DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

volume 2 ★ number 2 ★ Spring 2012

Military TBI Case Management Quarterly Newsletter

TBI Case Management Community of Interest

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Quarterly Highlight

The Resilience and Prevention Directorate

Mission: To enhance prevention and resilience, maximize recovery and promote reintegration for full operational capability in warriors, veterans and families.

As a part of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), the directorate provides consultation specifically related to resilience and prevention initiatives throughout the Defense Department utilizing a broad network of subject matter experts and federal partners to identify and disseminate best practices, and highlight innovative programs and practical tools to optimize the health of the force.

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Resilience and Prevention directorate
DCoE photo courtesy of Cmdr. Durgin

Please don't forget to complete our ICE Survey!

About the Quarterly Newsletter

The Military TBI Case Management Quarterly Newsletter is published by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). The quarterly newsletter is intended for case managers and other providers who support warriors with traumatic brain injury (TBI) and their families. Additionally, this quarterly newsletter is not intended to make more work for anyone, but to offer a means to share ideas, best practices and resources among the military TBI case management community.

The content will speak to the very best of TBI case management with the hopes of identifying and sharing best practices across the military.

Content suggestions, thoughts and ideas for future editions of quarterly newsletter can be sent to TBICM.Newsletter@tma.osd.mil.

DCoE
Real Warriors Campaign

DCoE
Real Warriors Campaign

DCoE Outreach Center: Available 24/7 | 866-966-1020 | resources@dcoeoutreach.org | www.dcoe.health.mil/24-7help.aspx

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1335 East West Highway | 9th Floor, Suite 640 | Silver Spring, Maryland 20910 | 301-295-3257
dcoe.health.mil

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Letter from the Editor

Resources for Returning Wounded, Ill or Injured Warriors

Greetings to all Military TBI Case Management colleagues!

I am truly glad spring is here! Spring brings a sense of newness and refreshment, not just outdoors, but in body, mind and spirit as well. This spring there is new information to share with you to enhance your practice treating wounded warriors with traumatic brain injury. Subject matter experts are taking deeper dives into research and treatment of traumatic brain injury at all levels. This newsletter will highlight areas such as neuroendocrine dysfunction, computer assisted devices and hyperbaric oxygen therapy. Our wounded warriors deserve the best we have to give, so when it comes to healing and reintegration, be creative, step "outside the box", and investigate a possible clinical trial if you think it may help your patients. A great resource to find out where different hyperbaric trials are and how to sign up is Sheila Galvin at Quantico, Va., (Sheila.Galvin@med.navy.mil).

As a reminder, DCoE has a 24/7 call center that can be reached toll-free at 866-966-1020 staffed with experts to help you navigate traumatic brain injury and psychological health concerns. It's a great resource to give patients, but it's also there to support you! I am also available for questions, resource finding, and a helping hand or to hear your success stories.

My office phone is 301-295-8367, Monday-Friday, 8 a.m. – 4:30 p.m. (EDT) or you can email me at susan.kennedy.ctr@tma.osd.mil. For newsletter related emails, use TBICM.Newsletter@tma.osd.mil.

Your feedback is very important to us. Thank you to all who have completed ICE surveys so far. If you have not yet had the chance to fill out the ICE survey, it is available in this issue as well. Please take a couple of minutes to give us your feedback so that we can continue to improve and get you the most relevant information possible.

Thank you,

Sue Kennedy, RN BSN CCM

HOT OFF THE PRESS

Neuroendocrine Dysfunction (NED) Clinical Recommendations

DCoE Clinical Recommendation
March 2012

Indications and Conditions for Neuroendocrine Dysfunction Screening Post Mild Traumatic Brain Injury

Introduction & Background

More than 233,345 traumatic brain injuries (TBI) have occurred in the military from 2000 through December 2011.[1] The majority of these (80-85 percent), have been classified as mild TBI (mTBI). Most patients with mTBI recover completely within three months or less of injury. However a small subset of these individuals experience persistent symptoms and difficulty in rehabilitation, particularly in the setting of co-occurring disorders.[2,3] Neuroendocrine dysfunction (NED) may be a contributing factor in the setting of prolonged symptoms or difficult rehabilitation following mTBI.[4,5]

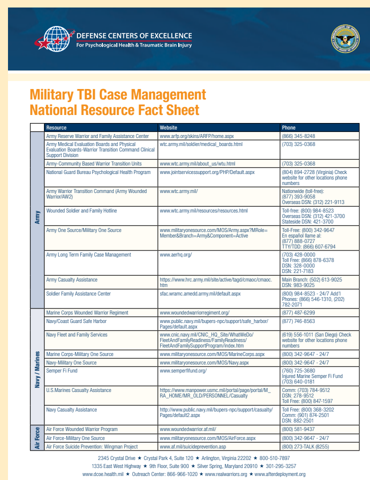
NED following TBI is the result of direct trauma or biochemical response that interferes with the normal production and regulation of inter-related hormonal processes. The anterior pituitary is the most vulnerable and most often affected endocrine structure.[3,4,5] The neuroendocrine pathways most frequently affected in mTBI are growth hormone and gonadotropin.[3,4,6,7,8] Deficiency of these hormones in adults may lead to symptoms such as fatigue, weight gain, low blood pressure, low libido, loss of muscle mass and amenorrhea. The screening strategy described below is recommended to identify most individuals with NED related to mTBI.[4,5,6] The onset of NED can occur anytime between the event and up to 36 months post injury. NED may adversely affect prognosis and impede recovery from TBI.[6,8,9,10] The diagnosis of NED may be difficult and is sometimes not considered because the symptoms may significantly overlap with post-concussion syndrome as well as other co-occurring conditions such as sleep disorders, PTSD or depression.[6,11] Service members diagnosed with concussion who are experiencing persistent symptoms suggestive of NED for greater than three months (or new onset up to 36 months) following mTBI may benefit from post-injury NED screening.[6,8,11,12]

