DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Today's webinar:

TBI Management in the Deployed Environment: The Concussion Care Center Model

Feb. 13, 2014, 1-2:30 p.m. (EST)

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Presenter:
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Assistant Chief of Occupational Therapy
Martin Army Community Hospital
Fort Benning, Ga.

Presenter:
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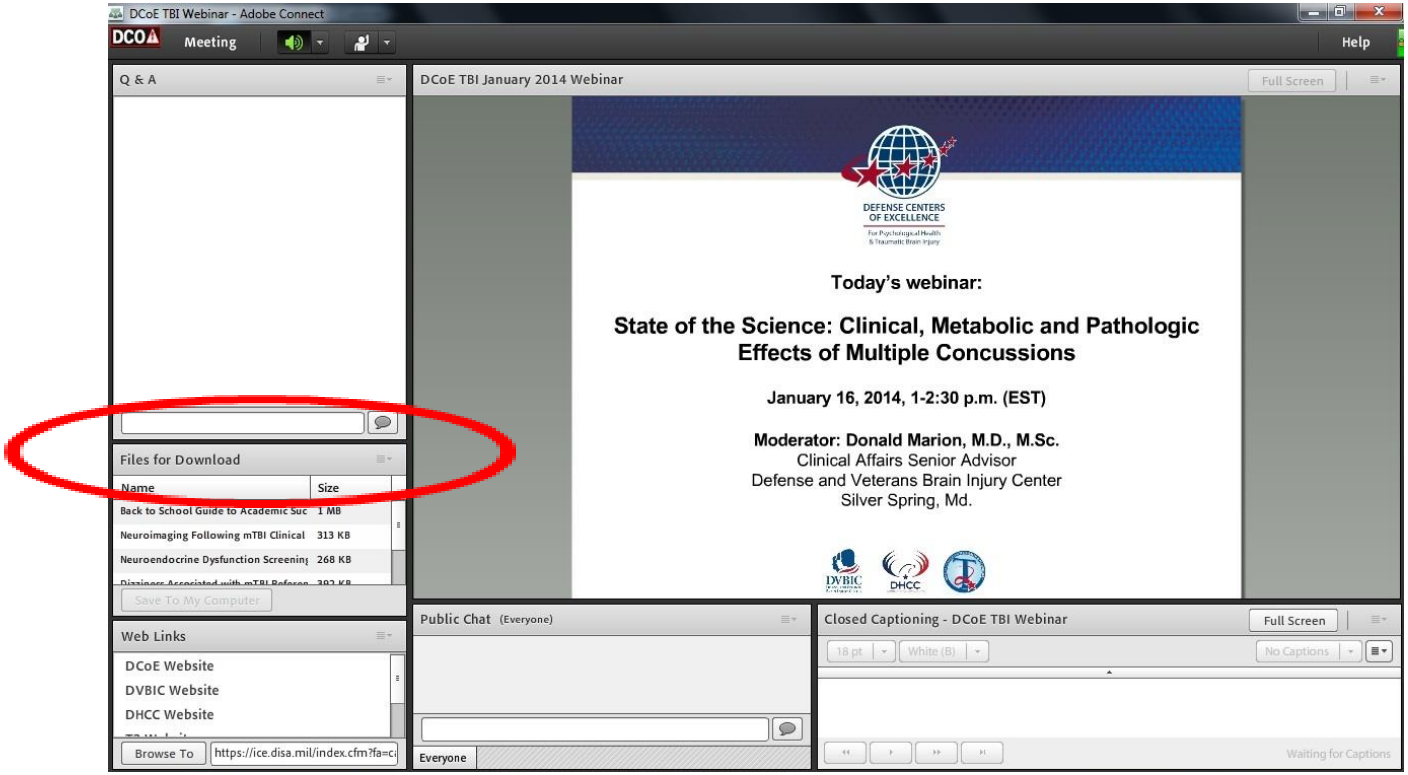
DVBIC Defense and Veterans Brain Injury Center
DHCC

Webinar Details

- Live closed captioning is available through Federal Relay Conference Captioning (see the “Closed Captioning” box)
- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
  - Dial: CONUS **888-877-0398**; International **210-234-5878**
  - Use participant pass code: **3938468**
- Question-and-answer session
  - Submit questions via the Q&A box

Resources Available for Download

- Today's presentation and resources are available for download in the "Files" box on the screen, or visit **dvbic.dcoe.mil/online-education**



Continuing Education Details

Continuing education credit is not available for this event.

Webinar Overview

Traumatic brain injury (TBI) occurs when trauma to the head disrupts the function of the brain. TBI is commonly known as the signature wound of the Afghanistan and Iraq conflicts. Drawing on personal experience at the National Atlantic Treaty Organization Role 3 Hospital in Kandahar, Afghanistan, the presenters will share their approach to TBI management in the deployed, multidisciplinary setting.

The discussion will delineate the role of the concussion care center, a role proven instrumental in contributing to a significant increase in the return-to-duty rates for service members. Additionally, the presentation will highlight psychological and trauma coping aspects affecting recovery following a concussion in a forward deployed location.

Webinar participants will learn to:

- Describe the interdisciplinary treatment approach to TBI in the deployed setting
- Explain the phases of recovery at a concussion care center
- Identify early interventions following a concussion to prevent posttraumatic stress disorder (PTSD)
- Evaluate the impact of post concussive symptoms and PTSD on cognitive functioning

Presenter: Capt. Katherine Hill, U.S. Army

- Assistant Chief of Occupational Therapy, Martin Army Community Hospital, Fort Benning, Ga.
- More than five years experience in occupational therapy, with a focus in orthopedics and mild TBI
- Served as Officer in Charge of the Concussion Care Center for Regional Command-South, Kandahar Airfield, Afghanistan

Capt. Katherine Hill

Mild Traumatic Brain Injury (mTBI) Care in a Deployed Setting

Capt. Katherine Hill, M.S., OTR/L, U.S.
Assistant Chief of Occupational Therapy
Martin Army Community Hospital
Fort Benning, Ga.

Disclaimer

- The views expressed in this presentation are my own and do not reflect the official policy of the U.S. Army, Defense Department or U.S. Government.
- I have no relevant financial relationships to disclose.
- I do not intend to discuss the off-label/investigative (unapproved) use of commercial products or devices.

