Analysis of Psychiatric Care and Prescribing Patterns for Patients with PTSD Treatment in a Federally Qualified Health Center

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Introduction

- Posttraumatic stress disorder (PTSD) has a lifetime prevalence of 6.8%, with prevalence about three times more common in females than males.[1]
- The lifetime prevalence of PTSD is found to be highest among Black/African Americans, followed by Caucasian, Hispanic, and Asian reported races.[2]
- Rates of depression and substance use disorders (SUDs) are higher in patients with PTSD.[3,4]
- Psychotherapy remains the mainstay treatment recommendation within PTSD guidelines, and consistency of pharmacotherapy treatment recommendations is lacking.

Objectives

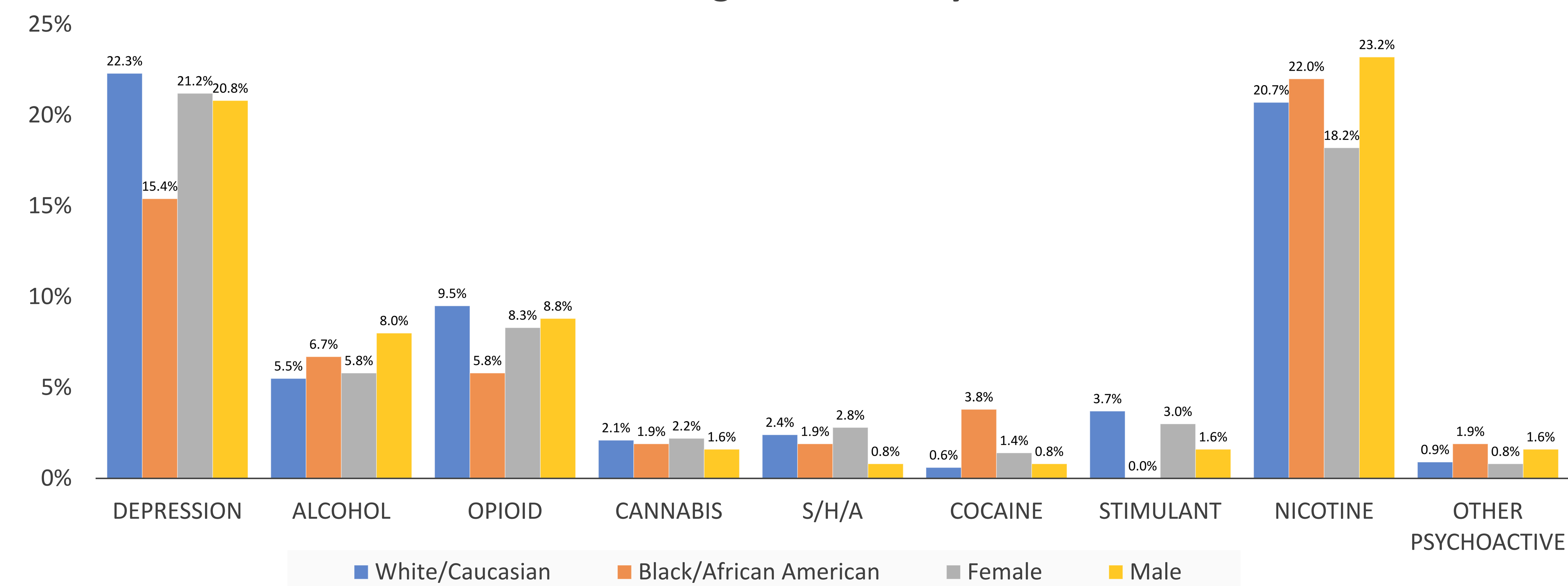
- Primary objective: to explore PTSD pharmacotherapy prescribing patterns at a federally qualified healthcare center (FQHC).
- Secondary objectives:
  - To assess the prevalence of co-occurring major depressive disorder (MDD) and SUDs in patients diagnosed with PTSD.
  - To compare the prevalence of these co-occurring disorders based upon:
    - Sex identified within the FQHC electronic health record (EHR)
    - Race and ethnicity

Methods

- IRB approval obtained from both SIUE and FCHC Review Boards
- Study Design: Retrospective Chart Review
- Data Source: FQHC EHR
- Study Period: July 12, 2020 – July 12, 2021
- Inclusion Criteria: Any patient receiving active treatment at this FQHC with a diagnosis of PTSD (ICD-10 code F43.1) during the study period
- Data Collected: One year of prescribing data, prescriber type, ICD-10 diagnosis codes for depression (F33) and SUDs, and patient demographics (race, ethnicity, sex, birth year)
  - ➢ Prescribers divided into 2 categories:
    1. Behavioral health (BH): 1 psychiatrist, 1 psychiatric pharmacist
    2. Non-behavioral (primary care): 25 PCPs, 18 family medicine residents
  - ➢ SUDs included: alcohol (F10), opioid (F11), cannabis (F12), sedative/hypnotic/anxiolytic (F13), cocaine (F14), stimulant (F15), hallucinogen (F16), nicotine (F17), inhalant (F18), and other psychoactive substances (F19)

