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)

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.

Results

Co-Occurring Conditions by Race and Sex

<table>
<thead>
<tr>
<th>Condition</th>
<th>White/Caucasian</th>
<th>Black/African American</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>25%</td>
<td>30%</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>10%</td>
<td>12%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Opioid</td>
<td>5%</td>
<td>6%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>SUDs</td>
<td>15%</td>
<td>20%</td>
<td>18%</td>
<td>22%</td>
</tr>
</tbody>
</table>

BH Provider Prescribing Patterns

- SSRIs 11%
- TCAs 2%
- Atypical Antipsychotics 16%
- Mood Stabilizers 7%
- Antidepressants 25%
- Mood Stabilizers 7%
- Antipsychotics 13%

Non-BH Provider Prescribing Patterns

- SSRIs 12%
- TCAs 2%
- Atypical Antipsychotics 12%
- Mood Stabilizers 9%
- Antipsychotics 13%

Discussion

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Limitations / Recommendations

• Unable to account for previously trialed psychiatric medications.
• Inconsistency and lack of diagnosis code 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.

References: