Performance in Practice:
Clinical Module for the Care of Patients With Posttraumatic Stress Disorder

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The American Psychiatric Association's (APA) Performance in Practice (PIP) clinical modules are designed to meet the requirements of the American Board of Medical Specialties (ABMS) and American Board of Psychiatry and Neurology (ABPN) Part IV of Maintenance of Certification (MOC), which will be in full effect by 2017. Part IV of the MOC, Practice Performance Assessment, is intended to assist in physicians' evaluation of the quality of care provided in their practice, compared with peers and national benchmarks, and to facilitate practice improvements through the incorporation of best evidence or consensus recommendations to improve patient care. Physicians are required to complete one PIP unit every 3 years. There are two components for each PIP unit: the Clinical Module, consisting of chart reviews of at least five patients in a specific category; and the Feedback Module, requiring collection of feedback surveys from at least five peers and five patients. The chart review displayed below is designed as a Clinical Module to facilitate physician practice assessment. The peer and patient feedback modules are beyond the scope of this report.

There are three stages involved in each PIP unit [ABPN 2013 – (1)]:

- STAGE A, the baseline retrospective chart review of at least 5 patients in a specified category, which is then compared with "published best practices, practice guidelines or peer-based standards"
- STAGE B, the design and implementation of a clinical practice improvement plan
- STAGE C, subsequent remeasurement via a second chart review of 5 patients within the same category within 2 years after the initial chart review. Although the MOC program requires the review of at least five patients as part of each PIP unit, it is important to note that larger samples, i.e. reviews of more than 5 charts, will provide more accurate estimates of quality within a practice.

The PIP module presented in Table 1 provides STAGE A, retrospective chart review for the assessment of care given to patients who meet DSM–5 criteria for posttraumatic stress disorder (PTSD) or other trauma and stressor-related disorders (2). The measures included in this module are based on recommendations of the 2004 APA Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder (3), the 2010 U.S. Departments of Veterans Affairs and Defense (VA/DoD) Clinical Practice Guideline for the Management of Post-Traumatic Stress

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All authors report no competing interests.

Adapted from **Performance in Practice: Clinical Tools to Improve the Care of Patients with Posttraumatic Stress Disorder** (Duffy FF, Craig T, Moscicki EK, West JC, Fochtmann LJ [Focus 2009; 7(2):186-191). This update includes DSM-5 changes in the diagnostic criteria for PTSD and the most recent evidence-based recommendations derived from practice guidelines.

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Disorder (4), and the 2009 APA Guideline Watch for PTSD (5). The selected practice guideline recommendations that are endorsed with moderate-to-substantial levels of clinical confidence (3), and those endorsed at evidence-rating levels A and B (4) have been highlighted in this module.

The PIP module for PTSD has been designed to be relevant across clinical settings (e.g. inpatient, outpatient), straightforward and easy to complete, and usable in a pen-and-paper format to aid adoption. As with other retrospective chart reviews, some questions on the form relate to the initial assessment and treatment of patients, whereas others relate to subsequent care. In general, treatment options for newly diagnosed patients who are being treated for the first time should judiciously follow the first-line evidence-based treatment recommendations. On occasion, however, there may be appropriate clinical reasons for deviation from recommended care, including patient preferences, co-occurring psychiatric or medical conditions and therapeutic benefits or side effects of prior treatments.

