

# Use of Guideline-Recommended Treatments for PTSD Among Community-Based Providers in Texas and Vermont: Implications for the Veterans Choice Program

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## Abstract

*Implementation of the Veterans Choice Program (VCP) allows Veterans to receive care paid for by the Department of Veterans Affairs (VA) in community settings. However, the quality of that care is unknown, particularly for complex conditions such as posttraumatic stress disorder (PTSD). A cross-sectional survey was conducted of 668 community primary care and mental health providers in Texas and Vermont to describe use of guideline-recommended treatments (GRTs) for PTSD. Relatively, few providers reported using guideline-recommended psychotherapy or prescribing*

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*practices. More than half of psychotherapists reported the use of at least one guideline-recommended psychotherapy for PTSD, but fewer reported the use of core treatment components, prior training in the GRT(s) they use, or adherence to a treatment manual. Suboptimal prescribing for PTSD patients was reported more commonly than optimal prescribing. Findings raise critical questions regarding how to ensure veterans seeking PTSD care in community settings receive psychotherapy and/or prescribing consistent with clinical practice guidelines.*

## Introduction

In 2014, Congress passed the Veterans Access, Choice, and Accountability Act (VACAA) with the goal of expanding access to healthcare for veterans in community settings. VACAA created what became known as the “Veterans Choice Program” (VCP) with the goal of increasing access to care for veterans facing long wait times or living more than 40 miles from the nearest VA facility. In order to expand the network of providers paid by the Department of Veterans Affairs (VA) in community settings, the VA built on networks of providers already partnering with them under prior mechanisms of community-based, VA-paid care (e.g., fee-basis care). Network expansion faced challenges in early VCP implementation, however, with Finley and associates finding that providers in both Texas and Vermont reported little participation during the first year of VCP implementation.<sup>1</sup> More importantly, VCP implementation has raised questions about the quality of community care, particularly for veterans with conditions such as posttraumatic stress disorder (PTSD), for which the VA has expertise but comparable skills and services may be lacking among non-VA providers.

PTSD is a complex condition that requires specialized care. To support delivery of high-quality PTSD care, the VA and Department of Defense (DoD) have developed PTSD treatment guidelines that emphasize the use of evidence-based psychotherapies and prescribing.<sup>2</sup> The VA has made significant investments in training and infrastructure to support the use of guideline-recommended treatments (GRTs) both within and outside of VA facilities.<sup>3,4</sup> Although the VA’s outreach programs have included expert phone consultation for non-VA providers nationwide, the level of training and support required for delivering high-quality PTSD care is frequently unavailable outside of the VA.<sup>5,6</sup> Lack of access to GRTs for PTSD outside of the VA has been identified as a gap in care, particularly in rural areas,<sup>7–9</sup> raising concerns about the quality of PTSD care received by veterans under VCP. Moreover, although the VA remains accountable under VACAA legislation for the quality of VCP care, there are few specific guidelines regarding training or use of best practices among community providers, which raises questions about how best to monitor the quality of VCP services at the system level.

To address these concerns and inform ongoing VCP evaluation, a survey was conducted of community-based mental health and primary care providers in two states, Texas and Vermont. Prior studies among community mental health providers have reported that relatively few assess for PTSD using validated screening measures or report use of recommended psychotherapies for

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Previous presentation

Portions of this work were presented at the VA QUERI Field-Based Meeting in Washington, DC on 8 August 2016.

*Journal of Behavioral Health Services & Research*, 2018, 217–233. © 2018 This is a U.S. government work and its text is not subject to copyright protection in the United States; however, its text may be subject to foreign copyright protection [YEAR]. DOI 10.1007/s11414-018-9613-z

PTSD, such as Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE).<sup>2,6,10</sup> Moreover, the literature on adoption of recommended psychotherapies among community providers more broadly indicates that, even when drawing upon recommended therapies, providers may pull eclectically from a variety of treatments, or selectively deliver certain components of a treatment while neglecting others.<sup>11–13</sup> The lack of detail available on community providers' use of specific treatment practices in psychotherapy for PTSD has made it difficult to assess potential therapeutic value for patients.

Data on prescribing for PTSD symptoms outside of the VA are similarly lacking, although studies of community physicians indicate that providers' knowledge of and self-efficacy for best practices in treatment of war-related conditions is low.<sup>7,8</sup> Studies of mental health prescribing more generally in the private sector indicate variable to poor compliance with recommendations for prescribing antipsychotic medications among patients with schizophrenia, mood-stabilizing medications among patients with bipolar disorder, and antidepressants among patients with depression.<sup>14–16</sup>

Therefore, the primary objective of the current study was to describe providers' use of GRTs for PTSD (i.e., psychotherapy and prescribing practices) in order to shed light on the quality of PTSD care available in community settings. The proportion of providers following guideline recommendations for patients with PTSD and the proportion with training in use of GRTs for PTSD was examined to provide a measure of care quality. A secondary objective was to assess differences in the use of GRTs by state and provider type, in order to examine whether regional and professional variation emerged in practice norms. It was hypothesized that state and provider type would both be associated with differences in use of GRTs for PTSD-related psychotherapy and prescribing, based on prior work identifying variation in PTSD treatment practices and local resources (e.g., academic detailing programs in Vermont that have emphasized guideline-concordant prescribing for PTSD).<sup>5,6,17–20</sup> With regard to provider type, it was hypothesized that doctoral-level psychologists would be more likely than master-level providers to report use of guideline-recommended psychotherapy for PTSD, and that prescribers with a psychiatry specialty would be more likely than those with a primary care specialty to report guideline-concordant prescribing for PTSD.