Objectives

Advance your knowledge in:

- mTBI screening and evaluation
- Care models
- Defense Department Policy Guidance and documentation
- Purple Heart considerations

TBI Severity Classification

Mild TBI is also known as a *Concussion*

- ***"Mild"*** does not refer to symptoms, but rather injury severity
- Concussion is the preferred term when communicating with service members

TBI Severity Classification

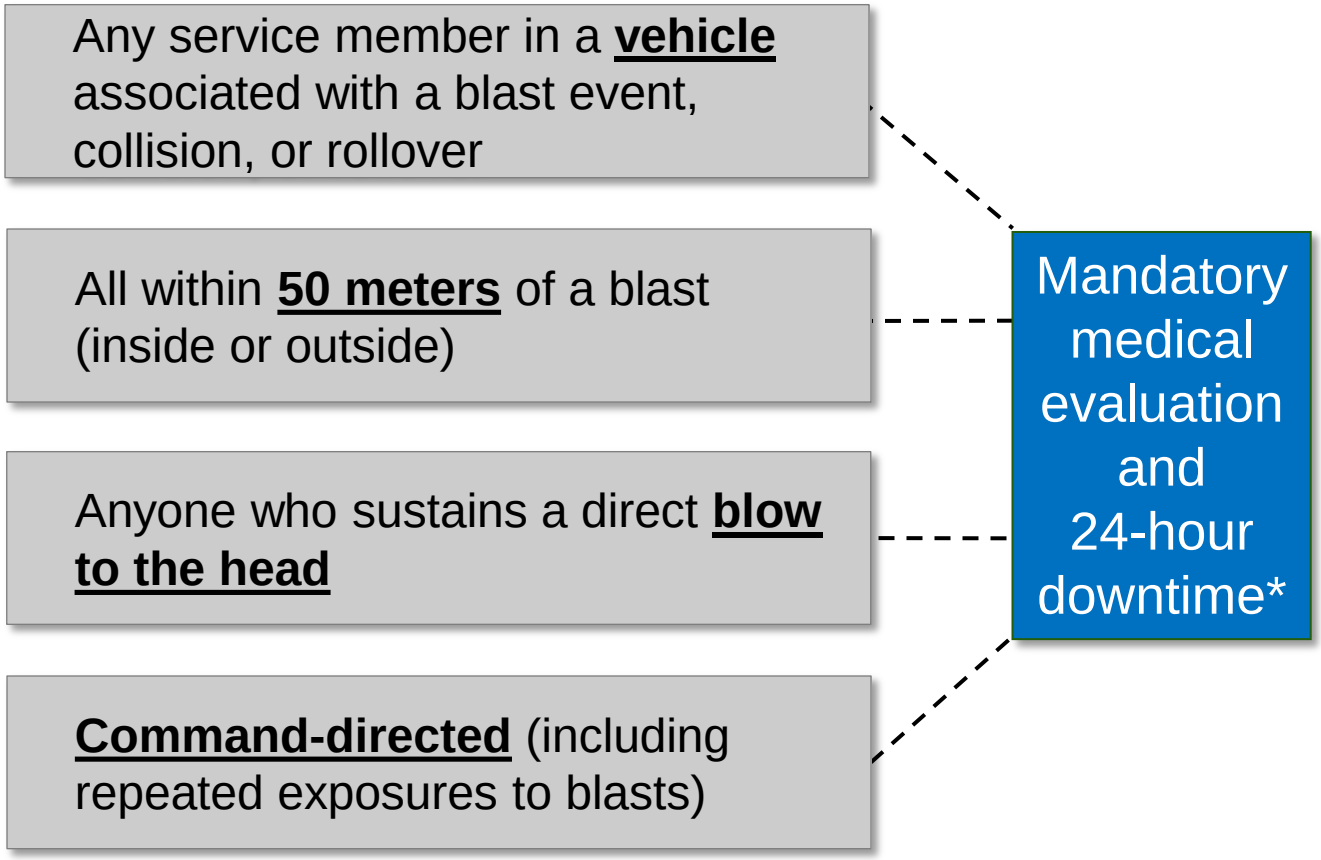
Mild	Moderate	Severe
Normal imaging	Normal or abnormal imaging	Normal or abnormal imaging
Loss of consciousness (LOC): 0-30 minutes	LOC > 30 min < 24 hours	LOC > 24 hours
Alteration of consciousness (AOC): up to 24 hours	AOC > 24 hours	
Post-traumatic amnesia (PTA): 0-1 day	PTA > 1 and < 7 days	PTA > 7 days

Key Points:

- LOC is **NOT** required for the diagnosis of concussion
- Symptoms alone (e.g., headache) do **NOT** equate to a concussion diagnosis

VA/DoD , 2009

Mandatory Event Screening and Reporting



NOTE: Commanders may delay or postpone 24-hour downtime based on mission requirements

DoD, 2012

DODi 6490.11: Policy Guidance for the Management of Concussion in the Deployed Setting

Potentially Concussive Events:

1- Involvement in a vehicle blast event, collision, or rollover

2- A direct blow to the head or witnessed loss of consciousness

3- Presence within 50 meters of a blast (inside or outside)

4- Exposure to more than one blast event/Command-directed

Medical Requirements

- Utilize the Military Acute Concussion Evaluation (MACE) when screening for concussion
- Document all encounters in the electronic health record and use appropriate ICD-9 codes
- Utilize the Concussion Management in Deployed Settings algorithms

Line Requirements

- Check out service members using the **IED/HEADS** checklist
- Ensure service members are evaluated by medical
- Report information into the **BECIR*** module within **CIDNE****