ACKNOWLEDGMENT

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REFERENCES

1. http://www.abms.org/Maintenance_of_Certification/MOC_competencies.aspx
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC, American Psychiatric Association, 2013
3. Ursano RJ, Bell C, Eth S, Friedman M, Norwood A, Pfefferbaum B, Pynoos JD, Zatzick DF, Benedek DM, McIntyre JS, Charles SC, Altshuler K, Cook I, Cross CD, Mellman L, Moench LA, Norquist G, Twemlow SW, Woods S, Yager J; Work Group on ASD and PTSD; ; Steering Committee on Practice Guidelines: Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Am J Psychiatry 2004; 161 (Suppl):3–31
4. Management of PTSD Working Group: VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress. Washington, DC, Departments of Veterans Affairs and Defense, 2010
5. Benedek DM, Friedman MJ, Zatzick D, Ursano RJ: Guideline Watch (Jan 2009): Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Focus 2009; 7:204–213
6. Kilpatrick DG, Resnick HS, Friedman MJ: National Stressful Events Survey PTSD Short Scale NSESSS-PTSD, 2010
7. Management of SUD Working Group: VA/DOD Clinical Practice Guideline Management for Substance Use Disorders (SUD). Washington, DC, Department of Veteran's Affairs, Department of Defense, 2009 http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp
8. Helping Patients Who Drink Too Much: A Clinician's Guide; U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, NIH Publication 07–3769 www.niaaa.nih.gov/guide Rockville, Md. 2005 edition, reprinted May 2007 http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
9. Gradus JL, Qin P, Lincoln AK, Miller M, Lawler E, Sørensen HT, Lash TL: Posttraumatic stress disorder and completed suicide. Am J Epidemiol 2010; 171:721–727
10. Ustün TB, Chatterji S, Kostanjsek N, Rehm J, Kennedy C, Epping-Jordan J, Saxena S, von Korff M, Pull CWHO/NIH Joint Project: Developing the World Health Organization Disability Assessment Schedule 2.0. Bull World Health Organ 2010; 88:815–823

NOTES

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Form for STAGE A and STAGE C: Physician Practice Assessment Retrospective Chart Review

Stage A—Chart Review

Instructions: Select charts for five patients with a primary diagnosis of PTSD. If the answer to a given question is "yes", place a check mark in the appropriate box. If the answer to the question is "no" or "unknown" leave the box unchecked. After reviewing the charts of five patients, complete the penultimate column to determine the relative portion of patients for whom the recommendation was followed. Any rows for which the total is less than 5 may be a useful focus for quality improvement efforts that potentially could be targeted during STAGE B (the design and implementation of an improvement plan –5 CME credits).

This form is for your use only and should not be submitted to the American Psychiatric Association (APA). Once the chart review step is finished, complete the evaluation (page 347) and submit the evaluation to the APA to receive 5 CME credits for this stage.

Stage C—Second Chart Review

Following completion of STAGE B (implementation of practice improvement –5 CME credits), the physician is required to reassess his or her performance via a second review of five patient charts (for this PIP, five patients with a primary diagnosis of PTSD) within a 2-year period (10 CME credits). The APA recommends a minimum of 30 days between stages A and C in order to ensure an adequate amount of time for the implementation of practice improvements during STAGE B. Please follow the instructions described under STAGE A to complete the form for STAGE C. Again, the physician retains all patient and chart data. Once the chart review step is finished, complete the evaluation on page 347 to earn 10 CME credits for STAGE C. Completing this PIP module and all three stages in sequence within 24 months earn the participant a total of 20 CME credits.

I. ASSESSMENT for PTSD	Patient #1	#2	#3	#4	#5	Number of patients with check mark in row?	Recommendations and Clinical Resources
Check box if this is a new patient initiating treatment	☐	☐	☐	☐	☐	__/5	
Did the initial evaluation assess:							
a. Exposure to trauma	☐	☐	☐	☐	☐	__/5	• Assessment for trauma exposure should include time of onset, recency (time elapsed since exposure), type, nature, severity, history, frequency, course, and level of distress (3, 4).
b. Signs/symptoms of PTSD	☐	☐	☐	☐	☐	__/5	• Screen patients for PTSD [recent or remote trauma exposure(s)] (4). • In military populations the VA/DoD guidelines recommend initial screening followed by screening annually or more frequently if clinically indicated (4). • If associated symptoms of PTSD are not routinely assessed, consider using a standardized tool for assessing and recording PTSD symptoms, such as the National Stressful Events PTSD Short Scale (NSESS) available for adults and for children and adolescents (6). • To establish a diagnosis of PTSD please refer to DSM–5 diagnostic criteria (2). To arrive at a diagnosis, a thorough assessment of the patient's current and prior exposure to traumatic event(s) is required (Criterion A). Additional criteria include: presence of one or more intrusion symptoms associated with the traumatic events, (Criterion B); persistent avoidance of stimuli associated with the trauma (one or both of Criterion C); negative alterations in cognitions and mood associated with the traumatic event(s) (two or more symptoms in Criterion D); marked alterations in arousal and reactivity associated with the traumatic event(s) (two or more Criterion E). The disturbance must also last 1 month or more (Criterion F) and must be associated with a reduction in functioning (Criterion G) (2). • If there are clinically significant symptoms with a duration of disturbance of 3 days to 1 month after exposure, consider a diagnosis of Acute Stress Disorder (ASD) rather than PTSD

