PTSD 101
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COURSE TRANSCRIPT FOR:
VA/DoD Clinical Practice Guideline for Management of Traumatic Stress
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Slide 1: VA/DoD Clinical Practice Guideline for Management of Traumatic Stress

Welcome to this presentation on the VA/DoD Clinical Practice Guidelines for the Management of Traumatic Stress. This is Dr. Harold Kudler. I am Coordinator for VISN 6 Mental Health Service Line and Co-Chair of the VA Under Secretary for Health's Special Committee on PTSD. Dr, Ruzek: And this is Joseph Ruzek. I am the Associate Director for Education at the National Center for PTSD in the VA Palo Alto health care system.

Slide 2: VA/DoD Clinical Guidelines

The VA/DoD Clinical Practice Guidelines are recommendations for the performance or exclusion of specific procedures or services for specific disease entities. In this case, problems related to survivors of severe psychological trauma.

These recommendations have been derived through a rigorous methodological approach, which we will describe. It has included a systematic review of the world literature to outline recommended clinical practices.

The guidelines are represented in the form of a flow chart algorithm, which means that they are prepared in such a way as to answer specific clinical questions within a finite number of steps.

Slide 3: VA/DoD Clinical Practice Guidelines for the Management of Posttraumatic Stress Disorder in Primary Care

You are looking at one section of the Clinical Practice Guideline algorithm and I can understand that it may not look exactly like a finite number of steps. You can reach this clinical practice guideline on the website—and we will be giving you the address at the end of this presentation—and it will take you to these flowchart designs. Let me explain a little about this particular flowchart section that you are looking at.

This one is for the management of Posttraumatic Stress Disorder in primary care settings. It opens with a box numbered—Box Number 4 in the upper left hand corner. This represents a state box. You will notice that the slightly curved edges. A state box says that a patient is in a particular situation or condition at this point in the algorithm. In this case, the patient is

presenting to a primary care clinic with symptoms suggestive of PTSD, which have been picked up on screening in the waiting area.

The arrow takes you to Box Number 6, which is a procedure box. In this case, the procedure is to assess dangerousness to self or others, based on observations. If you were to click on that box in the website, it would take you to a set of recommendations for how to go about that particular procedure.

The arrow then takes you to the next box, which is a decision box in hexagonal form. You get to decide which way in the algorithm you are going to proceed now. The question in this particular decision tree box is "is the patient dangerous to self or others, or in danger, or medically unstable." If the answer is yes, proceed to the right. And if the answer is no, proceed down.

Again, when you are in the Clinical Practice Guideline on the website, you will find that by clicking on one of these boxes, you will get full annotations and references, as well as an evidence table for each of the recommendations made.

On the right hand side of this slide you will also notice a box that says, "Symptom Clusters." Every once in a while, you will find these kinds of glossed statements in the Clinical Practice Guideline and they were provided there by the creators of the Guideline to give information that we felt might be of interest to many of the people reading. In this case, we thought it might be helpful to have a very brief summary of the symptom clusters of PTSD.

Slide 4: VA/DoD Clinical Guidelines

As you can see the VA/DoD Clinical Practice Guidelines are a potential solution to inefficiencies and inappropriate variations in care. Clinical Practice Guidelines are educational tools very much like textbooks or journals, but in a more user-friendly format. They are designed to inform and support clinicians, but not to constrain them.

In other words, a guideline offers ideas that a clinician might use, but they always have to be applied in a context of an individual provider's clinical judgment for the care of that particular patient.

Slide 5: The Process

Let me say a word about the process by which these guidelines were created.

The entire Clinical Practice Guideline series for VA and DoD was originally initiated by the Director of Quality and Performance for VA and the Chief for Outcomes Management and Practice Guideline Project Officer for the United States Army.

The actual orchestration of each individual guideline was orchestrated by a medical education specialist and a team from ACS Federal Health Care, Incorporated. And, they have been involved in the creation and construction of each of the VA/DoD Clinical Guidelines.

