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Executive Summary: Clinical Practice Guideline Guideline for Identifying Patients at Risk for Posttraumatic Stress Disorder (PTSD)

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Doris Dibia

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the review committee have been made.

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Walden University
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Executive Summary: Clinical Practice Guideline

Guideline for Identifying Patients at Risk for Posttraumatic Stress Disorder (PTSD)

by

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MS, Walden University, 2024

BS, Walden University, 2022

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Summary

In this Doctor of Nursing Practice (DNP) project, I developed a clinical practice guideline to address the absence of a standardized process for identifying adult outpatients at risk for posttraumatic stress disorder (PTSD) in a community-based mental health clinic. Without such a process, delays in trauma-focused care and inconsistent referrals may occur. The evidence base supports the use of brief, validated screening tools, such as the Primary Care PTSD Screen for DSM-5, for accurate risk identification in routine practice. The practice-focused question that I used to guide this project was: Will an evidence-based guideline for PTSD risk identification be approved by subject matter experts using the AGREE II evaluation tool?

The purpose of the project was to develop, assess, and enhance a clinical practice guideline for implementation within the organization. The analytical strategy included a critical appraisal and synthesis of current evidence, structured guideline development across the six AGREE II domains, expert review using the 23-item AGREE II instrument, descriptive analysis of item and domain ratings, and an end-user review to assess overall quality and recommendation status. Key deliverables from the project included the finalized clinical guideline and the development of a stepwise screening and referral workflow by the organization. Implications for nursing practice include enhanced assessment competencies, improved communication strategies that foster patient disclosure, and the development of equitable care pathways that reduce disparities among both civilian and military-affiliated individuals across community-based settings. This initiative promotes positive social change by facilitating earlier access to effective treatments and incorporating equity-focused design elements.

Background

PTSD is a pressing national health problem that affects millions, disrupts daily functioning, and drives substantial costs across care settings (Bovin et al., 2021). Because exposure to trauma is everyday in the general population and in medical environments, PTSD often presents in primary and specialty care, yet it frequently goes unrecognized during routine intake (Jacoby et al., 2022). Early identification and timely referral to trauma-focused treatments improve outcomes and reduce downstream utilization; therefore, screening at the point of entry represents a high-value practice priority. Further, consistent and culturally responsive processes advance equity for groups that experience greater trauma exposure (Jacoby et al, 2022). Establishing a clear evidence-based protocol for identifying PTSD risk at intake is essential at the national level, and it prepares the ground for action locally.

Through an organizational needs assessment, I identified a practice gap: the clinic lacked a unified, evidence-based protocol for assessing PTSD risk during patient intake. This gap contributes to inconsistent recognition of PTSD and delays in appropriate referrals. Local observations, quality indicators, and stakeholder feedback confirmed both the existence of the gap and its negative impact on patient outcomes and healthcare costs. The practice-focused question that I used to guide this project was: Will an evidence-based guideline for PTSD risk identification be approved by subject matter experts using the AGREE II evaluation tool? The purpose of the project was to develop, assess, and enhance a clinical practice guideline for implementation within the organization.

The evidence in the literature supporting a practice change is strong. A nationwide survey described limited routine screening in trauma care systems and

underscored the need for standardized processes (Bulger et al., 2022). Diagnostic accuracy data support brief first-line screening and structured follow-up with validated measures to guide referral decisions (Bovin et al., 2021). Randomized and comparative effectiveness studies show that trauma-focused psychotherapies are effective in health system settings, which justifies rapid referral once risk is identified (LoSavio et al., 2023; Maguen et al., 2023; Schnurr et al., 2022). A systematic review of treatment guidelines reported consistent recommendations emphasizing validated screening and care linkage (Martin et al., 2021). Moreover, recent literature highlights populations and contexts that experience significant trauma exposure, strengthening the case for early identification in general clinics and supporting equity considerations in design and delivery (Bianjiang et al., 2025; Deniz et al., 2025). Based on accepted hierarchies, this evidence includes Level I randomized trials, Level II comparative and quasi-experimental studies, systematic reviews, and high-quality observational studies, which together indicate strong support for a local practice change. According to Maguen (2023), organizational strengths, including experienced clinicians and leadership support, and weaknesses, including a lack of routine validated screening, provide additional rationale to proceed.