The final objective was to compare use of GRTs for PTSD across community providers who were and were not participating in VCP in order to evaluate the treatment practices of VCP providers and whether they differed significantly from standards of care in the community during early program implementation.

## Methods

### Participants

Participation was invited in a cross-sectional mailed survey from two separate, non-overlapping samples of community clinicians treating primarily adult patients in Texas and Vermont: the *community sample* and the *VCP-authorized sample*. Providers were excluded if they self-identified as treating < 1 patient in the prior year, working primarily with children/adolescents, or providing services at a VA clinic; among prescribers, only those practicing in primary care/family medicine or psychiatry specialties were included.

*Community Sample* The intention of the community sample was to facilitate understanding of standards for PTSD care among a general sample of community-based mental health and primary care providers in Texas and Vermont. Publicly available state rosters were used to identify licensed physicians and other health care providers, defining two main groups: (1)

*prescribers*, which included physicians and nurse practitioners reporting primary specialties in psychiatry, primary care, or family medicine; and (2) *psychotherapists*, which included clinical and counseling psychologists, social workers, licensed professional or mental health counselors, and licensed marriage and family therapists. Providers were categorized into non-overlapping strata by state and provider type, and surveys were sent to randomly selected samples in Texas ( $n=800$  prescribers,  $n=800$  psychotherapists) and Vermont ( $n=619$  prescribers,  $n=651$  psychotherapists).

**VCP-Authorized Sample** The intention of the VCP-authorized sample was to identify the use of GRTs among providers participating in either VCP or Patient-Centered Community Care (PC3), a nationwide community care program that predated VCP and whose providers were automatically enrolled in VCP at the time of implementation. The VA Chief Business Office provided a then-current list of all VCP and PC3 providers, based on network lists from the third-party administrators responsible for VCP implementation (TriWest and Health Net Federal). Because of the differing populations of providers in the two states, surveys were sent to all listed VCP-authorized providers in Vermont ( $n=30$  prescribers,  $n=15$  psychotherapists) and stratified random samples in Texas ( $n=391$  prescribers,  $n=218$  psychotherapists).

## Data Collection

Providers were invited via mailed letter to participate in a survey to improve the support the VA can offer to community healthcare providers and their patients with PTSD, including veterans. In order to allow respondents a choice of response format, the mailing included a hardcopy survey and a Web link to an online version of the survey with a unique username and password. Non-respondents were sent reminders 2 weeks later. All respondents received a \$20 gift card. The institutional review board of record determined this quality improvement project to be non-research.

Data collection occurred during the summer and fall of 2015. A total of 668 responses were received, including 553 from community sample providers and 115 from VCP-authorized providers. After accounting for incorrect addresses, this resulted in an overall response rate of 21.1%. Response rates among community sample subgroups ranged from 16 to 25% (see Table 1).

## Survey Measures

Survey items assessed provider (i.e., state, age, sex, race/ethnicity, provider type, veteran status, distance from VA facility, prior training, or employment in VA or Department of Defense facilities) and practice (e.g., currently treat patients with PTSD or veterans) characteristics. Providers were asked to specify their sources of reimbursement, including whether they receive VA reimbursement for fee-basis care, PC3, or VCP, or for CHAMPVA, a VA-paid health benefit for spouses and children of permanently disabled or deceased veterans.

Stand-alone and checklist items used in prior needs assessment and evaluation studies were adapted to assess providers' use of PTSD treatment practices recommended in the *VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress*.<sup>2,6,9,21</sup> As the strongest psychotherapy recommendation is given for trauma-focused therapies (i.e., CPT, PE, Eye Movement Desensitization and Reprocessing (EMDR)) and stress inoculation therapy (SIT), the use of these treatments was assessed. Treatment fidelity is defined as the degree to which intervention delivery is consistent with the protocol originally developed, including use of all