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I. ASSESSMENT for PTSD	Patient #1	#2	#3	#4	#5	Number of patients with check mark in row?	Recommendations and Clinical Resources
c. PTSD type: Acute, Chronic, PTSD with delayed onset	☐	☐	☐	☐	☐	__/5	• ***Posttraumatic Stress Disorder (PTSD) (2)***: clinically significant symptoms lasting more than 1 month after exposure to a trauma • ***Acute PTSD (4)***: clinically significant symptoms lasting more than 1 month but less than 3 months after exposure to trauma • ***Chronic PTSD (4)***: clinically significant symptoms lasting more than 3 months after exposure to trauma • ***PTSD with delayed onset***: clinically significant symptoms present at least 6 months after exposure to trauma (4)
d. Presence of other co-occurring psychiatric disorders	☐	☐	☐	☐	☐	__/5	• Co-occurring psychiatric disorders, such as other anxiety disorders, depression, substance use disorder, and Traumatic Brain Injury (TBI), are common in patients with PTSD and need to be considered when planning care (2, 4).
e. Alcohol Use or Alcohol Use Disorder	☐	☐	☐	☐	☐	__/5	• Use of alcohol or other substances can be problematic among patients with PTSD and can influence treatment response and suicide risk, even in the absence of a substance use disorder. • Available well-validated and guideline recommended screening tools include the NIAAA single question screener asking about the number of heavy drinking days in the past year, AUDIT-C (3-items) or full AUDIT (10-items) (7, 8): http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm.
f. Other Substance Use or Other Substance Use Disorder	☐	☐	☐	☐	☐	__/5	
g. Tobacco Use or Tobacco Use Disorder	☐	☐	☐	☐	☐	__/5	• Tobacco use leads to significant increases in morbidity and mortality among individuals with psychiatric diagnoses and effective treatments exist that can improve overall health outcomes
h. Traumatic brain injury (TBI)	☐	☐	☐	☐	☐	__/5	• Assessment of TBI should ascertain whether there is evidence of a traumatic brain injury—that is, an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull, with one or more of the following: loss of consciousness, posttraumatic amnesia, disorientation and confusion, and neurological signs (e.g. neuroimaging demonstrating injury; a new onset of seizures; a marked worsening of a preexisting seizure disorder; visual field cuts; anosmia; hemiparesis) (2).
i. Suicidal ideation/ plans/intentions	☐	☐	☐	☐	☐	__/5	• PTSD is associated with increased rates of suicidal ideation, attempts, and fatalities (2, 4, 9). A history of hospitalization, prior suicide attempts, or other self-harming behaviors is relevant in estimating suicide risk. The presence or absence of aggressive behaviors can also be important to risk assessment.
j. Suicidal behavior/ attempts	☐	☐	☐	☐	☐	__/5	
k. Nonsuicidal self-injurious behaviors	☐	☐	☐	☐	☐	__/5	