Slide 6: The Process

Early on in the process, LTC Bruce Crow, a psychologist of the U.S. Army, and Dr. Harold Kudler, myself, were identified as clinical champions for our respective departments. We were asked to work with the team from ACS to develop a list of research questions that would be pertinent to the construction of this particular guideline and those questions that initiated a pertinent literature review.

We were then asked as clinical champions to identify and convene a work group for a week-long meeting.

Slide 7: The Work Group

The DoD was represented on the work group by members of the Army, Navy and Air Force and the Department of Veterans Affairs was represented by staff of VA medical centers around the country, Readjustment Counseling Service and the National Center for PTSD.

Many disciplines were represented in the work group team and they included psychiatrists, primary care physicians, psychologists, nurses, pharmacists, occupational therapists, social workers, counselors, chaplains and administrators.

Slide 8: The Goal

Our overall goal was to create an algorithm to aid field personnel and health care workers in identifying, assessing and/or treating survivors of traumatic events.

This trauma may be related to combat, to peacekeeping operations and humanitarian efforts, to disaster response, to sexual or domestic abuse-- whether it was endured prior to, or during military service, or to a terrorist attack.

The Clinical Practice Guideline is unique in that it offers a decision tree for the prevention, assessment, and treatment of a variety of posttraumatic disorders with full annotation across a broad range of those disorders.

Slide 9: The Challenges

A number of challenges had to be addressed in creating the Clinical Practice Guideline.

First of all, there was a need to address a full range of posttraumatic reactions and disorders. The work group was quite aware that if we simply created a guideline for posttraumatic stress disorder it would be inadequate to deal with the range of problems one can expect to encounter in DoD and VA settings. Therefore, this is the Clinical Practice Guideline for the management of traumatic stress responses.

Among the disorders that we took on was one which the Army and other military components have identified over the years, but which is not an official DSM diagnosis. And this is combat stress response, also called combat and/or operational stress response and abbreviated as COSR.

This can also be called acute stress response in a non-military setting. Acute stress responses or COSR happen in the first two to four days after a traumatic stress. Acute stress disorder, which is defined in the DSM-IV (four), cannot be diagnosed for the first four days after an acute stress and it usually includes the symptoms of PTSD, plus a Dissociative response. For details, please see the DSM.

The group also had to tackle PTSD in its many forms, include acute PTSD, chronic PTSD, PTSD with co-morbid major depression and/or co-morbid substance abuse, complex PTSD which, for this purpose, can be defined as PTSD which has taken on characterological elements as well as the more classic PTSD elements as described in DSM-IV.

Complex PTSD is often associated with early life trauma, but can also accompany adult life trauma, which then becomes complicated by characterologic changes in the course of adaptation to that trauma.

Finally, the work group addressed negative health behaviors known to adversely affect clinical outcomes in people who have PTSD.

Slide 10: The Challenges

Among the other challenges is the fact that the research literature has yet to investigate a number of pertinent questions.

For example, it is not yet clear whether combined treatments, such as combining psychotherapy and a pharmacologic approach are more effective than simply doing one or the other treatment by itself. It is not clear whether a treatment that is known to be effective for combat veterans with PTSD would be equally useful for survivors of another kind of trauma, such as a recent sexual assault. Further, research on the treatment of PTSD with and without other co-morbid disorders is still in its infancy.

Slide 11: Formulating Recommendations

Because of these limitations, certain consensus rules had to be created in creating Clinical Practice Guideline. Whenever possible, the work group agreed that recommendations would be based on research findings. There are, however, many areas in which the team has no choice but to offer expert consensus as a basis for action. And this is clearly indicated in each such decision.

Slide 12: Defining Terms

A complete set of annotations is provided for each point made in the guidelines and taken together they create a very effective glossary for those who use the guideline and may not be familiar with particular terms, procedures or clinical concepts.

The annotations can be accessed directly from the algorithm flowchart by clicking on a box in which the issue is brought up. Each annotation includes a full set of references and an assessment of the strength of the recommendation made.

Slide 13: Example of An Evidence Table

Here we have an example of an evidence table. And in this case, it is the evidence table regarding psychodynamic psychotherapy. Four specific recommendations are made.

The first is that psychodynamic psychotherapy may be useful for the treatment of PTSD. The reference in the literature for making this recommendation is offered and the quality of the evidence offered in that particular reference is graded at a Level 1 in this case, which indicates that this comes from a randomized, double-blind clinical trial.

The overall quality of this reference is given as a "Good" and there is a grade B overall rating for this particular reference. The grade B rating comes from a decision made by the work group, who pointed out that while this is by definition a randomized, double-blind control trial of good overall quality, the work group felt that there were limitations to the design of the study to keep it from being higher than a grade B rating.

Such decisions were made with regard to each of the recommendations and you will find them laid out in the body of the Clinical Practice Guideline.

Slide 14: Initial Evaluation and Triage: PTSD Screening Recommendations

The next slides will illustrate some of the kind of content of the guideline and give a flavor of what the guideline has to offer. As Dr. Kudler has made clear, all phases of trauma response are covered in these guidelines, starting with acute stress reaction and moving towards management of chronic PTSD.

The guideline also discusses management of PTSD in special mental health settings, but also management of traumatic stress and PTSD in primary care medical settings.

In this slide you can see the recommendations for PTSD screening in the guideline. And the fundamental points here are that all new patients are recommended to be screened for symptoms of PTSD and that screening should take place on an annual basis. But, if there is reason to be concerned about the patient, the screening should be done more often. For example, if a person had recent exposure to a trauma or a history of PTSD.

It is also recommended that paper and pencil screens be used and that is a practice that is not yet standard across all treatment settings within the VA.

The points about PTSD screening also illustrate the necessity of avoiding stigmatization screening and talk about the need for more detailed assessment as a follow-up to individuals who screen positively.

Slide 15: PTSD Pharmacotherapy Recommendations

In the management of more chronic PTSD, there are both pharmacotherapy recommendations and recommended psychotherapies. This slide illustrates some of the take-home messages summary statements for pharmacotherapy for PTSD.

And you can see that there are recommendations about single therapies, for example the SSRIs are strongly recommended. There are some guidelines about when to change medications, other types of medications that may be considered, augmented medications for targeted symptoms (such as nightmares). Prazosin is talked about in the guideline.

There are discussions of medication guidelines and how to assess for that. And there are also in these guidelines recommendations against various practices. For example, here it is recommended against using Benzodiazepines to manage the core symptoms of PTSD

Slide 16: Recommended PTSD Psychotherapies

Of great interest to clinicians are the recommended PTSD psychotherapies and the guideline mentions particularly four psychotherapies that receive a recommendation of "strongly recommended." And these are cognitive therapy, exposure therapy, stress inoculation training and eye movement desensitization reprocessing.

There are some therapies that are also mentioned and recommended, but not recommended quite as strongly, because the evidence space was considered not to be so strong for these therapies, such as imaging rehearsal therapy, psychodynamic therapy and patient education.

Slide 17: Cognitive Therapy

Amongst the most strongly recommended therapies are cognitive therapies. Cognitive therapy will be familiar to many clinicians who have learned about Beck's cognitive therapy for depression. But cognitive therapy is also being applied to PTSD and traumatic stress issues and has been found to be very effective.

Cognitive therapy represents a systematic approach to challenging the negative trauma-related beliefs that many of our trauma survivors carry with them—feelings of guilt: I should have prevented the trauma from happening, and so on.