Clinical Practice Guideline Development

I developed a standardized and evidence-based clinical practice guideline on PTSD (see Appendix). Four subject matter experts evaluated the clinical practice guideline using the AGREE II tool.

The expert panel consisted of four subject matter experts with backgrounds in psychiatric nursing, clinical psychology, and trauma treatment. Selection criteria emphasized demonstrated expertise, active scholarly engagement, and recognition by

professional organizations, aligning with the standards for expert appraisal in guideline evaluation. The AGREE II tool materials specify that approval by four experts with domain scores of five or higher constitutes success, and the plan calls for anonymous scoring to promote independent judgment. The review process used the AGREE II tool which evaluates guidelines across six domains with twenty-three items. The procedure included distribution of standardized instructions and the collection of their ratings and comments for descriptive analysis and thematic synthesis, followed by revision and presentation to end users for an overall quality rating and a recommendation for use. Stakeholder participation included: clinic leadership, nursing staff, mental health providers, and the quality improvement team, and engagement activities include consultation, structured feedback, and workflow alignment to support successful adoption.

Results

The project plan required analyzing expert ratings and synthesizing reviewer comments, followed by an end-user assessment of overall quality and recommendation status, which then informs final revisions before dissemination. Each expert rated the guideline using the 23 items of the AGREE II tool. Ratings were collected on a 7-point Likerts scale (1 = strongly disagree, 7 = strongly agree). Figure 1 includes the descriptive statistics for each AGREE II domain, including means and standard deviations.

Figure 1

AGREE II Domain Scores for the Clinical Practice Guideline

Domain	Items	Possible range	1	2	3	4	*M*	*SD*
Scope and purpose	1 to 3	1 to 7	5	6	7	6	6	0.71
Stakeholder involvement	4 to 6	1 to 7	6	5	5	5	5.25	0.43
Rigor of development	7 to 14	1 to 7	5	6	6	6	5.75	0.43
Clarity of presentation	15 to 17	1 to 7	6	5	5	6	5.50	0.50
Applicability	18 to 21	1 to 7	6	6	6	7	6.25	0.43
Editorial independence	22 to 23	1 to 7	7	6	5	5	5.75	0.83

My analysis of the data revealed that the guideline was perceived as well-developed, relevant, and usable. Experts generally agreed that the guideline met the standards of methodological rigor and clarity expected in clinical practice. Open-ended feedback from the experts was analyzed using thematic synthesis to identify recurring themes, suggestions, and concerns. Targeted revisions were made based on both quantitative scores and qualitative insights to enhance clarity, applicability, and stakeholder alignment.

After expert review and revisions, the guideline was presented to end-users for overall quality ratings and usability feedback. End users included nurses, prescribers, and therapists who evaluated usability and fit with current documentation and clinical flow. Their input was summarized descriptively and used to finalize the guideline for organizational adoption. Adoption is expected to increase early identification and to

improve timely referrals to trauma-focused care. This aligns with system-wide evidence for improved outcomes following standardized approaches to screening and treatment (Bovin et al., 2021; Maguen et al., 2023).