References:
1. The National Institute of Mental Health. Post-Traumatic Stress Disorder (PTSD). National Institute of Mental Health (NIMH). Accessed January 8, 2022. https://www.nimh.nih.gov/health/statistics/post-traumatic-stress-disorder-ptsd
2. Roberts AL, Gilman SE, Breslau J, Breslau N, Koenen KC. Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. Psychol Med. 2011;41(1):71-83. doi:10.1017/S0033291710000401
3. McCauley JL, Killeen T, Gros DF, Brady KT, Back SE. Posttraumatic Stress Disorder and Co-Occurring Substance Use Disorders: Advances in Assessment and Treatment. Clin Psychol Publ Div Clin Psychol Am Psychol Assoc. 2012;19(3). doi:10.1111/cpsp.12006
4. Rytwinski NK, Scur MD, Feeny NC, Youngstrom EA. The co-occurrence of major depressive disorder among individuals with posttraumatic stress disorder: a meta-analysis. J Trauma Stress. 2013;26(3):299-309. doi:10.1002/jts.21814

Results

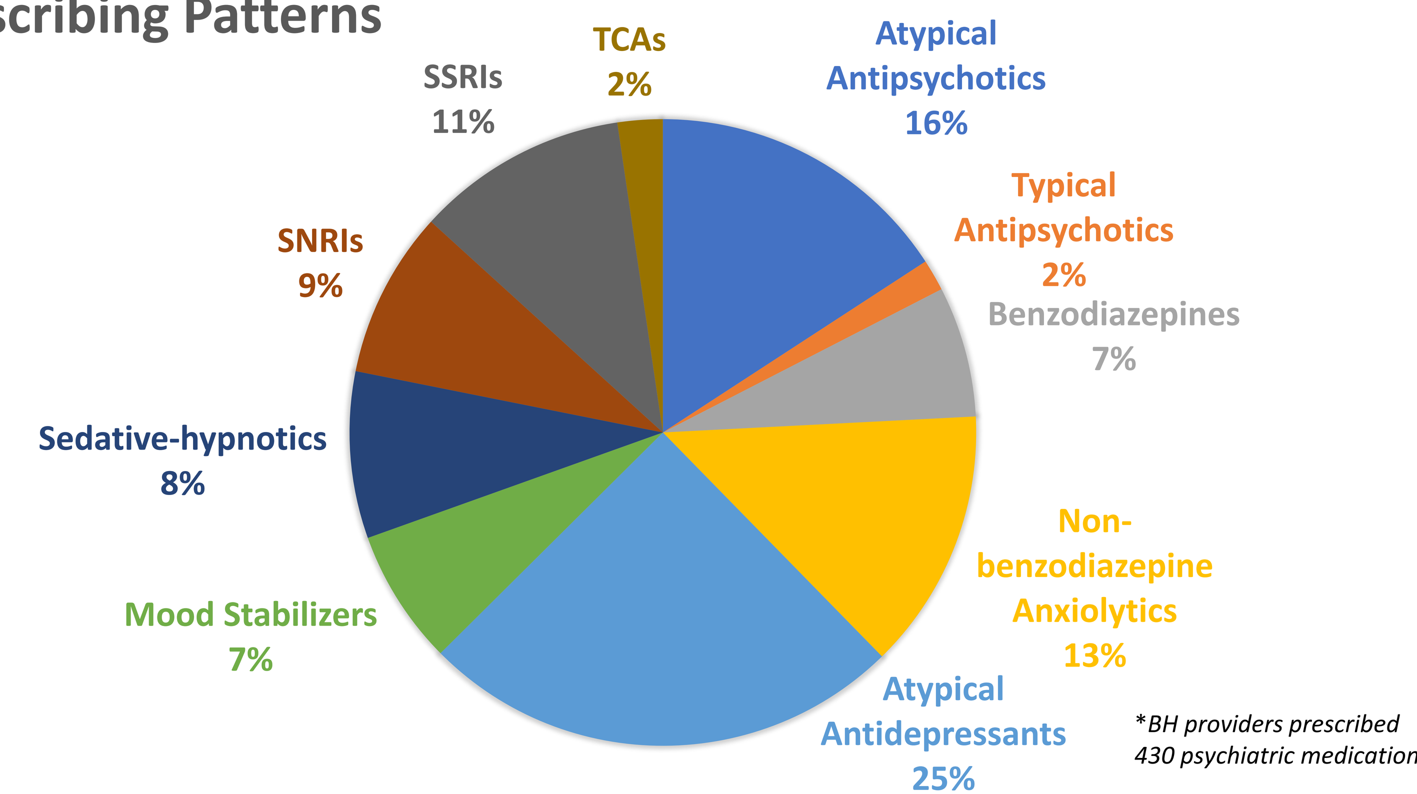


*The FQHC EHR is limited to reporting only biological sex at birth. Non-cisgender patients are not accurately represented through this reporting