***Blast Exposure and Concussion Incident Report**

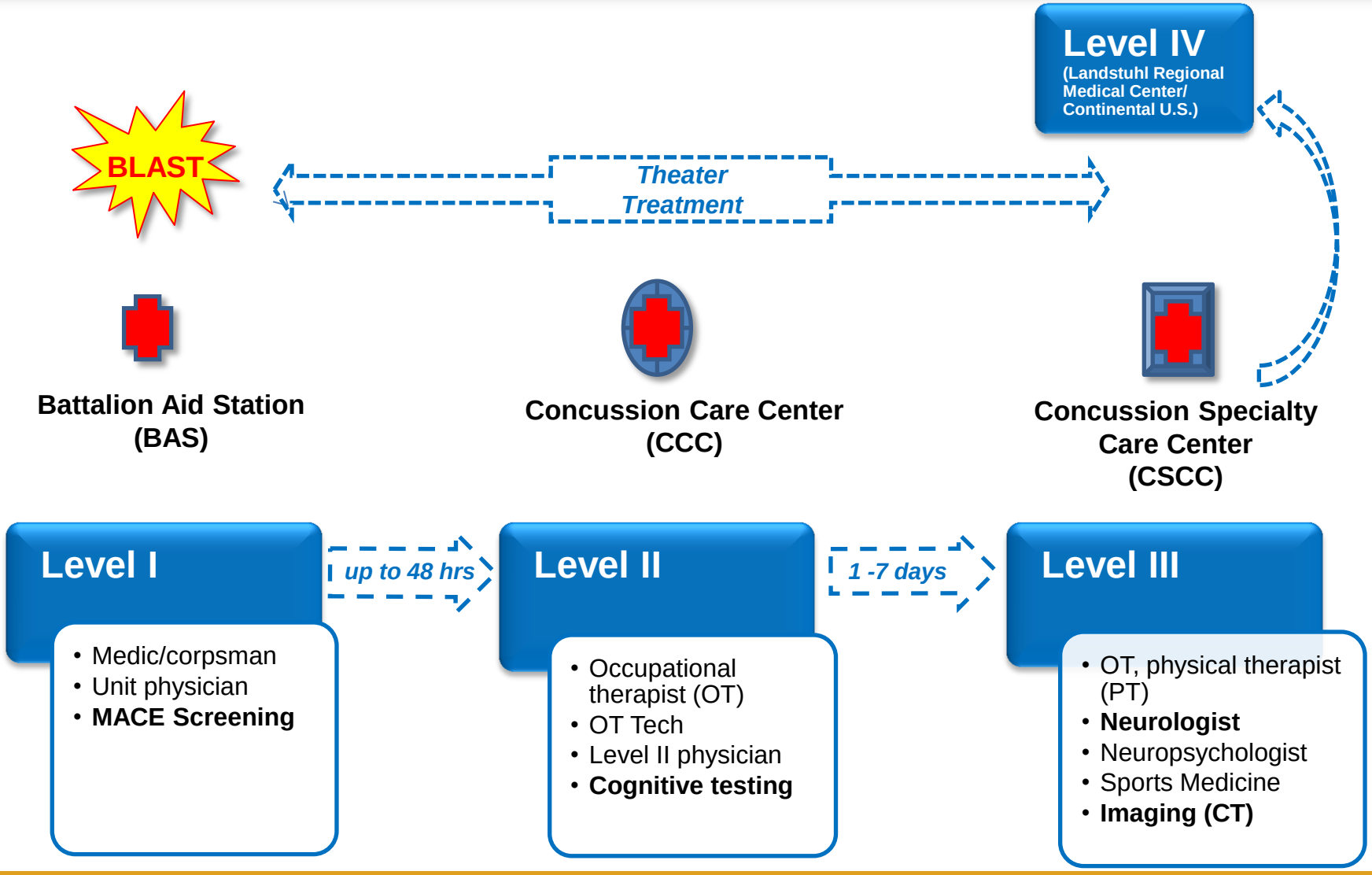
****Combined Information Data Network Exchange**

IED/HEADS Checklist

Injury	Physical damage to the body or body part of a service member?	(Yes/No)
Evaluation	**H** – Headaches and/or vomiting? **E** – Ear ringing? **A** – Amnesia, altered consciousness, and/or loss of consciousness? **D** – Double vision and/or dizziness? **S** – Something feels wrong or is not right?	(Yes/No) (Yes/No) (Yes/No) (Yes/No) (Yes/No)
Distance	Was the service member within 50 meters of the blast? Record the distance from the blast.	(Yes/No) N/A

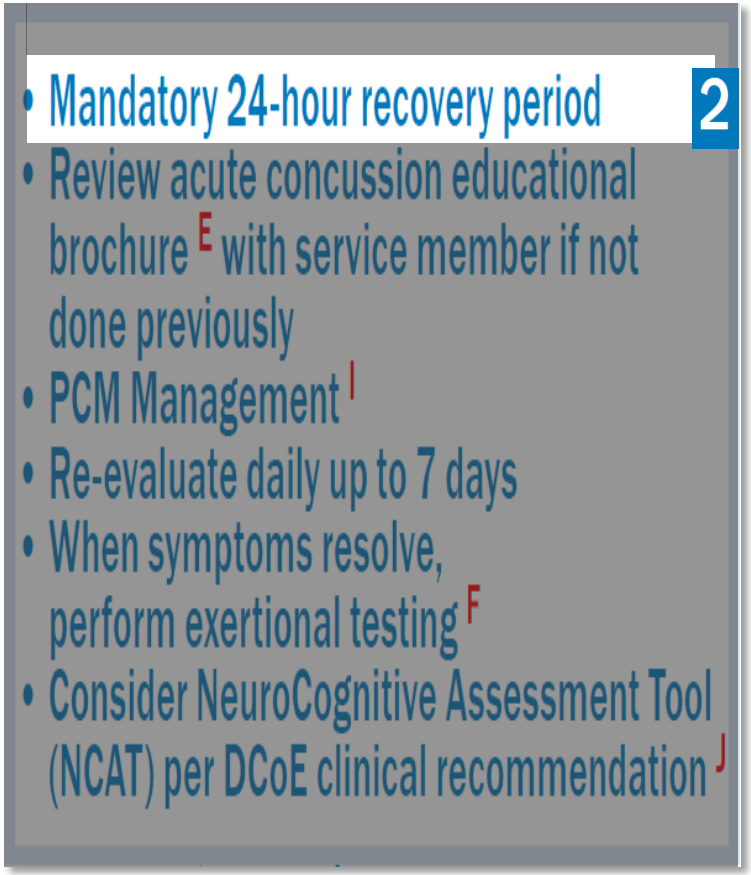
DoD, 2012

The Concussion Care Center Model



Concussion Management: 24-hour Recovery

- 24-hour clock starts at **time of injury**, and not from time of evaluation
- Sports and activities with risk of repeat concussion **prohibited** until medically cleared
- Commanders may waive mandatory recovery period, but must document in Significant Activities (**SIGACTS)** in **CIDNE-BECIR** report



DVBIC/DCoE, 2012

Concussion Management: Primary Care Management (PCM)

PCM:

- Restful environment and quality sleep
- Headache management
- Implement duty restrictions
- Patient education

- Re-evaluate **daily up to 48 hours**
- If PCM not effective, refer to a Level II or III Concussion Care Center

Primary Care Management (PCM): S2

1. Give acute concussion educational brochure to all concussion patients, available at: www.DVBIC.org
2. Reduce environmental stimuli
3. Mandatory 24-hour recovery period
4. Aggressive headache management
   - Use acetaminophen q 6 hrs x 48 hrs
   After 48 hours may use naproxen prn
5. Avoid tramadol, Fioricet, excessive triptans and narcotics
6. Consider nortriptyline q HS or amitriptyline q HS for persistent headache (> 7 days). Prescribe no more than 10 pills.
7. Implement duty restrictions
8. Address any sleep issues. Ambien 10mg po QHS may be considered for short-term (2 weeks) sleep regulation
9. Pain management if applicable
10. Send consult to TBI.consult@us.army.mil for further guidance if needed
11. Consider evacuation to higher level of care if clinically indicated
12. Document concussion diagnosis in EMR

Key Point:

- **Avoid ALL** narcotics, Tramadol (Ultram), Fioricet, benzodiazepines, etc.