This evaluation has some limitations that shape interpretation and early implementation. First, reliance on expert judgment rather than patient outcomes means the current approval reflects perceived quality and feasibility. However, it does not demonstrate clinical effectiveness, equity impact, or cost offsets in real patients. Moreover, panel ratings may contain response bias due to professional allegiances, shared training backgrounds, or optimism toward guideline-driven care, and anonymous scoring reduces but does not eliminate these influences. Additionally, finite resources for staff training constrain dosage, follow-up coaching, and audit with feedback; therefore, early fidelity may vary across shifts and disciplines, and short-term outcomes may appear modest. Furthermore, limited capacity for data capture, information technology integration, and change management may delay consistent documentation and measurement, which slows learning cycles. Finally, a small expert sample and a single organizational context may limit generalizability until multi-site replication and patient-level outcome evaluation occur, so results should be interpreted as provisional and oriented toward iterative refinement.

The project remains important beyond the local site because it models a reproducible process using current evidence and a rigorous evaluation method that other outpatient clinics can adapt to improve equity and access, including strategies to enhance engagement through brief therapies and technology-assisted outreach (Jacoby et al., 2022; Lenton Brym et al., 2025). The project offers a practical roadmap that supports

scale and sustainability across diverse settings by specifying transparent governance, training, and fidelity monitoring steps. In addition, using standard metrics for screening, referral, and follow-up enables benchmarking and shared learning, strengthening system-wide quality improvement over time.

Conclusions

The organization benefits from the development of this clinical practice guideline because the guideline delivers a practical, evidence-based intake pathway that supports consistent identification and timely referral to effective trauma-focused treatments, which improves clinical consistency and advances patient safety (Maguen et al., 2023; Schnurr et al., 2022). Further recommendations include structured staff education on trauma-informed communication, the integration of screening and referral templates into the electronic record, the designation of clinic champions to monitor fidelity, and the exploration of digital or machine learning enabled prompts that increase access and engagement for underserved groups (Bianjiang et al., 2025). Implications for nursing practice include enhanced assessment competencies, improved communication strategies that foster patient disclosure, and the development of equitable care pathways that reduce disparities among both civilian and military-affiliated individuals across community-based settings (Jacoby et al., 2022). This initiative promotes positive social change by facilitating earlier access to effective treatments and incorporating equity-focused design elements. The evaluation method centered on a structured expert panel review using the AGREE II tool, incorporating descriptive statistics and thematic synthesis. This was followed by end-user ratings and targeted revisions to refine the guideline for organizational adoption and broader implementation.

References

Bianjiang, Z., Jianchun, Z., Xiaoyu, S., & Jian, Y. (2025). Mind–body intervention for post-traumatic stress disorder in adolescents: a systematic review and network meta-analysis. *BMC Psychiatry*, *25*(1), 178. https://doi.org/10.1186/s12888-025-06620-x

Bovin, M. J., Kimerling, R., Weathers, F. W., Prins, A., Marx, B. P., Post, E. P., & Schnurr, P. P. (2021). Diagnostic accuracy and acceptability of the primary care posttraumatic stress disorder screen for the diagnostic and statistical manual of mental disorders among US veterans. *JAMA Network Open*, *4*(2), e2036733-e2036733. https://doi.org/10.1001/jamanetworkopen.2020.36733

Bulger, E. M., Johnson, P., Parker, L., Moloney, K. E., Roberts, M. K., Vaziri, N., ... & Zatzick, D. (2022). Nationwide survey of trauma center screening and intervention practices for posttraumatic stress disorder, firearm violence, mental health, and substance use disorders. *Journal of the American College of Surgeons*, *234*(3), 274-287. https://doi.org/10.1097/XCS.0000000000000064

Deniz, S., İnceoğlu, F., & Koca, M. (2025). Psychological effects of earthquake on health professionals: Investigation of post-traumatic stress disorder and related factors. *Nigerian Journal of Clinical Practice*, *28*(3), 305-312. https://doi.org/10.4103/njcp.njcp_538_24

Jacoby, V. M., Straud, C. L., Bagley, J. M., Tyler, H., Baker, S. N., Denejkina, A., ... & STRONG STAR Training Initiative. (2022). Evidence-based posttraumatic stress disorder treatment in a community sample: Military-affiliated versus civilian

patient outcomes. *Journal of Traumatic Stress*, *35*(4), 1072-1086. https://doi.org/10.1002/jts.22812