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I. ASSESSMENT for PTSD	Patient #1	#2	#3	#4	#5	Number of patients with check mark in row?	Recommendations and Clinical Resources
l. Presence of medical condition(s)	☐	☐	☐	☐	☐	__/5	• As a part of DSM–5 diagnostic formulation, clinicians need to determine whether observed psychiatric disturbance(s) are attributable to other nonpsychiatric medical condition(s) (2). Moreover, co-occurring medical conditions and their treatments can exacerbate existing psychiatric symptoms or require adjustments in medication doses. Medications prescribed for psychiatric disorders can interact with those given for other medical conditions and produce side effects.
m. Functional impairment	☐	☐	☐	☐	☐	__/5	• The patient's level of functioning is important in making a diagnosis of PTSD but is equally important in understanding psychosocial issues and in examining response to treatment (2, 4). It is also a primary focus of patients and their families as well as a major determinant of illness related disability. Consider using a standardized tool such as the World Health Organization Disability Assessment Schedule (WHO-DAS 2.0) (10)
n. Patient's prior history of psychiatric hospitalization	☐	☐	☐	☐	☐	__/5	
o. Patient's prior response to treatment for PTSD	☐	☐	☐	☐	☐	__/5	
p. Availability or lack of social support	☐	☐	☐	☐	☐	__/5	

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II. TREATMENT / MANAGEMENT of PTSD
Does the treatment plan currently include, refer, or consider the following treatment management approaches for PTSD?

II. TREATMENT / MANAGEMENT of PTSD	Patient #1	#2	#3	#4	#5	Number of patients with check mark in row?	Recommendations and Clinical Resources
Check if any one of the psychotherapeutic interventions are provided a. First-line psychotherapeutic interventions for PTSD include exposure-based cognitive behavioral therapy, cognitive processing therapy, prolonged exposure therapy, brief exposure therapy (4 to 5 sessions). Additionally, stress management therapy (e.g. stress inoculation therapy) and eye movement desensitization and reprocessing are also considered first-line psychotherapeutic interventions.	☐	☐	☐	☐	☐	__/5	• Trauma-focused psychotherapy that includes components of exposure and/or cognitive restructuring (e.g., exposure-based cognitive behavioral therapy, cognitive processing therapy, prolonged exposure therapy, brief exposure therapy), or stress inoculation therapy, are considered first-line evidence-based psychotherapeutic interventions (3, 4). • **NOTE:** Exposure therapies are not indicated and should be used with caution for "patients living in dangerous situations (e.g., domestic violence) or for patients with current suicidal ideation, substance abuse not in stable remission, comorbid psychosis, or health problems that preclude exposure to intense physiological arousal."(3, 4) • There is strong evidence against the use of psychological debriefing as it may have long-term adverse consequences without any apparent benefits (3, 4).
b. Appropriate psychopharmacologic intervention for PTSD (e.g. SSRIs, SNRIs, TCAs, MAOIs)	☐	☐	☐	☐	☐	__/5	• SSRIs are first-line psychopharmacologic treatments for PTSD (3, 4). • NOTE: Based on the most recent evidence outlined in the 2010 VA/DoD Clinical Practice Guideline for PTSD, results are insufficient or conflicting regarding the use of SSRIs for combat-related PTSD; therefore SSRIs may be no longer recommended with the same level of confidence for veterans with combat-related PTSD as for patients with non-combat-related PTSD (4, 5). • Second-line psychopharmacologic treatment for PTSD includes TCAs and MAOIs (3, 4). • Consider if any of the medications require blood level monitoring or other follow-up laboratory testing (3, 4) • If the patient has residual symptoms, assess the adequacy of the medication dose and determine if changes in medication or dose are indicated (3, 4). • NOTE - There are recommendations against: • Long-term use of benzodiazepines to manage core PTSD symptoms (4)