DVBIC/DCoE, 2012

Important Information to be Recorded in Medical Record

- MACE score
- Number of concussions in the past 12 months (three or more concussions mandate a recurrent concussion evaluation)
- Symptoms, if any
- Sleep quality
- Detailed description of the event
- Results of any screenings (Examples: Neurobehavioral Symptom Inventory Checklist, Acute Stress Reaction, Epworth Sleepiness Scale, Combat Exposure Scale, Posttraumatic Stress Disorder Checklist – Military, Graded Symptom Checklist, Trails Making Testing, Test of Memory Malingering [TOMM], Balance Error Scoring System, Automated Neuropsychological Assessment Metrics [ANAM])

DoD, 2012

MACE Guidance

- The MACE is a **standardized** concussion **interview** and **assessment** tool
- Consistent administration of the MACE in the proper sequence is crucial to obtaining accurate results
- The MACE should always be used in conjunction with clinical judgment
- Mean MACE cognitive score in non-concussed individuals is 28; a score less than 30 does **NOT** imply a concussion has occurred
- Factors such as sleep deprivation, medications, anxiety or pain may affect the MACE cognitive score
- Three-part score: **Cognitive**, **Neurological**, **Symptoms** (**24**/**Red**/**B**)

NeuroCognitive Assessment Tool (NCAT)

- Consider NCAT to help inform post-injury return to duty (RTD) recommendations:
  - Multiple concussions
  - Persistent symptoms after 48 hours
- **ANAM** NCAT available at Level II and III Concussion Care Center
- Serial testing may be performed to evaluate a service member's progress

DCoE NeuroCognitive Assessment Tool (NCAT) Recommendation: S3

Current DoD policy is that all service members must be tested with a neurocognitive assessment tool (NCAT) prior to deployment. Among several tests that are available, the DoD has selected the Automated Neuropsychological Assessment Metrics (ANAM) as the NCAT to use for both pre-deployment baseline testing and for post-concussion assessment in theater. Detailed instructions for administering a post-injury ANAM are provided at www.DVBIC.org.

Key Point:

- **ANAM** is NOT intended as a diagnostic tool, or as an acute screen or triage for concussion; use is for post-concussion assessment only

DVBIC/DCoE, 2012

Concussion Care Centers

Level II

- Utilize the MACE and other screenings when evaluating for concussion
- No neurologist, psychologist, TBI-dedicated physician, etc.
- Occupational therapist/tech available
- Worked closely with Medical Company (C-MED)
- Trained physicians and physician assistants at C-MED on mTBI care
- Trained physicians, surgeons, nurses, etc. at the Forward Surgical Team on mTBI care
- Teletraining provided to outlying combat outposts (COPs)
- Line leaders/units more directly available

Level III

- Utilize the MACE and other screenings when evaluating for concussion
- Occupational therapist/tech, physical therapist/tech, neurologist, neuropsychologist, behavioral health available
- Worked closely with Role III hospital staff (Referral Care Center and Emergency Room were CCC “gatekeepers”)
- Trained providers and medics/ corpsmen at Regional Command (RC)-South Compound through Reception, Staging, Onward Movement, Integration (RSOI) before they moved on to their post/base
- Teletraining provided to outlying combat outposts (COPs)
- Line leaders/units conferred with via telephone/email

What Activities HELP Brain Recovery?

Cognitive

- Maximize downtime or rest during the day
- Adequate sleep at night
- Easing service member back into normal routines while monitoring symptoms

Physical

- Keep the heart rate low
- Stay out of the heat
- Limit physical activity

What Activities HURT Brain Recovery?

Cognitive

- Mental exertion
  - Activities requiring intense concentration
  - Playing video games
- Inadequate sleep
  - Caffeine, “energy” enhancers
  - Irregular sleep schedule

Physical

- Physical exertion
  - Working outdoors
  - Heavy lifting
  - Exercising
- Second concussion
  - Combat missions
  - Sports
  - Combatives

Cumulative Concussions

Cumulative concussions influence length of downtime:

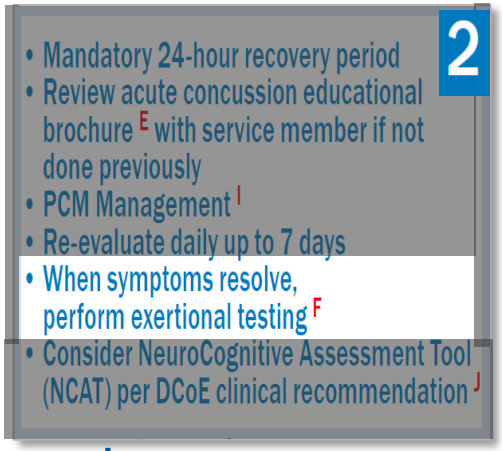
1st concussion within past 12 months	• RTD delayed **<u>24 hours</u>** from time of injury
2nd concussion within past 12 months	• RTD delayed **seven <u>days</u> following symptom resolution**
3rd concussion within past 12 months	• RTD delayed **<u>until</u>** recurrent concussion evaluation has completed

- If 1st concussion in past 12 months, mandatory 24-hour recovery period **2**
- If 2nd concussion in the past 12 months, mandatory 7-day recovery period following symptom resolution before RTD
- If 3rd concussion in the past 12 months, refer for recurrent concussion evaluation*

DVBIC/DCoE, 2012

Concussion Management: Exertional Testing

- Perform exertional testing **only** if the service member is **asymptomatic**
- Exertional testing assesses whether or not any symptoms recur during or after strenuous activity
- If symptoms recur during exertion, stop testing



F Exertional Testing: S2

1. Exert to 65-85% of target heart rate (THR=220-age) using push-ups, sit-ups, running in place, step aerobic, stationary bike, treadmill and/or hand crank
2. Maintain this level of exertion for approximately 2 minutes
3. Assess for symptoms (headache, vertigo, photophobia, balance, dizziness, nausea, visual changes, etc.)
4. If symptoms/red flags exist with exertional testing, stop testing, and consult with provider

DVBIC/DCoE, 2012

Purple Heart Criteria

- A service member who:
  - Suffers a wound, injury or death **directly resulting from** enemy or hostile act, international terrorist attack or friendly fire,

AND

  - injury must require **medical treatment** by a medical professional,

AND

  - diagnosis and treatment must be **documented** in the service member's medical record.

mTBI Diagnostic Criteria

- Requires **two** conditions to be met:
  1) An **injury event** due to an external force
  2) At least **one** of the following immediately following event:
     - Any period of loss or decreased level of consciousness
     - Any loss of memory for events immediately before or after injury
     - Any alteration in mental state at time of injury (confusion, disorientation, slowed thinking, etc.)
     - Neurological deficits or intracranial lesion

Key Point:
- Headache, dizziness, ear ringing or poor concentration may support mTBI diagnosis, but are **NOT** sufficient unless accompanied by at least one of the criteria above

DoD, 2012

Treatment and Documentation

- The wound for which the Purple Heart is awarded requires **treatment** – not merely examination – by a medical officer
- The treatment must be **documented** in the service member's health record
- Combat theater policies dictating mandatory rest periods following a potential concussive event **DO NOT**, in and of themselves, constitute qualifying medical treatment

Examples of mTBI Treatment: Army

- Limitation of duty following incident
- Recovery or rest period **directed by a medical professional**
- Pain medication
- Referral to a theater Concussion Care Center
- Referral to a neurologist or neuropsychologist or other medical specialists
- Rehabilitation required to treat injury