**Table 1**

Provider characteristics among community sample respondents

	Psychotherapists		Prescribers	
	Texas (n = 140)	Vermont (n = 144)	Texas (n = 116)	Vermont (n = 108)
% response rate	20.4	25.0	15.8	19.7
Provider and practice characteristics				
Mean Age (SE)	50.1 (1.2)	54.1 (1.0)** <sup>a</sup>	48.1 (2.1)	54.1 (1.1)** <sup>a</sup>
Female (% (SE))	69.4 (4.7)	70.0 (3.9)	57.9 (8.6)	59.9 (6.0)** <sup>b</sup>
Ethnicity (% (SE))				
Non-Hispanic White	84.6 (3.6)	96.2 (1.7)** <sup>a</sup>	58.8 (9.3)** <sup>b</sup>	97.1 (1.3)** <sup>a</sup>
Non-Hispanic Black	3.9 (1.8)	0.0	5.3 (2.0)	0.6 (0.5)** <sup>a</sup>
Hispanic	8.5 (2.8)	1.8 (1.3)** <sup>a</sup>	11.3 (5.5)	0.6 (0.5)** <sup>a</sup>
Other	3.0 (1.7)	2.0 (1.1)	24.5 (8.7)** <sup>b</sup>	1.8 (1.0)** <sup>a</sup>
Profession (% (SE))				
Master-level psychotherapist	84.2 (3.1)	75.2 (3.6)** <sup>a</sup>	—	—
Psychologist	15.8 (3.1)	24.8 (3.6)** <sup>a</sup>	—	—
Mental health prescriber	—	—	8.7 (2.6)	17.3 (3.6)** <sup>a</sup>
Primary care prescriber	—	—	91.3 (2.6)	82.7 (3.6)** <sup>a</sup>
Provider is a veteran	8.2 (2.8)	9.7 (2.5)	7.8 (2.3)	12.8 (4.6)
Distance of practice from nearest VA medical facility (% (SE))				
Up to 1 h driving time	72.2 (4.6)	48.1 (4.4)** <sup>a</sup>	82.2 (5.8)	54.0 (6.4)** <sup>a</sup>
More than 1 h or unknown	27.8 (4.6)	51.9 (5.0)** <sup>a</sup>	17.8 (5.8)	46.0 (6.4)** <sup>a</sup>
Previously trained or employed as a health professional (in VA or DoD)	15.8 (2.9)	12.7 (3.1)	35.3 (8.9)** <sup>b</sup>	32.5 (5.8)** <sup>b</sup>
Receives VA reimbursement through fee-basis care (PC3 or VCP)	7.1 (2.7)	2.3 (1.6)	11.2 (6.9)	3.0 (2.5)
Receives VA	8.9 (2.7)	14.1 (3.2)	12.5 (5.6)	32.8 (6.1)** <sup>a,b</sup>

**Table 1**  
(continued)

	Psychotherapists		Prescribers	
	Texas (n = 140)	Vermont (n = 144)	Texas (n = 116)	Vermont (n = 108)
reimbursement through ChampVA				
Number of clients with PTSD in past 12 months (% (SE))				
Few (0–6 therapist; 0–10 prescriber)	54.5 (5.1)	40.3 (4.4) <sup>*a</sup>	77.2 (7.2) <sup>*b</sup>	57.9 (5.7) <sup>*b</sup>
Many (7+ among therapists; 11+ among prescribers)	45.5 (5.1)	59.7 (4.4) <sup>*a</sup>	22.8 (7.2) <sup>*b</sup>	42.1 (5.7) <sup>*b</sup>
Treated any veterans in past year	68.7 (4.7)	49.6 (4.4) <sup>*a</sup>	69.5 (8.4)	88.2 (3.1) <sup>*a,b</sup>
(If treating veterans) Veteran also gets care at VA	65.1 (5.5)	69.6 (5.8)	71.3 (10.8)	85.2 (4.3) <sup>*b</sup>
Reports providing treatment for patients with PTSD, occasionally or more often	73.3 (4.6)	77.2 (3.8)	46.7 (9.0) <sup>*b</sup>	78.2 (5.2) <sup>*a</sup>

\*Significant difference in proportion at 0.05 level of significance

<sup>a</sup>Significant difference by state, i.e., between providers of the same type in Texas vs. Vermont (e.g., VT psychotherapists compared to TX psychotherapists)

<sup>b</sup>Significant difference by provider type, i.e., between prescribers and therapists in the same state

core components.<sup>22</sup> To provide an assessment of treatment fidelity in this study, psychotherapists were also asked how frequently (never/seldom/occasionally/often/always) they use core components for each treatment; these items were drawn from a previous survey of VA providers conducted by Rosen et al. and updated to reflect current guidelines.<sup>9,21</sup> With regard to medication, the VA/DoD guidelines recommend selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) as first-line pharmacotherapy for PTSD<sup>2</sup>; prazosin is recommended for sleep disruption and nightmares. Benzodiazepines are contraindicated for patients with PTSD. Prescribers were therefore asked about common medications by class (e.g., SSRIs, SNRIs, benzodiazepines, etc.), including frequency of use (never/seldom/occasionally/often/always) and whether prescribed for PTSD, sleep, and/or pain.

Survey items were drawn or adapted from those validated in prior studies<sup>7,21,23</sup> and refined where necessary based on feedback from local providers, organizational leadership, and VA partners from the Office of Analytics and Business Integrity, Quality Enhancement Research Initiative, and National Center for PTSD. The survey took an estimated 10–15 min to complete.