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II. TREATMENT / MANAGEMENT of PTSD	Patient #1	#2	#3	#4	#5	Number of patients with check mark in row?	Recommendations and Clinical Resources
							• Use of the following medications for monotherapy for the management of PTSD: benzodiazepines, guanafacine, anticonvulsants (tiagabine, topiramate, or valproate) NOTE - There is insufficient evidence to support: Use of the following medications for monotherapy for the management of PTSD: prazosin, bupropion, trazadone, anticonvulsants (lamotrigine or gabapentin) or atypical antipsychotics (4)
c. Ongoing follow-up and monitoring	☐	☐	☐	☐	☐	__/5	• According to the VA/DoD practice guidelines consider follow-up and re-assessment (4): • Following initial treatment, reassess at 2-4 weeks. If treatment is not tolerable consider switching to another antidepressant • Re-assess at 4-6 weeks to include assessment for treatment adherence, co-occurring disorders that may have not been adequately addressed, and accuracy of the original diagnosis. If no response to initial dose, modify treatment (e.g., increase dose, consider longer duration, switch to another SSRI/SNRI, add psychotherapy) • If no response to second trial of antidepressants, reassess at 8-12 weeks. Treatment can be modified by switching to another SSRI/SNRI, adding psychotherapy, consider augmentation. • If no response to third trial >12 weeks, re-evaluate diagnosis and treatment (e.g., switch to TCA, consider consultation/referral)
d. Patient/family education about illness/treatments	☐	☐	☐	☐	☐	__/5	• Psychosocial rehabilitation services are effective in improving quality of life. Consider psychosocial rehabilitation services, including: patient/family psychoeducation, self-care and independent living skills techniques, health education, skills training, peer support group, supported housing, marital/family skills training, social skills training, supportive employment intervention, vocational rehabilitation, occupational/recreational therapy, and case management (3, 4).
e. Treatment for co-occurring substance use disorders	☐	☐	☐	☐	☐	__/5	• PTSD and co-occurring mental health conditions should be treated concurrently with co-occurring substance use disorders or other co-occurring psychiatric disorders (4).
f. Treatment for other co-occurring psychiatric disorders	☐	☐	☐	☐	☐	__/5	

Directions for completing the PERFORMANCE IN PRACTICE (PIP) CLINICAL MODULE (MOC Part 4)

Performance In Practice: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder

The PIP module, *Performance in Practice: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder* can be used to fulfill a Maintenance of Certification (MOC) Part 4 Performance in Practice (PIP) requirement. The module is approved for MOC Part 4 by the American Board of Psychiatry and Neurology (ABPN). **Forms for chart review data collected in Stages A and C, as well as the improvement plan documentation STAGE B, are included in this issue of Focus. The data are for your use. You do not submit the data to the ABPN. To earn credit, submit an evaluation (see p. 349) to APA as you complete each of the three stages (A, B, C) of a module. You must complete Stages A, B, and C of a PIP module within 24 months, to qualify for a completed MOC Part 4 activity. The PIP module provides clinicians with an opportunity for practice assessment. The evidence-based quality indicators presented in this module are core components of the care of patients with a diagnosis of major depressive disorder.

Instructions to Use a Module to Fulfill ABPN MOC Part 4 Requirement and Earn CME credit.
STAGE A: Chart Review

Through chart review, the physician uses the Practice Assessment Tool to assess whether their current assessment and treatment is consistent with evidence-based recommendations.

Program Evaluation Stage A – complete the evaluation for Stage A and submit it to American Psychiatric Association (APA).
CME Credit for Stage A – 5 AMA PRA category 1 credits™

STAGE B: Documentation of Your Improvement Plan and Suggested Interventions
After comparing the charted patient data to quality measures in STAGE A, the physician should initiate and document a plan for improvement, STAGE B. This improvement plan is for the personal use of the physician and does not need to be submitted to the American Psychiatric Association (APA).

The physician may decide to access additional resources as part of the improvement plan. For example:

1. Use of specific recommendations and clinical resources outlined in STAGE A of the clinical module.
2. Review of the APA Guideline Watch 1) Benedek DM, Friedman MJ, Zatzick D, Ursano RJ. Guideline Watch (January 2009): Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. FOCUS: Mar 2009; 7 (2); 204-213. (http://psychiatryonline.org/guidelines.aspx).
3. Review of Influential Publications on the topic of posttraumatic stress included in this issue (see pages 379-436).
4. Individualized self-designed plan for improvement.

Five credits are awarded for completion of Stage B. In order to earn credit and document completion of STAGE B, complete the evaluation on page 349 and submit the evaluation to APA.

Improvement Plan Documentation
Record your improvement plan in the space below or on a separate sheet for your own use. Your improvement plan is not submitted.