But, cognitive therapy represents a very systematic way of going after these negative cognitions, starting with educating the patient about the role of beliefs in causing or maintaining his or her distress, going through a systematic identification of distressing beliefs that may be causing problems, going through a very careful review of the evidence for and against the beliefs, a discussion of their implications and a generation of alternative ways of looking at the situation.

And finally, moving on to systematic practice of new beliefs. A good example of this cognitive therapy approach is embodied in the cognitive processing therapy developed by Patricia Resick.

Slide 18: Exposure Therapy

Exposure therapy is also strongly recommended. This is the practice which involves repetitive exposure to the traumatic memory or to the traumatic stimuli which are continuing to cause distress for the survivor.

Imaginal exposure involves revisiting the event in imagination, usually through repeated retelling of the trauma story. And, while the person is talking about their traumas in detail, they are usually experiencing emotional activation, and that is important to the process.

Real world exposure, otherwise known as in vivo exposure, also compliments imaginal exposure. And in this procedure, patients are given the assignments as homework to confront their fear stimuli in a safe environment. So, for example, a woman who might fear visiting a cafeteria because she was sexually assaulted in a cafeteria might be encouraged to now confront that cafeteria in the future and learn to handle the emotion and distress that she experiences there.

Exposure therapy is characterized by multiple repetitions of exposure. This is usually accomplished by homework in which a patient is encouraged to listen to a cassette recording of his or her trauma narrative or to write down the experience on a repetitive basis as homework.

Slide 19: Stress Inoculation Training

More familiar and more used by clinicians, are a variety of approaches to stress management or anxiety management. One particular form of this, stress inoculation training, receives a strong recommendation in the guideline. This procedure was developed by Dr. Donald Michenbaum and is a skills approach to giving people skills to manage their anxiety.

These skills include muscular relaxation training, breathing retraining and a variety of other skills: assertion skills, role playing skills, thought stopping skills, and so on.

Slide 20: EMDR

The final strongly recommended psychotherapy is eye movement desensitization reprocessing, otherwise known as EMDR. This more recent therapy was developed by Dr. Francine Shapiro and has received careful investigation and has a strong evidence base.

It involves a number of complex procedures, but at base, patients are encouraged to identify a disturbing imaging which characterizes the worst part of their trauma for them, an associated body sensation and negative cognition, which is also connected with the worst moments of the trauma.

They are encouraged to hold that image and sensation in their mind while tracking the clinician's moving finger with their eyes for twenty seconds at a time. This refers to the eye movement process.

Through this process they begin to change their ways of processing the trauma and experience a reduction in posttraumatic stress symptomotology. Through repeated tracking episodes benefits may be obtained.

So EMDR has also received strong evidence support for its efficacy with PTSD.

Slide 21: Imagery Rehearsal Therapy

There are also a variety of other therapies, some of which are less familiar to the clinician, that are recommended or discussed in the guideline. An example is imagery rehearsal therapy, which is a relatively new treatment for nightmares related to trauma.

In this treatment, to describe very briefly, the patient selects a nightmare, is given the instruction that he or she can change the nightmare any way that they wish. Write down the nightmare with its new ending or new changes. Rehearse it on a daily basis. The treatment also involves education and the provision of tools for controlling imagery.

It has been found to be effective with nightmares and improving PTSD symptoms.

Slide 22: Evaluation of Treatment Effectiveness: Recommendations

The guideline also has many recommendations that refer not to specific psychotherapies, but more to the processes of conducting therapy.

A good example is its recommendations regarding the evaluation of treatment effectiveness. The guideline recommends the routine use of self-administered checklists in order to track and monitor the changes that the client may experience throughout treatment.

In particular, it recommends that follow-up status be routinely monitored at least every three months, using both interview and questionnaire methods. This process enables the clinician to more carefully evaluate the on-going success of his or her treatment methods and provides an opportunity for treatment to be changed if it needs to be modified throughout the course of therapy.

Slide 23: Acute Stress Reaction

In addition to the management of more chronic PTSD, the guideline also discusses early traumatic stress reactions, Acute Stress Reaction, and management of those.

