. In addition to dealing with PTSD they may also have other struggles with returning to civilian life.

Some resilience factors that may reduce the risk of PTSD include:[3]

- Seeking out support from other people, such as friends and family
- Finding a support group after a traumatic event
- Learning to feel good about one's own actions in the face of danger
- Having a positive coping strategy, or a way of getting through the bad event and learning from it
- Being able to act and respond effectively despite feeling fear

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **Symptoms**: Member will have at least 5 hours of uninterrupted sleep at night >80% of the time as evidenced by sleep log.
- **Symptoms**: Member will show a reduction of symptoms such as panic attacks, flashbacks or nightmares by >20% as evidenced by member written symptom log or provider report
- **Adherence**: Member will be compliant with medications >80% of the time as evidenced by pharmacy claims and member report
- **Adherence:** Member will attend schedule therapy appointments >80% of the time as evidenced by medical claims and provider report
- **Engagement**: Member will attend a job, school, or volunteer opportunity at least 20 hours a week as evidenced by member, provider or caregiver report
- **Engagement**: Member will have increased attendance at work or at school by >20% as evidenced by member, provider or caregiver report
- **Engagement**: Member will engage in physical activity at least 20 minutes a day >80% of the time as evidenced

by member report
- **Utilization**: Member will have a reduction of BH inpatient days by >50% related to self-harm behaviors such as cutting or suicidal thoughts as evidenced by medical claims and service authorizations

CASE MANAGEMENT GOALS

Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which lead to the targeted health outcomes above.

- **Symptoms**: Member will verbalize at least 2 ways physical activity reduces stress and list at least 3 activities member can do to increase physical activity
- **Symptoms**: Member will be able to identify at least 2 triggers and at least 2 grounding techniques that can be used to cope with symptoms such as flashbacks
- **Symptoms**: Member will be able to list at least 2 relaxation techniques that can be used to reduce anxiety and verbalize how to practice these relaxation techniques
- **Symptoms**: Member will be able to list at least 3 sleep hygiene suggestions and will obtain a journal for logging sleep patterns
- **Symptoms**: Member will be able to verbalize at least 2 positive coping skills that can be used instead of engaging in self-harm behaviors such as cutting
- **Symptoms**: Member will obtain a daily journal and will verbalize the benefit of recording daily mood, PTSD symptoms, coping skills utilized, and mood after using coping skills
- **Engagement**: Member will obtain a journal or daily planner and identify at least one short term goal a day that can be reasonably accomplished
- **Engagement**: Member will be able to list at least 2 supportive people and reach out to at least one of them to schedule a social activity
- **Engagement**: Member will be connected to an employment or education support program or a volunteer opportunity
- **Adherence:** Member will be connected to therapist for management of PTSD
- **Specific for Members requiring hospitalization:** The Member participates in provider follow-up visit within 7 days of hospital discharge.

CASE MANAGEMENT OBJECTIVES

- Educate member about PTSD including normal stress reactions, symptoms of PTSD and triggers.
- Evaluate for suicidality including thoughts, plans, intent, means and past attempts and develop a Crisis/Safety plan with member.
- Ask about access to firearms and other lethal means available and have a plan for removing, securing or limiting access to means in Crisis/Safety plan.
- Assess for comorbid physical and behavioral health disorders including substance abuse and chronic pain.
- Educate member on breaking up large tasks into small ones, setting priorities and doing what they can in a day.
- Educate member on grounding techniques.
- Educate member on relaxation techniques such as mindfulness, meditation and yoga.
- Educate on the importance of exercise in improving mood and reducing stress.
- Refer to a local PTSD support group and a family support group through agencies such as NAMI, Mental Health America, the National Center for Trauma Informed Care and the National Center for PTSD.
- Refer Veteran's with PTSD to PTSD support groups specifically for Veterans and VA PTSD providers.
- Discuss with Veteran's how they can discuss PTSD with their civilian support system without getting into traumatic details of events.
- Ensure member has a stable and safe place to live and refer to resources as needed.
- Refer to Cobalt if indicated.
- Educate member on the role pets and service animals may play in reducing symptoms of PTSD.
- Educate member on treatment options and refer to a therapist that has experience with managing PTSD and that member will feel comfortable with (e.g., some members may feel safer with a therapist of a certain gender).
- Discuss the benefits and outcomes of therapy for PTSD but that treatment may feel threatening or intrusive.
- Refer to a psychiatrist if needed.

- Refer to community resources (e.g., financial assistance, employment assistance, parenting classes).
- Assess for current safety concerns including any domestic violence or abusive relationships and refer to appropriate resources as needed.
- Refer to a grief support group such as GriefShare if needed.
- Educate on medications including when and how to take medications, how long it will take for medications to improve symptoms and side effects or precautions.
- Educate on sleep hygiene and creating a sleep log to monitor sleeping patterns.
- Educate on coping skills including physical activity and exercise in reducing stress.
- Educate on creating a mood journal to monitor daily mood, symptoms, coping skills used, and reaction to coping skills.
- Educate on maladaptive coping mechanisms for managing trauma such as dissociative symptoms.