## Data Analysis

Statistical analysis compared providers' personal and practice characteristics. Analyses for the community sample were weighted to account for differing selection and response rates across provider groups and two states of different population size. Statistical calculations accounted for the different selection rates and response rates of each provider group in each state by weighting the survey responses inversely proportional to the probability that a particular provider would have responded from within her/his group and state. The weight assigned to a particular record therefore corresponds to the number of therapists or prescribers within her/his specialty that the provider represents. The SURVEYFREQ procedure within SAS 9.4 was used for these calculations.<sup>24</sup> VCP-authorized sample calculations were not weighted due to low cell counts for Vermont.

Use of GRTs among psychotherapy and prescribing providers for the community sample was compared by state and provider type, as well as among VCP-authorized vs. non-VCP-authorized providers. For the purpose of comparing use of treatment practices among VCP-authorized and non-VCP-authorized providers, community sample respondents who reported VCP participation were considered part of the VCP-authorized group. Comparisons were conducted using the Rao-Scott Chi-Square test for weighted community sample data and binomial test of proportions or Fisher's exact test for the VCP-authorized sample.

Among providers who reported treating patients with PTSD, the use of guideline-recommended psychotherapy or prescribing was assessed.<sup>2</sup> Among psychotherapists, the use of recommended psychotherapies and core treatment components, receipt of prior supervision or advanced training in the psychotherapy used and reported fidelity to the treatment manual were assessed. Among prescribers, because medication guidelines address both "recommended" and "harmful" practices, an algorithm to identify "optimal" vs. "suboptimal" patterns of prescribing was developed. Prescription practices were considered suboptimal when providers stated they "often" or "always" prescribed medications identified in the VA/DoD guideline as level C (no recommendation), D (recommended against), or I (insufficient evidence). Prescription practices not meeting the above criteria were considered optimal when providers prescribed at least one level A (strongly recommended) or B (recommended) medication as or more often than the most frequently prescribed C, D, or I medication.

## Results

### Provider Characteristics

Table 1 summarizes the characteristics of providers in the community sample. The majority of responding psychotherapists were master-level providers, while the majority of responding prescribers were primary care providers. About one third of prescribing providers had received training or been employed by the VA or the DoD. Fewer than 10% of all providers reported receiving VA reimbursement through fee basis, PC3, or VCP. Nearly three fourths of psychotherapists and prescribing providers reported providing treatment for patients with PTSD occasionally or more often.

### Treatment Practices of Psychotherapists by State and Provider Type

Table 2 summarizes treatment practices among community sample psychotherapists treating PTSD patients. More than half of psychotherapists reported using at least one GRT for PTSD with patients; however, only about a third had received supervision or advanced training/certification in the GRT they use. Psychotherapists reporting use of PE, CPT, or EMDR varied in how regularly they completed the core components for those treatments. The use of GRTs also varied by state, with significantly more psychologists in Texas than Vermont reporting use of either PE or CPT with their clients with PTSD. Significantly fewer master-level-trained psychotherapists in Texas reported using PE as compared with psychologists. Fewer than 20% of psychotherapists overall reported regularly using a GRT for PTSD in which they have received advanced training/certification and for which they consistently follow the treatment manual.

**Table 2**

Psychotherapist treatment practices among community sample providers who treat PTSD patients at least occasionally

Therapies used by psychotherapists (% (SE))	Psychologists		Master's level	
	Texas ( <i>n</i> = 30)	Vermont ( <i>n</i> = 32)	Texas ( <i>n</i> = 80)	Vermont ( <i>n</i> = 83)
Provide education on stress response in PTSD (often/always)	90.0 (5.5)	77.4 (7.4)	82.7 (5.1)	87.0 (4.1)
Teach skills for coping with PTSD symptoms (often/always)	93.3 (4.6)	100 (0.0)	91.1 (4.1)	95.8 (2.5)
Conduct therapy for PTSD using a treatment manual (often/always)	23.3 (7.8)	6.5 (4.3)	27.4 (6.3)	13.5 (4.5)
Guideline-recommended treatment (GRT) used with clients with PTSD				
Prolonged exposure (PE)	40.0 (9.1)	12.5 (5.7) <sup>*,a</sup>	9.6 (3.8) <sup>*,b</sup>	5.2 (2.6)
Use PE core components <sup>c</sup> (often/always)	16.7	3.1	3.8	1.2
Cognitive processing (CPT)	60.0 (9.1)	28.1 (7.8) <sup>*,a</sup>	46.6 (6.8)	32.4 (5.7)
Use CPT core components <sup>c</sup> (often/always)	20.0	6.3	11.3	4.8
Eye movement desensitization	10.0 (5.5)	25.0 (7.5)	17.8 (5.4)	28.4 (5.5)