U.S. Army, 2011

Concussion/mTBI Criteria: Marines/Navy

- **Marines must meet one of the following criteria:**
  - Diagnosed mTBI **with associated LOC**

  OR

  - Diagnosed mTBI **with** persistent signs, symptoms, or functional impairment resulting in "not fit for full duty" for **greater than 48 hours**

- Medical officer disposition with either LOC or > 48 hour "not fit for full duty" must be made **within seven days** of injury event

U.S. Marine Corps, 2011

Nomination and Approval

- **Purple Heart Nomination can be initiated by:**
  1. Chain of command
  2. Service members themselves who believe they are eligible for award
- Approval process governed by Service-specific guidance:
  - Army Regulation 600-8-22, Military Awards
  - Navy/Marines: SEC NAV Instruction 1650.1, Navy and Marine Corps Awards Manual
  - Air Force Instruction 36-2803, Air Force Awards and Decorations Program

Polling Questions

- How many hours of mandatory downtime does a service member receive following a head injury event?
  - A. 12
  - B. 24
  - C. 36
  - D. 48
- When does the downtime clock start?
  - A. Immediately after the head injury event
  - B. After mission completion
  - C. Upon Medic/Corpsman evaluation
  - D. Upon provider evaluation
- What percentage of service members who sustain concussion in theater are able to return to duty?
  - A. >95%
  - B. 75-94%
  - C. 50-74%
  - D. Less than 50%

Summary

- mTBI screening and evaluation
- Care models
- Defense Department Policy Guidance and documentation
- Purple Heart considerations

References

1. Defense and Veterans Brain Injury Center/Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. (2012) *Concussion management in deployed settings* (Version 4.0). Retrieved from http://dvbic.dcoe.mil/material/concussion-management-algorithm-cma-pocket-cards

2. U.S. Department of the Army. (2011). *Army directive 2011-07 (Awarding the Purple Heart)* (Milper Message Number 11-125). Retrieved from http://www.maine.gov/dvem/bvs/mtbi/Milper-Message-2011-125.pdf

3. U.S. Department of Defense. (2012). *DoD policy guidance for management of mild traumatic brain injury/concussion in the deployed setting* (DoD Instruction Number 6490.11). Retrieved from http://www.dtic.mil/whs/directives/corres/pdf/649011p.pdf

4. U.S. Department of Veterans Affairs/Department of Defense. (2009). *Clinical practice guideline for management of concussion/mild traumatic brain injury*. Retrieved from http://www.healthquality.va.gov/mtbi/concussion_mtbi_full_1_0.pdf

5. U.S. Marine Corps. (2011). *Purple Heart Medal-Revised criteria for mild traumatic brain injury and updated coordinating instructions* (MARADMIN 245-11). Retrieved from http://www.marines.mil/News/Messages/MessagesDisplay/tabid/13286/Article/111311/purple-heart-medal-revised-criteria-for-mild-traumatic-brain-injury-and-updated.aspx

Presenter: Cmdr. Randy Reese, U.S. Navy

- Senior Neuropsychologist, Intrepid Spirit Concussion Recovery Center, Naval Hospital Camp Lejeune, N.C.
- More than 10 years as a U.S. Navy clinical psychologist and specialization in neuropsychology
- Served in support of the Warrior Recovery Center, NATO Role 3 Hospital in Kandahar, Afghanistan

Cmdr. Randy Reese

Early Intervention for Psychological Factors Affecting Acute Concussion Recovery in Theater

Cmdr. Randy Reese, MSC, U. S. Navy
Clinical Neuropsychologist
Intrepid Spirit Concussion Recovery Center
Naval Hospital
Camp Lejeune, N.C.

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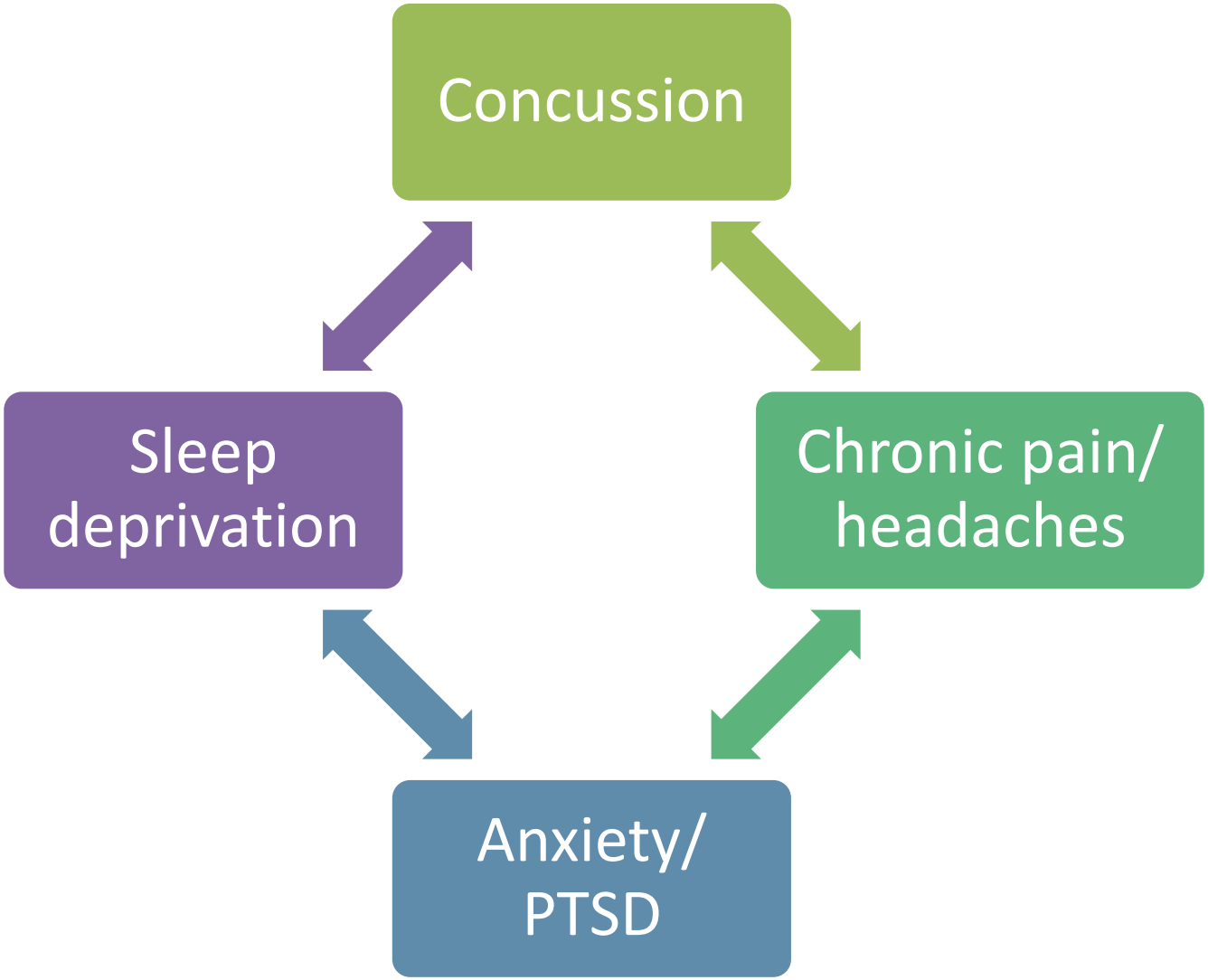
Objectives