Lenton-Brym, A. P., Collins, A., Lane, J., Busso, C., Ouyang, J., Fitzpatrick, S., ... & Monson, C. M. (2025). Using machine learning to increase access to and engagement with trauma-focused interventions for posttraumatic stress disorder. *British Journal of Clinical Psychology*, *64*(1), 125-136. https://doi.org/10.1111/bjc.12468

LoSavio, S. T., Worley, C. B., Aajmain, S. T., Rosen, C. S., Wiltsey Stirman, S., & Sloan, D. M. (2023). Effectiveness of written exposure therapy for posttraumatic stress disorder in the Department of Veterans Affairs Healthcare System. *Psychological Trauma: Theory, Research, Practice, and Policy*, *15*(5), 748. https://doi.org/10.1037/tra0001148

Maguen, S., Madden, E., Holder, N., Li, Y., Seal, K. H., Neylan, T. C., ... & Shiner, B. (2023). Effectiveness and comparative effectiveness of evidence-based psychotherapies for posttraumatic stress disorder in clinical practice. *Psychological Medicine*, *53*(2), 419-428. https://doi.org/10.1017/S0033291721001628

Martin, A., Naunton, M., Kosari, S., Peterson, G., Thomas, J., & Christenson, J. K. (2021). Treatment guidelines for PTSD: a systematic review. *Journal of Clinical Medicine*, *10*(18), 4175. https://doi.org/10.3390/jcm10184175

Schnurr, P. P., Chard, K. M., Ruzek, J. I., Chow, B. K., Resick, P. A., Foa, E. B., ... & Shih, M. C. (2022). Comparison of prolonged exposure vs cognitive processing therapy for treatment of posttraumatic stress disorder among US veterans: a

randomized clinical trial. *JAMA Network Open*, *5*(1), e2136921-e2136921.

https://doi.org/10.1001/jamanetworkopen.2021.36921

Appendix: Clinical Practice Guideline PTSD

Clinical Practice Guideline for Identifying Patients at Risk for Posttraumatic Stress Disorder (PTSD)

Purpose

This guideline provides evidence-based recommendations to support the early identification of patients at risk for PTSD in outpatient mental health and primary care settings. Its implementation aims to reduce delayed diagnosis, improve access to trauma-focused care, and standardize clinical screening practices.

Practice Question

Will a CPG designed to support the process of identifying patients at risk for PTSD be approved by a group of SMEs utilizing the AGREE II Tool?

Target Users

1. Psychiatric Mental Health Nurse Practitioners (PMHNPs)
2. Outpatient Behavioral Health Nurses
3. Primary Care Providers
4. Mental Health Intake Specialists
5. Trauma Therapists

Clinical Setting

The intended setting is a community-based outpatient mental health clinic. Staffing includes PMHNPs, LCSWs, behavioral health nurses, and case managers. The setting currently lacks a consistent screening tool or workflow to flag trauma-exposed patients early.

Stakeholders

1. Clinical Director
2. PMHNPs
3. Clinical Psychologists
4. Quality Improvement Team
5. Frontline Clinicians (Nurses, Therapists)

AGREE II Domains Incorporated

1. Scope and Purpose

This guideline targets adults at risk for PTSD, particularly those with a history of trauma exposure. Its primary goal is to establish a standardized screening, referral, and follow-up process to support early identification and access to care.

2. Stakeholder Involvement

The guideline was developed with input from psychiatric nurse practitioners, psychologists, and trauma specialists through structured discussions and content review. End users include outpatient clinicians such as nurses, therapists, and primary care providers.

3. Rigor of Development

Ten peer-reviewed sources were critically appraised using the Johns Hopkins Evidence-Based Practice (JHEBP) structured tools. Recommendations were synthesized using the JHEBP evidence summary and translation tools.