**Table 2**  
(continued)

Therapies used by psychotherapists (% (SE))	Psychologists		Master's level	
	Texas (n = 30)	Vermont (n = 32)	Texas (n = 80)	Vermont (n = 83)
and reprocessing (EMDR)				
Use EMDR core components <sup>c</sup> (often/always)	6.7	15.6	7.5	20.5
Stress inoculation therapy (SIT)	16.7 (6.9)	6.3 (4.2)	7.4 (3.9)	2.3 (1.4)
At least 1 of the above	73.3 (8.2)	56.3 (8.6)	55.9 (6.7)	52.5 (6.1)
GRT used and have received supervision or advanced training/certification				
PE	30.0 (8.3)	9.4 (5.0)	3.1 (2.4)* <sup>b</sup>	5.2 (2.6)
CPT	33.3 (8.7)	12.5 (5.7)	20.9 (5.8)	19.7 (4.8)
EMDR	10.0 (5.5)	21.9 (7.2)	12.8 (4.7)	23.2 (5.2)
SIT	6.7 (4.6)	3.1 (3.0)	4.7 (3.3)	2.1 (1.4)
At least 1 of the above	46.7 (9.2)	37.5 (8.4)	31.7 (6.4)	38.7 (6.0)
At least 1 GRT used and supervised/trained/certified and follow treatment manual (often/always)	20.0 (7.4)	6.3 (4.2)	10.1 (4.4)	8.3 (3.7)

\*Significant difference in proportion at 0.05 level of significance

<sup>a</sup>Indicates significant difference by state, i.e., between providers of the same type (e.g., VT psychotherapists compared to TX psychotherapists)

<sup>b</sup>Significant difference by provider type, i.e., between psychologists and master-level therapists in the same state

<sup>c</sup>Use of GRT core components was defined as follows: prolonged exposure (PE) combined provider responses to items assessing frequency provider asks “client to recount the traumatic event(s) aloud repeatedly, including telling you the details of the event, their thoughts, and feelings” and “either [asking] the client to listen to recording of his or her recounting of the traumatic event, or work on in vivo exposure tasks in between sessions;” cognitive processing therapy (CPT) combined provider frequency of “(asking) the client to write about the meaning of his or her traumatic event and how it has changed them” and “(asking) the client to complete self-monitoring homework through Antecedent Behavior Consequence (ABC) worksheets, identifying the connection between events, thoughts, and feelings”; eye movement desensitization and reprocessing therapy (EMDR) assessed providers’ frequency of “(having) the client focus on the traumatic image, negative thoughts, and body sensation while either (a) moving his/her eyes back and forth/laterally tracking your finger, or (b) tracking auditory tones, tapping or other tactile stimulations.” Specific core components for SIT were not assessed

### Treatment Practices of Prescribers by State and Provider Type

Table 3 summarizes treatment practices among prescribers treating PTSD patients in the community sample. The percentage of community sample prescribers who reported prior training in appropriate prescribing for PTSD patients varied by specialty, with prior training reported by more than three fourths of psychiatric specialty care providers but fewer than half of primary care providers.

**Table 3**

Prescriber practices among community sample providers who prescribe for PTSD patients at least occasionally

Evidence <sup>c</sup>	Psychiatric specialty (% (SE))		Primary care (% (SE))	
	Texas (n = 54)	Vermont (n = 37)	Texas (n = 25)	Vermont (n = 47)
Have previously received training in appropriate prescribing for PTSD patients	76.2 (7.5)	96.3 (1.6) <sup>*a</sup>	45.3 (13.3)	18.0 (6.1) <sup>*b</sup>
Medication practices (prescribe this type drug often or always)				
Indication: PTSD				
SNRI and/or SSRI	91.4 (5.0)	85.3 (6.5)	63.9 (13.9) <sup>*b</sup>	71.0 (8.0)
Tricyclics, MAOIs, and/or nefazodone/mirtazapine/trazadone	51.0 (8.5)	29.3 (8.4)	48.8 (15.7)	29.0 (8.0)
Prazosin	43.7 (8.5)	58.5 (9.3)	7.0 (3.8) <sup>*b</sup>	7.7 (4.3) <sup>*b</sup>
Benzodiazepines	10.5 (5.3)	2.5 (1.3) <sup>*a</sup>	15.1 (13.0)	12.9 (6.4) <sup>*b</sup>
Anticonvulsants	17.6 (5.3)	10.9 (6.3)	17.4 (13.1)	9.0 (5.5)
Antipsychotics (e.g., risperidone)	24.2 (7.1)	14.7 (6.5)	4.7 (3.2) <sup>*b</sup>	0.9 (0.9) <sup>*b</sup>
Dibenzo derivatives	27.5 (7.3)	33.3 (9.2)	9.3 (4.3) <sup>*b</sup>	5.9 (4.1) <sup>*b</sup>
Antiadrenergics	18.0 (6.3)	35.3 (9.2)	2.3 (2.3) <sup>*b</sup>	11.7 (5.7) <sup>*b</sup>
Indication: sleep				
Prazosin	47.9 (8.7)	57.3 (9.3)	7.0 (3.8) <sup>*b</sup>	2.8 (1.5) <sup>*b</sup>
Zolpidem, eszopiclone, diphenhydramine, trazadone, and/or hydroxyzine	71.9 (8.1)	61.1 (9.3)	43.1 (13.8)	44.6 (8.9)
Benzodiazepines	10.9 (5.4)	0.0 (0.0)	22.6 (15.3)	12.6 (6.7)
Indication: pain				
NSAIDs	11.9 (4.1)	31.1 (9.1) <sup>*a</sup>	70.9 (13.8) <sup>*b</sup>	81.5 (6.8) <sup>*b</sup>
Gabapentin, tramadol, acetaminophen, NSIADs	26.9 (6.8)	59.4 (9.6) <sup>*a</sup>	80.2 (13.3) <sup>*b</sup>	87.5 (5.7) <sup>*b</sup>
Opioids	3.5 (3.5)	0.0 (0.0)	19.8 (13.3)	4.9 (4.0)
Guideline-concordant prescribing				