- Review cognitive impact of concussion
- Understand potentially complicating factors for concussion recovery
- Understand available early interventions and their limitations
- Identify alternative interventions

Concussion - Recovery

- Typical course, monitoring, and interventions reviewed
- In theater, concussions typically sustained in traumatic situations/events
- Potential for traumatic stress reactions

Concussion Recovery
Chronic Symptoms



Concussion Recovery

DCoE, 2010

Concussion

- Processing speed
- Attention
- Memory

Anxiety

- Working memory
- Attention - switching
- (Frontal - executive)

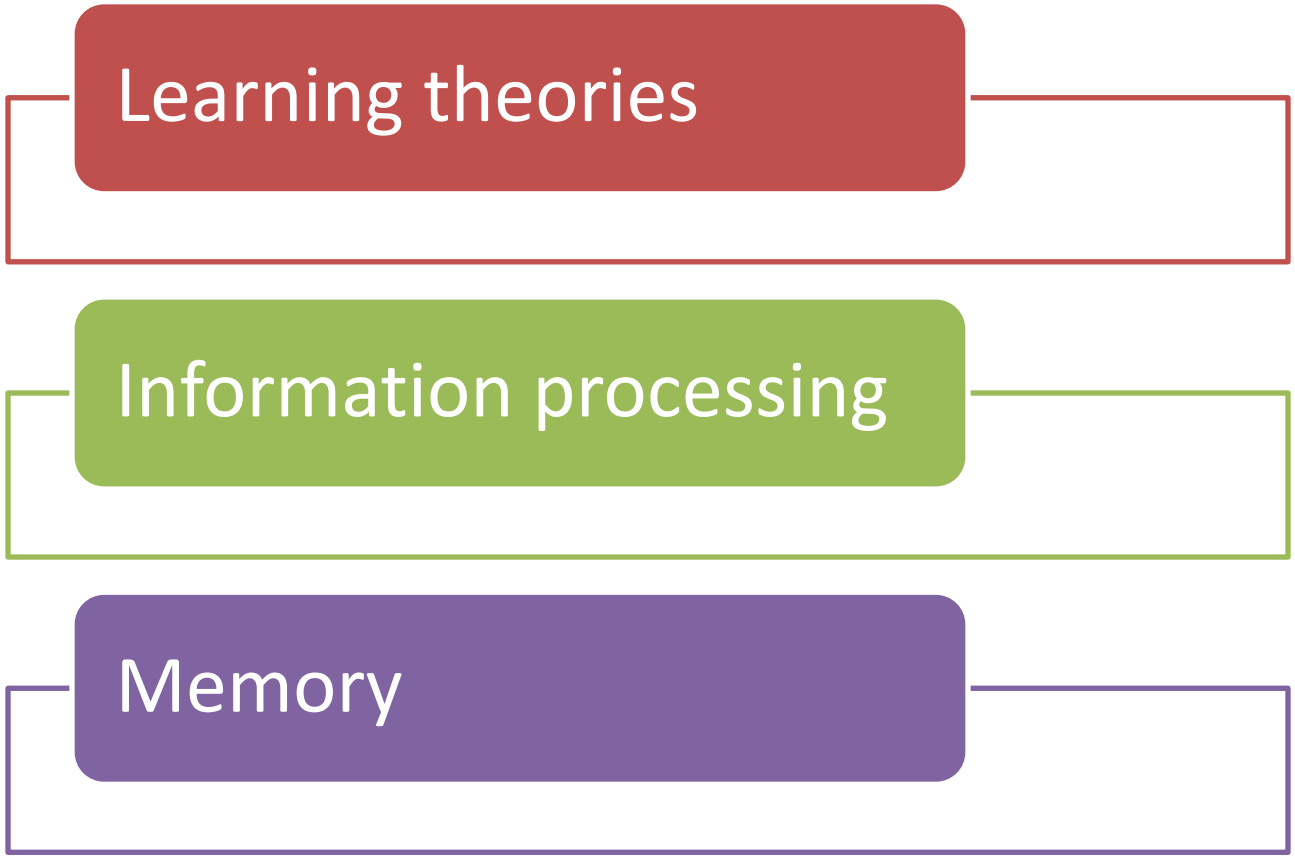
Sleep

- Speed
- Accuracy

Trauma Reaction

- Normal trauma reaction
- Acute stress disorder
- PTSD

What is PTSD?



What is PTSD?

- **Learning**:
  - Associations learned during traumatic event form a "fear network" of associations
  - Activates a "program" to escape danger (classical/operant conditioning)
  - Includes learning to fear internal cues, e.g., racing heart (interoceptive conditioning)