Program Evaluation Stage B – complete the evaluation for Stage B and submit it to APA.
CME Credit for Stage B – 5 AMA PRA category 1 credits™

STAGE C: Repeat Chart Review
Within 24 months following your initial chart review and completion of an improvement plan, and within a reasonable time to enact and be able to see review improvements in your chart (at least 30 days is recommended) complete a second chart review using the same module. Reevaluate your performance by comparing results of Stage C with Stage A. You may use the same or different patient charts. Document Improvement for your records.

Program Evaluation Stage C – complete the evaluation for Stage C and submit it to APA.
CME Credit for Stage C – 10 AMA PRA category 1 credits™ and Completion of Part 4 MOC ABPN Clinical Module Requirements.

**Completion of this PIP module does not fulfill MOC Part 4 Patient and Peer feedback requirements. Forms for MOC Part 4 Peer and Patient Feedback are available on the ABPN website at: http://www.abpn.com/forms

EVALUATION SURVEYS FOR USE WITH PERFORMANCE IN PRACTICE PHYSICIAN PRACTICE ASSESSMENT TOOL

Performance in Practice: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder.

Check the Stage you are Evaluating Stage A ____, B ____, or C ____.

CME credit Begin Date: August 2013 End Date: August 2016

To earn AMA PRA category 1 credit™ for **Performance in Practice: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder**, and to document participation in an ABPN approved MOC Part 4 activity, physicians should use the assessment tool as indicated. Physicians who complete in sequence, the three stages (A-C) of a Performance in Practice module may be awarded a total of 20 credits. Participants should complete an evaluation survey for each of the three STAGES of a module.

CME credit is earned for each of the three stages in sequence. Stage A = 5 credits, Stage B = 5 credits, Stage C = 10 credits. Stages are completed within a 24 month period.

Objective: After completion of this activity, physicians will have the foundation for performance improvement initiatives aimed at enhancing outcomes for the care of patients with a diagnosis of Posttraumatic stress disorder.

The APA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide Continuing Medical Education for physicians. APA designates this PI CME activity (completion of Stages A-C) for a maximum of *20 AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This Performance in Practice Module: **Performance in Practice: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder**. is approved by the American Board of Psychiatry and Neurology (ABPN) for MOC Part 4.

EVALUATION SURVEY FOR STAGES A or C

		1	2	3	4	5	
1. Overall, I am satisfied with the usefulness of this PIP tool in assessing my practice patterns.	Strongly disagree	0	0	0	0	0	Strongly agree
2. The material was presented without bias.	Strongly disagree	0	0	0	0	0	Strongly agree
3. Completing this PIP tool has helped me to verify that I am providing appropriate care to my patients.	Strongly disagree	0	0	0	0	0	Strongly agree
4. By completing this PIP tool, I have identified at least one way in which I can improve my care of patients.	Strongly disagree	0	0	0	0	0	Strongly agree

EVALUATION SURVEY FOR STAGE B

		1	2	3	4	5	
1. Overall I am satisfied with the usefulness of STAGE B	Strongly disagree	0	0	0	0	0	Strongly agree
2. Based on STAGE A in STAGE B I accessed additional resources and/or increased awareness of key recommendations	Strongly disagree	0	0	0	0	0	Strongly agree
3. In STAGE B I developed an improvement plan that I will apply in practice	Strongly disagree	0	0	0	0	0	Strongly agree
4. This activity promotes competence, performance or improvements in patient care	Strongly disagree	0	0	0	0	0	Strongly agree

Please explain how this PIP tool will improve your practice _____

_____

Use this space for additional comments or suggestions _____

_____

Date_____ APA Member: Yes _____ No _____

Focus subscriber number _____

_____

Last name First name Middle initial Degree

_____

Mailing address

_____

City State Zip code Country

Fax number: _____ E-mail address: _____

To earn credit for each completed stage of a Performance in Practice Module, complete the evaluation and send this page to the APA. Retain a copy of this form for your records.

I would like to receive my certificate by: Fax ____ E-mail ____

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