**Table 3**  
(continued)

	Evidence <sup>c</sup>	Psychiatric specialty (% (SE))		
		Texas (n = 54)	Vermont (n = 37)	Primary care (% (SE))
for patients with PTSD (%)				Vermont (n = 47)
Optimal		43.5 (8.4)	24.5 (7.6)	36.1 (13.9)
Neither optimal nor suboptimal		0.0 (0.0)	4.8 (4.6)	2.3 (2.3)
Suboptimal		56.5 (8.4)	70.7 (8.4)	61.6 (13.9)

Level A, strong recommendation with no significant benefit; level B, fair evidence with some benefit; level C, no recommendation with unknown benefit; level D, inefficient or harmful with no benefit; level I, insufficient evidence with unknown benefit

\*Significant difference in proportion at 0.05 level of significance

<sup>a</sup>Significant difference by state, i.e., between prescribers of the same type (e.g., VT psych specialty compared with TX psych specialty)

<sup>b</sup>Significant difference by provider type, i.e., between psychiatric specialty and primary care in the same state

<sup>c</sup>Evidence of strength of recommendation from The Management of Post-Traumatic Stress Working Group<sup>2</sup>

**Table 4**

Psychotherapist treatment practices, among providers who treat PTSD patients at least occasionally, comparing VCP-authorized to non-VCP authorized

<b>Therapies used by psychotherapists (% (SE))</b>	<b>VCP authorized (n = 77)</b>	<b>Non-VCP authorized (n = 226)</b>
Provide education on stress response in PTSD (often/always)	87.0 (3.8)	84.9 (2.4)
Teach skills for coping with PTSD symptoms (often/always)	93.4 (2.8)	95.1 (1.5)
Conduct therapy for PTSD using a treatment manual (often/always)	20.8 (4.6)	14.8 (2.4)
Guideline-recommended treatment (GRT) used with clients with PTSD (%)		
Prolonged exposure (PE)	6.5 (2.8)*	12.8 (2.2)
Cognitive processing therapy (CPT)	41.6 (5.6)	39.4 (3.3)
Eye movement desensitization and reprocessing (EMDR)	19.5 (4.5)	19.9 (2.7)
Stress inoculation therapy (SIT)	5.2 (2.5)	6.2 (1.6)
At least one of the above	53.3 (5.7)	55.8 (3.3)
GRT used and have received supervision or advanced training/certification (%)		
PE	6.5 (2.8)	8.4 (1.9)
CPT	22.1 (4.7)	18.6 (2.6)
EMDR	14.3 (4.0)	16.4 (2.5)
SIT	2.6 (1.8)	3.1 (1.2)
At least 1 of the above	37.7 (5.5)	35.0 (3.2)
At least 1 GRT used and supervised/trained/certified and follow treatment manual (often/always (%))	14.3 (4.0)	8.4 (1.9)

Data presented un-weighted; method for selecting therapists to answer survey was different for each group due to source of data. Community sample respondents who reported VCP participation were included in the VCP-authorized group for the purpose of comparative analysis

\*Significant difference in proportion at 0.05 level of significance

First-line recommended SSRIs and SNRIs were the most commonly prescribed medications for patients with PTSD across all prescriber types, although primary care providers in Texas were significantly less likely than psychiatric specialty care providers in the state to report consistent use of SSRIs or SNRIs with PTSD patients. Fewer than 15% of prescribers reported commonly (often or always) prescribing benzodiazepines for PTSD symptoms; psychiatric specialty care providers in Vermont were significantly less likely to prescribe benzodiazepines for PTSD than all other prescriber groups. Psychiatric specialty care providers were significantly more likely than primary care providers to report frequent use of antipsychotics, antiadrenergics, and dibenzothiapine derivatives for PTSD symptoms; they were also significantly more likely to report prescribing prazosin for PTSD and sleep-related symptoms.

Across community sample prescribers in both states, suboptimal prescribing patterns for PTSD were reported more frequently than optimal prescribing patterns, except among Vermont primary care providers.

## Treatment Practices of Psychotherapists by VCP Authorization

Table 4 summarizes treatment practices among VCP-authorized and non-VCP-authorized psychotherapists treating PTSD patients. More than half of psychotherapists reported using at least one GRT for clients with PTSD. Psychotherapists authorized under VCP were less likely than providers not authorized under VCP to use PE with their clients with PTSD. In all other aspects, practices among VCP-authorized psychotherapists were similar to those of the non-VCP-authorized group.