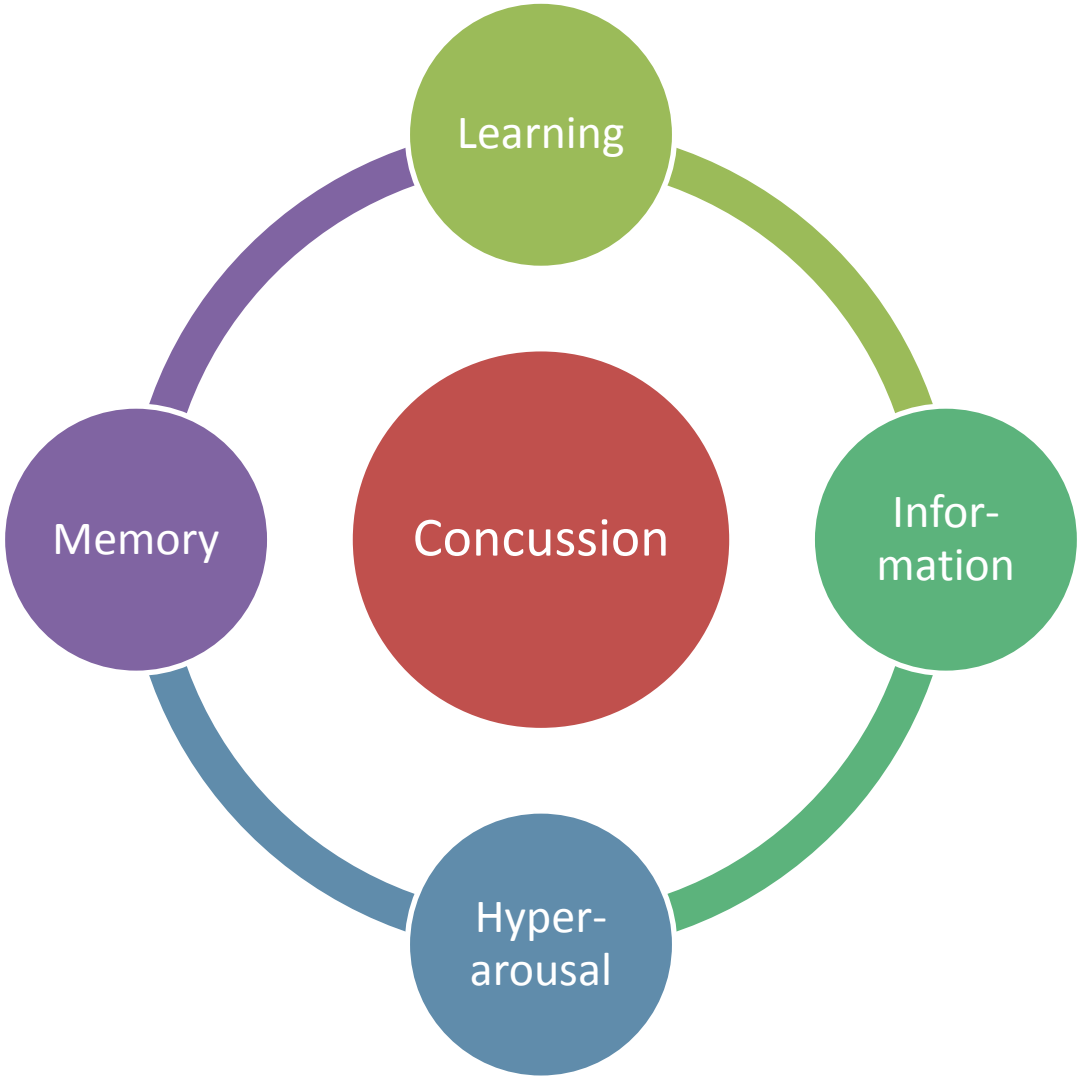
What is PTSD?

- **<u>Information Processing</u>**:
  - Inability to integrate traumatic experience into schemas (completion tendency)
  - Remains in “active memory”
  - “Just world” belief
  - Emotion processing may become chronic

What is PTSD?

- **Memory**:
  - Disorganized and fragmented memories of event
  - Strong associations make memories overly accessible

Concussion Recovery



Concussion Recovery

- In theater, in addition to concussion recovery, attempted to intervene in trauma reaction processes to resolve complicating symptoms and prevent PTSD
- Limited evidence for efficacious prevention treatments

Psychological Debriefing

- Targeted to people with trauma exposure
- Express cognitive and emotional experience
- Guided and structured
- Mobilize resources

Feldner, Beh Mod, 2007

Psychological Debriefing

- Findings:
  - Venting without cognitive behavioral therapy (CBT) does not seem to reduce risk
  - Most studies show critical incident stress debriefing (CISD) does not effectively prevent PTSD
  - Risk of increasing PTSD?

Feldner, Beh Mod, 2007

Brief Psychological Intervention

- Two studies
  - Forced sexual assault victims – education on relaxation and self-directed exposure - not significant, but improved outcome
  - Traffic accident victims – memory integration and narrative repetition – lower PTSD

Feldner, Beh Mod, 2007

Stepped Collaborative Care

- Lowest – Case Manager available 24/7
- Alcohol problems – Motivational interviewing
- High psychological distress – Psychiatric evaluation
- Sustained distress for greater than 24 hrs – Pharmacological
- PTSD at three months – Pharmacotherapy/ psychotherapy or both
- Stepped care – No increase in PTSD
- Control – PTSD increase by six percent

Feldner, Beh Mod, 2007

Acute Stress Disorder Treatment

- Four to 16 cognitive behavioral therapy (CBT) sessions
- Repeat assessment versus four-session CBT
  - Lower PTSD rates at two months (70 percent versus 10 percent), no difference at five months
- Group CBT four to six hours versus repeat assessment
  - No significant effects of intervention
- Three similar studies – 20 percent fewer with PTSD at six months, maintained for four years