In particular, it discusses Psychological First Aid as a series of pragmatic actions to help the survivor manage their acute stress reactions and provide for their basic needs. Here, you can see some of the points that are covered under Psychological First Aid, including providing for basic

survival needs, restoring sleep, connecting people with loved ones, and helping them find out about the personal safety of loved ones and friends.

Psychological First Aid has recently been manualized by the National Center for PTSD. For those who are interested in learning more about Psychological First Aid, the recently created manual can be obtained by visiting the National Center for PTSD website at www.ncptsd.va.gov.

Slide 24: Acute Stress Reaction

Here are some more of the psychological first aid actions to round out the approach. And, you can see that it includes recommendations to help the survivor take practical steps to resume ordinary life roles in day-to-day life, to resume family, community, school and work activities and to also help them manage problematic anxiety and to reduce that to manageable levels.

Slide 25: Immediate Crisis Intervention if…

In the acute stress phase, there are also some guidelines for immediate crisis intervention, which include things like extreme panic, intense grief. And there are some recommendations about what to do in those cases.

There is recommendation as well to pay attention to the cultural context of the emotional display. Because, for example, loud wailing in some cultures may not be an extreme response, but something that is culturally common and to be expected.

Slide 26: Psychological Debriefing

Common approaches to early intervention for trauma survivors are discussed in the guideline, and most notably there is an extended discussion and investigation of psychological debriefing. Debriefing is of course a widely practiced to helping disaster survivors, emergency mental health responders and other groups in the immediate aftermath of trauma.

The guideline, however, has reviewed the evidence and, along with emerging consensus in the field, has found that debriefing itself is not an effective intervention to prevent PTSD. It is true that operational debriefings and other forms of debriefing may accomplish some other kinds of objectives, organizational objectives for example of communicating interest in the employee or otherwise showing concern.

But, in general, the recommendation is that the evidence has shown that there is relatively little help and that in fact some potential harm may be done in prevention of PTSD.

Slide 27: Debriefing Recommendations

So, the debriefing recommendations include a variety of points. It is recommended against using psychological debriefing, specifically for managing acute stress reaction or posttraumatic distress. In other words, it is not an effective way of preventing PTSD.

Group debriefing, which is the usual way that most debriefing is provided, has not received as much investigation and so is recommended that there is insufficient evidence at the current time to recommend for or against structured group debriefing.

It is also expressed that there is some concern that compulsorily mandating that a person recount their traumatic experience within a group setting may be counterproductive. It may increase distress and potentially is felt to be harmful.

Group debriefing with pre-existing groups, such as emergency workers who work together, groups of firefighters and so on, may assist with group cohesion, morale or other goals, but this has not this has not been yet demonstrated empirically.

So, the overarching view is that group participation should be voluntary.

Slide 28: ASD and PTSD in Primary Care

There is also in the guideline extensive consideration of the primary care setting following the idea that it is believed it is very important to integrate mental health care into medical care inside VA and in other settings as well.

So, here it is recommended that in a primary care setting that people be screened for PTSD and if there is presumed PTSD or people screen positively, then it is important to follow-up with a more detailed assessment.

And there are guidelines on assessment that are provided. Some of the domains that are important to explore are listed here.

Slide 29: Primary Care Practitioners Encouraged to…

Primary care practitioners are encouraged to get heavily involved in the care process, both to formulate presumptive diagnosis, to consider the initiation of treatment or referral. They are encouraged to treat the associate complicating problems of pain or insomnia and so on. But to work closely with mental health, to refer to them if necessary, to consult with them on an on-going basis. But the idea is that the primary care practitioner should stay involved in treatment throughout the course of care.

Slide 30: Primary Care Encouraged to…

So, primary care practitioners are encouraged to screen for and provide for early recognition of PTSD, to support the survivor and in particular to also deliver PTSD-related education, to help the person understand their symptoms, the consequences that PTSD may be having for them and to explore with them practical ways of coping with their symptoms.