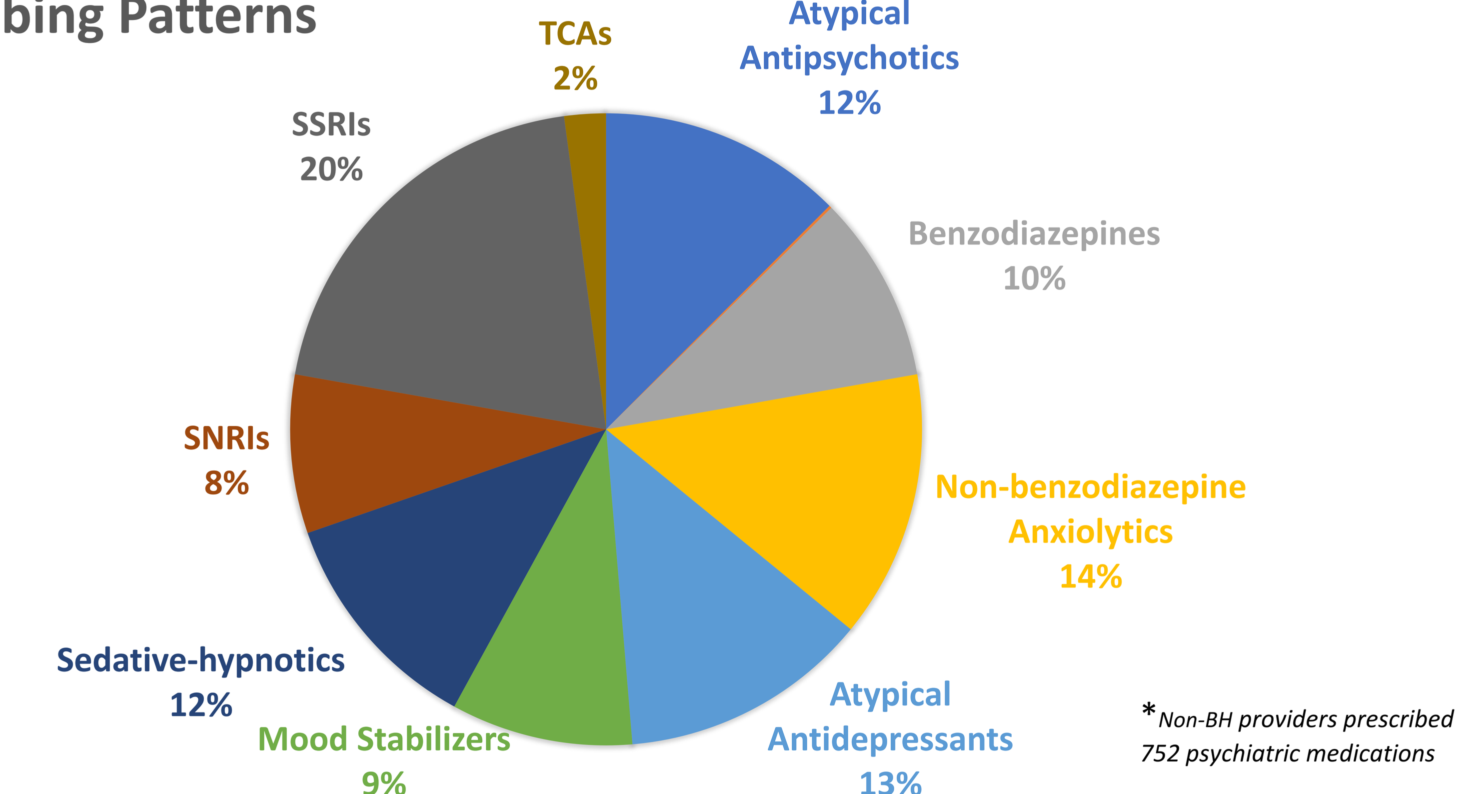
*Race and ethnicity are not always captured within the FQHC EHR

→White/Caucasian: n = 328 (70%)
→Black/African American: n = 104 (21.2%)
→Female: n =363 (74.1%)
→Male: n = 125 (25.5%)

BH Provider Prescribing Patterns



Non-BH Provider Prescribing Patterns



Discussion

- White/Caucasian race represented the highest patient population diagnosed with PTSD.
- Overall, non-BH provider prescribing more closely matched current treatment guidelines.
  - Non-BH providers were more likely to prescribe SSRIs
  - BH providers were more likely to prescribe atypical antidepressants (e.g.- mirtazapine, bupropion, trazodone).
- The results of this study likely reflect the integrated healthcare model of this FQHC: non-BH providers are encouraged to initiate 1st -line treatments for PTSD and then refer to BH providers with more refractory patient cases.

Limitations / Recommendations

Limitations:
- Unable to account for previously trialed psychiatric medications.
- Inconsistency and lack of diagnosis codes attached to prescriptions.
- Only 2 BH providers represented at this FQHC.

Recommendations:
- More routine screening for trauma exposure, PTSD, and SUDs among ALL patient races and ethnicities within primary care settings.
- More consistent prescribing of SSRIs with greater evidence for efficacy in PTSD (e.g.- sertraline, fluoxetine, and paroxetine).
- De-prescribing of benzodiazepines in patients with a diagnosis of PTSD.