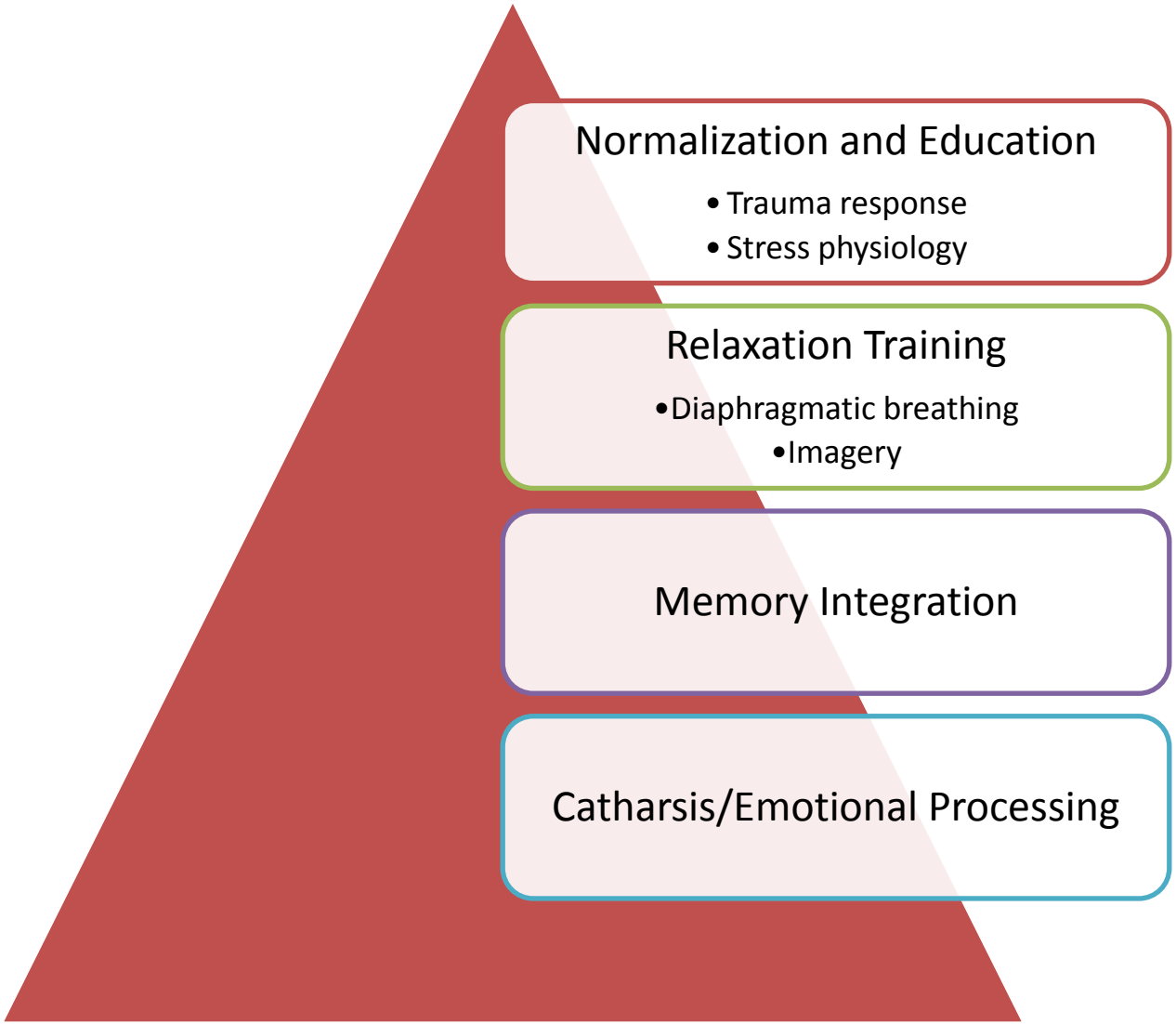
Feldner, Beh Mod, 2007

Summary

- Efficacy
  - CBT
  - Reduce acute posttraumatic adrenergic or HPA elevations/activity
- Non-efficacious/iatrogenic?
  - CISD
  - Benzodiazepine

Feldner, Beh Mod, 2007

Psychological Interventions in Theater



Alternative Interventions

AlphaStim

Cranial electrotherapy stimulation

Biofeedback

Heart rate variability

iRest

Yoga nidra

Yoga of sleep

Concussion Recovery

- Average stay for concussion recovery with no psychological symptoms – five days
- Average stay for concussion recovery with psychological symptoms – eight days
- Expectation is that postconcussive syndrome (PCS) symptoms will be reduced
- No follow up to long-term benefit in relation to PTSD or PCS diagnosis

Polling Questions

- What early interventions for trauma exposure show the most benefit in reducing future PTSD?
  - A. Critical Incident Stress Debriefing
  - B. Cognitive Behavioral Therapy
  - C. Stepped Approach to Care
  - D. Benzodiazepines
  - E. B & C
  - F. All of the above
- There is good clinical evidence that use of heart rate variability biofeedback and cranial electrotherapy stimulation are effective interventions to prevent PTSD if used within the first 30 days of exposure to trauma.
  - True
  - False

Future Directions

- Well-designed research for early intervention in theater
- Research on efficacy of various treatment modalities, and combinations
- Better understanding of interplay between neurophysiology of trauma exposure and concussion

References

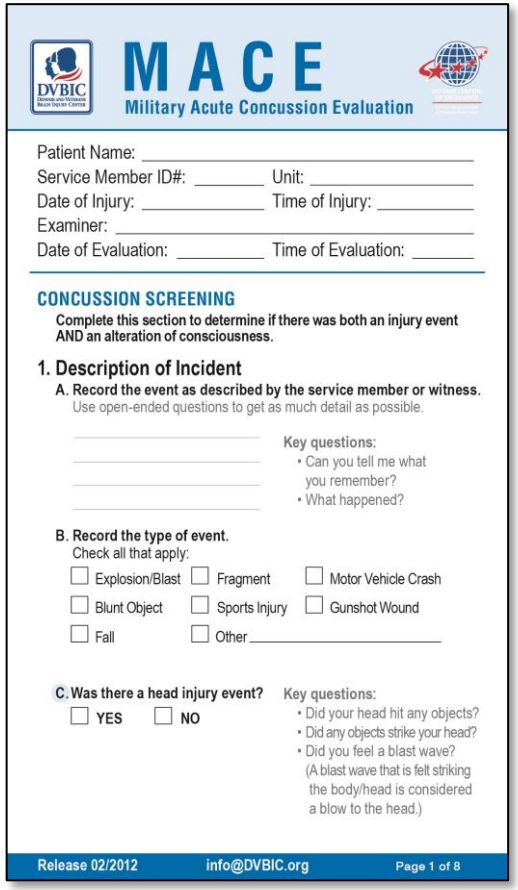
1. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. (2010). *Mild traumatic brain injury pocket guide (CONUS)* [Online image]. Retrieved February 10, 2014 from http://www.dcoe.mil/Content/Navigation/Documents/Mild%20Traumatic%20Brain%20Injury%20Pocket%20Guide.pdf

2. Feldner, M. T., Monson, C. M., & Friedman, M. J. (2007). A critical analysis of approaches to targeted PTSD prevention: Current status and theoretically derived future directions. *Behavior Modification, 31*(1), 80-116. doi:10.1177/0145445506295057

Military Acute Concussion Evaluation (MACE)

- Concussion screening tool for the acute assessment of service members involved in a potentially concussive event
- Includes a concussion screening, a symptom screening, and cognitive and neurological exams
- Intended audience includes military health care providers in the deployed setting or pre-deployment training arena

  If you are a medical provider and would like to request the MACE concussion screening tool or more information about this product, please visit **dvbic.dcoe.mil** or email us at **info@DVBIC.org**



MACE
Military Acute Concussion Evaluation

Patient Name: _____
Service Member ID#: _____ Unit: _____
Date of Injury: _____ Time of Injury: _____
Examiner: _____
Date of Evaluation: _____ Time of Evaluation: _____

CONCUSSION SCREENING

Complete this section to determine if there was both an injury event AND an alteration of consciousness.

1. Description of Incident

A. Record the event as described by the service member or witness.
Use open-ended questions to get as much detail as possible.

Key questions:
- Can you tell me what you remember?
- What happened?

B. Record the type of event.
Check all that apply:

☐ Explosion/Blast ☐ Fragment ☐ Motor Vehicle Crash
☐ Blunt Object ☐ Sports Injury ☐ Gunshot Wound
☐ Fall ☐ Other _____

C. Was there a head injury event? ☐ YES ☐ NO

Key questions:
- Did your head hit any objects?
- Did any objects strike your head?
- Did you feel a blast wave? (A blast wave that is felt striking the body/head is considered a blow to the head.)

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Questions?

- Submit questions via the question box located on the screen.
- The question box is monitored and questions will be forwarded to our presenter for response.
- We will respond to as many questions as time permits.

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We want your feedback!

- Please take the **Interactive Customer Evaluation**
- Or send comments to **usarmy.ncr.medcom-usamrmc-dcoe.mbx.dcoe-monthly@mail.mil**

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Next DCoE Psychological Health Webinar:
Smoking Cessation in Military and Veteran Populations
Feb. 27, 2014
1-2:30 p.m. (EST)

Next DCoE TBI Webinar:
Progressive Return to Activity Following Concussion
March 13, 2014
1-2:30 p.m. (EST)

DCoE Contact Info

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