They should also be involved in regular follow-up and ongoing monitoring of the symptoms of their patients with PTSD.

Slide 31: Steps Toward Guideline Concordance

The guidelines themselves are a complex set of recommendations and so here we want to enumerate a few very simple but general steps toward greater accordance with the guidelines.

Simply describing the guideline in written form is of course not enough to encourage us all to move to practicing in a way that is concorded with it. So, we wanted to identify a few specific steps toward increasing guideline concordance among all of us who are clinicians inside VA.

In particular, we think that there are some very simple steps to improving assessment that may be taken. Those include taking steps to make sure that we systematically assess the war zone experiences of our patients. That we routinely screen in all settings for PTSD and trauma history. And that we move toward greater routine use of standardized initial and follow-up assessments, including using self-administered checklists. And to monitor treatment and evaluate the effectiveness of what we are doing with our patients.

It is also important that we also increasingly move toward the use of the "strongly recommended" treatments that have been discussed here today, including particularly prolonged exposure in cognitive therapy which, although they are listed in the guidelines separately, the most effective treatment involves combining those two approaches.

It is also important to increase the use of stress inoculation training in the EMDR.

For those of you who are interested in receiving consultation or finding ways of becoming trained in these more evidence-based treatments, please contact us and please feel free to contact me. You can see my email there.

Slide 32: Systematic Assessment of War-Zone Experiences

You can make some suggestions for systematically assessing war zone experiences. There now is available the Deployment Risk and Resilience Inventory developed by the Kings and Dr. Dawne Vogt and published in 2003.

Slide 33: Deployment Risk and Resilience Inventory

You can see from this listing of the various sub-scales of the Deployment Risk and Resilience Inventory that this instrument is a kind of one-stop-shopping to find out about war zone experiences. There are a couple of pre-deployment factors that are assessed, including prior stressors and childhood family environment. But there are a full ten different kinds of sub-scales regarding deployment in war zone factors that may effect posttraumatic stress symptomotology, including things like sense of preparedness, the living and working environment, concerns about life and family disruptions during deployment, sexual harassment and sexual assault experiences, and some of the factors that we know are directly related to PTSD, such as perceived life threat and other types of combat experiences.

Also included are such things as self-reports of nuclear, biological or chemical exposures.

Then finally, there are also some post-deployment, post-war factors, such as post-deployment social support, post-deployment stressors.

Slide 34: Importance of Screening for PTSD

Everywhere throughout the guideline is emphasized the importance of routine screening for PTSD. And of course, there are a number of tools available to us, including the OIF/OEF Clinical Reminder, the PC-PTSD four-item screener for PTSD that has been developed for use in primary care settings, and also the PTSD Checklist, which is a 17-item screener for PTSD that is more appropriate to specialized mental health settings.

So, the settings that need to include attention to screening, include not only our specialist mental health settings, but substance abuse, primary care settings and also the range of medical care settings where our patients with PTSD may be found.

Slide 35: Importance of Screening for Trauma History

No audio

Slide 36: Systematic Assessment and Outcome Evaluation

In mental health specialty care the stated goal of the guideline is to promote the use of standardized initial and follow-up assessments. And the guideline recommends the routine use of self-administered checklists and that such checklists be administered at least every three months using both interview and questionnaire methods.

Again, there are now tools that have been well-established that will help the clinician in monitoring his or her effectiveness in treatment and we strongly recommend that we all move toward greater assessment systemisticity as we provide care for our patients.

Slide 37: Planning for the Future 1

As Dr. Ruzek has pointed out, the Clinical Practice Guideline contains a good deal of advice about how to measure and monitor the status of your patient and then gauge their response to your interventions. In the same sense, it is important that the people who create guidelines and update them periodically are paying careful attention to outcome measures of the guidelines themselves.