MEDICAL BEHAVIORAL INTEGRATION

Co-occurring substance abuse is common with those diagnosed with PTSD with approximately half of individuals seeking treatment for substance abuse also meeting criteria for PTSD. Prognosis for individuals seeking substance abuse treatment that also have PTSD is poorer than those who do not have PTSD; with those with PTSD reporting more cravings and relapsing sooner.[12] A significant percentage of people seeking treatment for PTSD also report chronic pain and a significant portion of people with chronic pain also have PTSD. The pain often has occurred as a result of the traumatic event such as a MVA or physical assault. People with chronic pain and PTSD are more likely than those with chronic pain alone to report more severe pain and pain related impairment and are also more likely to be prescribed opioids for pain and have high-risk opioid use. People diagnosed with PTSD also have a higher rate of co-morbid psychiatric diagnoses such as depression.[13] People diagnosed with PTSD are also more likely than the general population to be diagnosed with numerous medical conditions such as diabetes, non-cirrhotic liver disease, angina, tachycardia, hypercholesterolemia, heart disease, stomach ulcer, HIV, gastritis, arthritis, asthma, COPD, fibromyalgia, migraines, cancer and metabolic syndrome. One possible reason for this is that stress can weaken the immune system.[14]

MEMBER EDUCATIONAL RESOURCES

There are currently no Krames educational materials available for this topic.

PHARMACOLOGY

SSRIs are usually recommended as the first line of defense for PTSD because they have been shown to improve PTSD symptoms, are effective treatments against comorbid behavioral health conditions that often occur with PTSD such as depression, may reduce suicidality, impulsivity and aggression that can exacerbate PTSD and have relatively little side effects. Tricyclic antidepressants and MAOIs may also be used. Prazosin has also been shown to be effective in reducing nightmares and improving sleep in people with PTSD. Benzodiazepines may be useful in reducing anxiety and improving sleep, however, they have an addictive potential and should be used with caution in those with comorbid substance use. There is also some evidence of symptoms worsening after benzodiazepines have been discontinued. Anticonvulsants such as Depakote, Tegretol, Topamax and Lamictal have also been shown to reduce PTSD symptoms such as flashbacks. Second-generation antipsychotics may be helpful to use in patients where first-line approaches have been ineffective.[2]

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Anxiety Disorders (HS-1057); Behavioral Health Screening in Primary Care Settings (HS-1036); Depressive Disorders Adults in Children and Adolescents (HS-1022); Substance Use Disorders (HS-1031);* and *Suicidal Behavior (HS-1027).*

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

References

1. Grinage BD. Diagnosis and Management of Post-traumatic Stress Disorder. Am Fam Physician. 2003 Dec 15;68(12):2401-2409. http://www.aafp.org/afp/2003/1215/p2401.html. Accessed April 18, 2018.
2. Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder. American Psychiatric Association Web site. http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf. Published

March 2009. Accessed April 18, 2018.
3. Post-Traumatic Stress Disorder. National Institute of Mental Health Web site. https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml. Published February 2016. Accessed April 18, 2018.
4. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013.
5. VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder: Clinician Summary. United States Department of Veterans Affairs Web site. https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf. Published 2017. Accessed April 18, 2018.
6. VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder. United States Department of Veterans Affairs Web site.https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal.pdf. Published 2017.Accessed April 18, 2018.
7. VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder: Pocket Card. https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGPocketCardFinal.pdf. United States Department of Veterans Affairs Web site.
8. Guideline Watch 2009: Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder. American Psychiatric Association Web site. http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd-watch.pdf. Published March 2009. Accessed April 18, 2018.
9. Treating Patients With Acute Stress Disorder and Posttraumatic Stress Disorder: A Quick Reference Guide. American Psychiatric Association Web site. http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd-guide.pdf. Accessed April 18, 2018.
10. Interventions for the Prevention of Posttraumatic Stress Disorder (PTSD) in Adults After Exposure to Psychological Trauma. Agency for Healthcare Research and Quality Web site. https://effectivehealthcare.ahrq.gov/topics/ptsd-adults-trauma-interventions/research. Published April 2, 2013. Accessed April 18, 2018.
11. Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder (PTSD). Agency for Healthcare Research and Quality Web site. https://effectivehealthcare.ahrq.gov/topics/ptsd-adult-treatment/research. Published April 2, 2013. Accessed April 18, 2018.
12. Berenz, Erin C., and Scott F. Coffey. "Treatment of Co-Occurring Posttraumatic Stress Disorder and Substance Use Disorders." *Current psychiatry reports* 14.5 (2012): 469–477. *PMC*. Web. 13 July 2017.
13. Morasco, Benjamin J. et al. "The Relationship between PTSD and Chronic Pain: Mediating Role of Coping Strategies and Depression." *Pain* 154.4 (2013): 609–616. *PMC*. Web. 13 July 2017.
14. Pietrzak, Robert H. et al. "Medical Comorbidity of Full and Partial Posttraumatic Stress Disorder in United States Adults: Results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions." *Psychosomatic medicine* 73.8 (2011): 697–707. *PMC*. Web. 13 July 2017.

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Medical Policy Committee Approval History

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