4. Clarity of Presentation

The guideline presents five concise, evidence-based recommendations. Each is designed to be easily understood and applied in outpatient settings without ambiguity.

5. Applicability

Implementation tools such as the PCL-5, screening flowcharts, referral guidelines, and reassessment protocols are included to support integration into clinical practice.

6. Editorial Independence

No funding influenced the development of this guideline. All contributors disclosed no conflicts of interest, ensuring unbiased, evidence-driven recommendations.

CPG Recommendations

Recommendation 1: Implement routine PTSD risk screening using the PCL-5 during initial intake or primary visits

The PCL-5 (Posttraumatic Stress Disorder Checklist for DSM-5) is a validated self-report instrument that can identify at-risk individuals effectively. Evidence shows it has strong internal consistency (α > .90), is quick to administer, and correlates with symptom severity (Bovin et al., 2021). Level of Evidence: Level II, Quality Rating: High quality

Routine screening supports early intervention and can be applied to civilian and military-affiliated populations (Jacoby et al., 2022). **Level of Evidence**: II, **Quality Rating**: Good quality

Recommendation 2: Integrate trauma exposure checklists into standard patient history collection workflows

Incorporating brief trauma exposure inventories ensures providers gather essential contextual data that supports risk stratification. Studies show that combining trauma history tools with symptom-based screening improves diagnostic precision. (Schnurr et al., 2022) **Level of Evidence**: II, **Quality Rating**: High quality; (Lenton-Brym et al., 2024) **Level of Evidence**: V, **Quality Rating:** High quality. Trauma history documentation also facilitates timely referrals to behavioral health. (Martin et al., 2021 **Level of Evidence**: IV, **Quality Rating:** High quality

Recommendation 3: Train providers on trauma-informed communication techniques to enhance screening accuracy and patient disclosure

Patients are more likely to disclose traumatic experiences in safe, supportive clinical environments. Provider training in trauma-informed care has been shown to increase PTSD identification rates and patient satisfaction (Bianjiang et al., 2025). **Level of Evidence**: Level I, **Quality Rating**: High quality

Recommendation 4: Establish a referral protocol to behavioral health for patients with elevated PTSD risk

Clear, consistent referral pathways reduce treatment delays and ensure continuity of care. Data support that structured referral protocols linked to PCL-5 thresholds result in higher

treatment uptake and improved patient outcomes (Bovin et al., 2021). **Level of Evidence**: Level III**, Quality Rating**: Good quality

Recommendation 5: Reassess patients with elevated risk within 30 days using PCL-5 and PHQ-9

Follow-up screening enhances diagnostic accuracy and ensures appropriate engagement in care. Evidence supports a 30-day reassessment to distinguish between acute stress reactions and PTSD (Jacoby et al., 2022). **Level of Evidence**: Level II, **Quality Rating**: Good quality

Evaluation

1. SMEs will complete the AGREE II tool to assess guideline quality.
2. Approval by 4 SMEs with scores ≥5 on all domains will constitute success.
3. Revise CPG as needed based on analysis of AGREE II scores and comments
4. Present the revised guideline to end-users who will be made up of local key stakeholders and experts and invite them to complete a review and make comments.
5. End users will evaluate the 2-items on the Agree II under Overall Guideline Assessment to rate the overall quality of the guideline and recommendation of the CPG for use (Yes, Yes. with modification, or No).
6. Conduct analysis of the end-user review of the CPG.
7. Complete thematic analysis on summative comment evaluation results.

8. Revise CPG as needed based on end users' review to make a final copy of the CPG.

Implementation Plan (Summary)

1. Distribute digital and paper copies of the CPG to all outpatient staff.
2. Hold a staff in-service education session with role-playing for trauma-informed interactions.
3. Assign clinic champions (PMHNP + RN) to oversee the fidelity of the screening-referral process.
4. Use EHR templates to document PCL-5 scores and referral outcomes.