## Treatment Practices of Prescribers by VCP Authorization.

Table 5 summarizes treatment practices among VCP-authorized and non-VCP-authorized prescribers treating patients with PTSD. About three fourths of prescribing providers reported using first-line SNRIs and SSRIs for PTSD. Significantly more of the non-VCP-authorized providers reported use of prazosin for PTSD symptoms; however, all providers authorized under VCP reported the use of prazosin for sleep-related concerns. Overall, nearly three fourths of VCP-authorized providers reported optimal guideline-concordant prescribing for patients with PTSD, while more than half of non-VCP-authorized providers reported suboptimal prescribing for PTSD.

**Table 5**

Prescriber practices among providers who prescribe for PTSD patients at least occasionally, comparing VCP-authorized to non-VCP-authorized

	Evidence <sup>a</sup>	VCP-authorized (n = 14)	Non-VCP-authorized (n = 166)
Have previously received training in appropriate prescribing for PTSD patients (% (SE))		38.5 (13.5)	57.7 (3.9)
Medication practices (prescribe this type drug (often or always)) (% (SE))			
Indication: PTSD			
SNRI and/or SSRI	Level A	71.4 (12.1)	78.3 (3.2)
Tricyclics, MAOIs, and/or nefazodone/mirtazapine/ trazadone	Level B	28.6 (12.1)	39.8 (3.8)
Prazosin	Level C	7.1 (6.9)*	35.0 (3.7)
Benzodiazepines	Level D	21.4 (11.0)	8.5 (2.2)
Anticonvulsants	Level D	7.1 (6.9)	15.2 (2.8)
Antipsychotics (e.g., risperidone)	Level D	7.7 (7.4)	15.4 (2.8)
Dibenzo derivatives	Level I	14.3 (9.4)	22.0 (3.2)
Antiadrenergics	Level D or I	14.3 (9.4)	18.3 (3.0)
Indication: sleep			
Prazosin	Level B	100 (0.0)*	34.0 (3.7)
Zolpidem, eszopiclone,	Implied	50.0 (13.4)	64.2 (3.7)

**Table 5**  
(continued)

	Evidence <sup>a</sup>	VCP-authorized (n = 14)	Non-VCP-authorized (n = 166)
diphenhydramine, trazadone, and/or hydroxyzine	Level B		
Benzodiazepines	Level D	21.4 (11.0)	8.1 (2.2)
Indication: pain			
NSAIDs	Level B	78.6 (11.0)*	48.2 (3.9)
Gabapentin, tramadol, acetaminophen, NSIADs	Any level B	85.7 (9.4)*	63.4 (3.8)
Opioids	Level C	7.1 (6.9)	4.3 (1.6)
Guideline-concordant prescribing for patients with PTSD (%):			
Optimal		71.4 (12.1)*	44.6 (3.9)
Neither optimal nor suboptimal		0.0 (0.0)	1.8 (1.0)
Suboptimal		28.6 (12.1)*	53.6 (3.9)

Data presented un-weighted; method for selecting therapists to answer survey was different for each group due to source of data. Community Sample respondents who reported VCP participation were included in the VCP-Authorized group for purpose of comparative analysis

Level A, strong recommendation with no significant benefit; level B, fair evidence with some benefit; level C, no recommendation with unknown benefit; level D, inefficient or harmful with no benefit; level I, insufficient evidence with unknown benefit

\*Significant difference in proportion at 0.05 level of significance

<sup>a</sup>Evidence of strength of recommendation from The Management of Post-Traumatic Stress Working Group<sup>2</sup>

## Discussion

The findings presented here raise important questions for understanding the quality of VCP care available for veterans with PTSD in community settings. Relatively few community-based providers reported using guideline-recommended psychotherapy or prescribing practices when compared with studies of GRT use in the VA.<sup>4,14</sup> Among psychotherapists, the use of GRTs initially appeared promising, with more than half reporting use of at least one guideline-recommended psychotherapy for patients with PTSD. Closer inspection revealed that fewer psychotherapists reported use of core components for the GRT(s) they use, having received supervision or advanced training in the GRT(s) they use, or consistently following a PTSD treatment manual. This finding substantiates anecdotal reports from VA mental health leadership regarding the challenge of finding community providers willing and able to provide GRTs for veterans with PTSD who have been referred out under VCP.