What I mean here is that we need to know if the guideline is in fact being used and, if the guideline is being used, what difference is it making in the clinical response of patients. Among the clinical measures we are interested in are:

Are the guidelines actually helping to decrease the symptoms of service men, women and veterans with respect to Posttraumatic Stress Disorder, Acute Stress Disorder and Combat or Operational Stress Disorder?

Are they helping to decrease the comorbid conditions often associated with these posttraumatic disorders?

Is the use of the guideline associated with an overall decrease in health care utilization?

Is the use of the guideline associated with a decrease of overall morbidity and mortality in people who have been identified to have posttraumatic stress disorder? It is known that people with PTSD tend to have greater than the average morbidity and mortality.

And finally, is the use of the guideline preventing Posttraumatic Stress Disorder if, for instance, there is an earlier intervention at the point of combat and/or operational stress reaction or Acute Stress Disorder? Does that actually decrease the likelihood of developing acute or chronic PTSD? This of course is a core question as we deal with new combat veterans returning from Afghanistan and Iraq.

Slide 38: Planning for the Future 2

Another consideration in creating a Clinical Practice Guideline, that spans the entire DoD/VA continuum of care, is whether that guideline can be effectively integrated into the computerized medical record used in those two agencies. And at present, the fact is that many of the DoD's clinical records are still paper and that even where the Department of Defense is using computerized records, they are not yet interoperable, at least not fully, with VA's computerized patient record system. So, there are challenges that need to be overcome.

Ultimately, we would like to see in both DoD and VA computer systems a simple pop-up menu that would allow easy access to the guideline whenever a clinician encounters a patient in whom they suspect there are problems with traumatic stress disorders. We would like software that would automate the generation of clinical progress notes in the process of running the Clinical Practice Guideline.

In other words, once you pop up the guideline and see the boxes and begin to ask the questions and fill in the information, we would like to see software that would allow a computerized progress note to be generated automatically in the background as you pop in each bit of information. This would be a real time and trouble saver for clinicians and the fact is that, unless Clinical Practice Guidelines make clinical practice easier and more effective, they are simply not going to appeal to clinicians and they will not be used.

We would also like to see the ability to collect and grasp data along the course of each individual patient's treatment so that if I am a clinician and seeing a patient on the third visit, I would like to see, Where were they when they started with this particular course of treatment in terms of these symptoms? How have those symptoms progressed in response to treatment? Where are we getting good responses and where might I want to consider adjunctive treatment because there is a lag in response?

In addition, we would like to look across selected populations. Are new OEF/OIF veterans seen at a given medical center responding to treatment? Which particular treatments are they

responding to and which are they not responding to? Is one medical center getting better results than another medical center such that we could look at best practices that can be imported from one site to another?

Using the Clinical Practice Guidelines and a computerized medical record, these kinds of operations are possible, but they will require new computer software to make them do-able.

Ultimately, we would like to see the ability to generate studies of prevalence, of disease progression, of response interventions, whether they are of individual or an aggregated group. And we would like to assess the overall ability to prevent posttraumatic stress disorders through the use of Clinical Practice Guideline evidence-based measures.

It has also been suggested that we need software that will allow clinicians to integrate the Clinical Practice Guideline with the use of hand-held personal assistance devices. And, where that would be of practical value to clinicians, we would like to see that done.

Slide 39: What Can <u>You</u> Do?

In our final slide, we raise the question to you the audience what can you do to help? And we recommend that you use the Clinical Practice Guideline. It is available at the website seen on your screen.

We recommend that you make personal copies of the Clinical Practice Guideline and of its pocket cards and keep them updated. These pocket cards can be gotten through the Office of Quality and Performance of the VA and there is a link at the website where you can go directly there and begin to request the materials.

We hope that you will log on and join us in the use of the Clinical Practice Guideline and in its continuous improvement.

Thank you.