Substantial variation in treatment practice was found among prescribers. Although first-line recommended SSRIs and SNRIs were frequently used, suboptimal prescribing for PTSD patients was reported more commonly than optimal prescribing across community sample providers. Despite being contraindicated as potentially harmful for patients with PTSD,<sup>2</sup> benzodiazepines were prescribed “often” or “always” for patients with PTSD by 15% of providers overall, and by 20% when prescribing for sleep-related symptoms was taken into account. Interestingly, psychiatric specialty was not a guarantee of optimal prescribing. Psychiatric specialty care providers reported more frequent prescribing of prazosin for sleep/

nightmares, as recommended, but also of antipsychotics, antiadrenergics, and dibenzothiazepine derivatives, for which the evidence is inconclusive or suggests potential harm. This may reflect more severe illness and/or comorbidity among their patient population. On a positive note, VCP-authorized prescribers, although a small group ( $n=14$ ), were significantly more likely than non-VCP-authorized prescribers to report optimal prescribing for PTSD. Overall, the findings presented here are consistent with prior work finding greater use of guideline-concordant mental health prescribing among VA than non-VA clinicians,<sup>14</sup> and compare poorly with studies that indicate VA providers report regular (although not invariable) use of guideline-recommended psychotherapies for PTSD.<sup>3,4,17</sup>

It has been previously reported, but remains worthy of note, that a majority of respondents across both community and VCP-authorized samples reported treating veterans within the prior year<sup>1</sup>; this finding underscores the fact that veterans commonly receive treatment for PTSD and other conditions in non-VA settings whose providers may have varying levels of training and experience in appropriate care.<sup>7-9,25</sup> In addition to care reported by VCP-authorized providers, a small number (less than 10%) of community sample providers also reported receiving VA reimbursement for care of veterans under other mechanisms, including fee basis and PC3. As the VA expands its use of VCP and similar mechanisms for delivery of community-based care, it will be important to consider how best to ensure the quality of such care, and how best to apply those efforts across all existing mechanisms.

There are several limitations of the current study. First, the response rate of 21% is modest, although generally consistent with mental health provider response rates for practice assessment surveys,<sup>6,18,26</sup> and with declining provider survey response rates more generally.<sup>27</sup> Lower rates among VCP-authorized providers may reflect previously reported inaccuracies in provider network lists during early implementation.<sup>1</sup> It was not possible to determine whether mail-based surveys were received by the targeted provider, particularly those operating in hospital- or clinic-based settings; in calculating the response rate, it was assumed that all mailed surveys were received unless confirmed otherwise by returned mail.

Regardless, results may overestimate the number of providers serving veterans, as respondents may have been more likely to respond because of particular interest in caring for veterans. Similarly, these data may suggest a “best case” for use of GRTs, as responding providers may have specific interest in use of GRTs or care for those with PTSD. In addition, findings regarding use of GRTs are based on self-report and may not provide an accurate reflection of clinical practice. These data cannot speak directly to the quality of PTSD care under VCP, both because the measures used to characterize guideline-recommended psychotherapy and prescribing are subject to error, and because so few providers reported participating in the VCP. Given these limitations, it is important to remain cautious regarding the generalizability of findings; nonetheless, the data presented here raise important questions regarding how best to ensure the highest possible quality of care for veterans receiving PTSD care in community settings.

Although achieving universal guideline-recommended psychotherapy and prescribing for PTSD remains an ongoing challenge at the VA,<sup>4</sup> the VA has made significant investment in building provider capacity to deliver high-quality PTSD care, and few providers in community settings are likely to have comparable training or experience in use of GRTs for PTSD, or in their application among veterans. Moreover, the availability and treatment strengths of local providers may vary by region, suggesting VA medical centers may need to engage in local assessments to identify provider capabilities and/or training needs in their area. Given that few significant differences emerged between psychologists and master-level psychotherapists in reported use of GRTs, master-level providers may represent important potential partners in strengthening provider networks, particularly in rural or provider shortage areas.

## Implications for Behavioral Health

These findings raise critical questions regarding how best to ensure that veterans accessing VCP care for PTSD in community settings receive psychotherapy and/or prescribing that is consistent with guideline recommendations. VCP was initially implemented as a means of increasing veterans' access to timely and convenient care; however, as growing numbers of veterans receive VA-paid care in community settings ("community care"), the question of how to assess and ensure the quality of community care remains challenging and essential. PTSD may offer one example of the kind of complex condition that is more common among veterans, for which VA providers are likely to have greater experience and training than are community-based clinicians, similar to traumatic brain injury or Agent Orange exposure. For such conditions, the greatest benefit may result from further expanding the VA's ability to provide care, whether through growing the workforce and/or investing in telehealth capacity. Additional options include ensuring VCP-authorized providers meet basic training requirements, offering additional training in guideline-concordant care to VCP-authorized providers, and developing system- and provider-level mechanisms for monitoring and improving care quality (e.g., through administrative data review or audit and feedback). The nation's veterans deserve high-quality care delivered when and where they need it. It is likely to require ongoing effort, continuous evaluation, and partnership across the full spectrum of VA and community-based service providers to ensure these standards are met.

*Disclaimer* The views expressed are those of the authors and do not reflect the official views or policy of the Department of Veterans Affairs (VA) or US Government.

*Conflict of Interest* The authors declare that they have no conflict of interest.

**Funding Information** We gratefully acknowledge funding received through the VA Quality Enhancement and Research Initiative (QUERI; PEC 15-243), in partnership with the VA Office of Analytics and Business Intelligence. We would like to extend special thanks to Dr. Amy Kilbourne and Dr. Joseph Francis for their support throughout the course of this work. During manuscript preparation, Dr. Finley was also supported by the VA-funded EMPOWER QUERI program (QUE 15-272).

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