This Clinical Recommendation is intended to offer the health care provider an approach to identifying patients with mTBI who may benefit from further endocrine evaluation and care and is specifically intended to support the primary care provider. The recommendation is based on a review of current published literature as well as the proceedings of a December 2010 expert panel convened by DCoE that included clinical subject matter experts representing the military services, the Department of Veterans Affairs, DCoE and civilian sectors. It was reviewed and approved by the Defense Department's TBI Quad Services Cell, which includes TBI representation from the Air Force, Army, Marines and Navy.

Clinical Recommendation

- Consider NED in the differential diagnosis after confirmed mTBI when symptoms suggestive of NED persist for greater than three months (or new onset up to 36 months) following injury. These symptoms may include fatigue, insomnia, impaired cognition and memory loss, difficulty concentrating, emotional and mood disturbance.
- Symptoms of NED are similar to the symptoms of other post mTBI medical diagnoses such as sleep disorder, memory difficulties, depression, PTSD and /or post concussive syndrome.[12] Considering NED may avoid a delay in diagnosis and improve prognosis.[4,5,11]
- Anterior pituitary deficiencies account for the majority of chronic neuroendocrine disorders following mTBI. Growth hormone and gonadotropin deficiencies are most common, but TSH deficiency (secondary hypothyroidism) and ACTH deficiency (adrenal insufficiency) may occur as well (less than 10 percent of cases with TBI associated NED).[13] Therefore, the following screening strategy is recommended as a rational approach to the initial evaluation in the primary care environment.
- The following describes the typical symptoms suggestive of the previously stated neuroendocrine deficiencies.
  - » **Growth Hormone Deficiencies:** Characterized by loss of lean muscle mass and strength,

Military Case Management National Resource Fact Sheet



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Military TBI Case Management National Resource Fact Sheet

	Resource	Website	Phone
Army	Army Reserve Warrior and Family Assistance Center	www.arfp.org/skins/ARFP/home.aspx	(866) 345-8248
	Army Medical Evaluation Boards and Physical Evaluation Boards-Warrior Transition Command Clinical Support Division	wtc.army.mil/soldier/medical_boards.html	(703) 325-0368
	Army-Community Based Warrior Transition Units	www.wtc.army.mil/about_us/wtu.html	(703) 325-0368
	National Guard Bureau Psychological Health Program	www.jointservicessupport.org/PHP/Default.aspx	(804) 894-2728 (Virginia) Check website for other locations phone numbers
	Army Warrior Transition Command (Army Wounded Warrior/AW2)	www.wtc.army.mil/	Nationwide (toll-free): (877) 393-9058 Overseas DSN: (312) 221-9113
	Wounded Soldier and Family Hotline	www.wtc.army.mil/resources/resources.html	Toll-free: (800) 984-8523 Overseas DSN: (312) 421-3700 Stateside DSN: 421-3700
	Army One Source/Military One Source	www.militaryonesource.com/MOS/Army.aspx?MRole=Member&Branch=Army&Component=Active	Toll-Free: (800) 342-9647 En español llame al: (877) 888-0727 TTY/TDD: (866) 607-6794
	Army Long Term Family Case Management	www.aerhq.org/	(703) 428-0000 Toll Free: (866) 878-6378 DSN: 328-0000 DSN: 221-7183
	Army Casualty Assistance	https://www.hrc.army.mil/site/active/tagd/cmaoc/cmaoc.htm	Main Branch: (502) 613-9025 DSN: 983-9025
	Soldier Family Assistance Center	sfac.wramc.amedd.army.mil/default.aspx	(800) 984-8523 - 24/7 Add'l Phones: (866) 546-1310, (202) 782-2071
Navy / Marines	Marine Corps Wounded Warrior Regiment	www.woundedwarriorregiment.org/	(877) 487-6299
	Navy/Coast Guard Safe Harbor	www.public.navy.mil/bupers-npc/support/safe_harbor/Pages/default.aspx	(877) 746-8563
	Navy Fleet and Family Services	www.cnic.navy.mil/CNIC_HQ_Site/WhatWeDo/FleetAndFamilyReadiness/FamilyReadiness/FleetAndFamilySupportProgram/index.htm	(619) 556-1011 (San Diego) Check website for other locations phone numbers
	Marine Corps-Military One Source	www.militaryonesource.com/MOS/MarineCorps.aspx	(800) 342-9647 - 24/7
	Navy-Military One Source	www.militaryonesource.com/MOS/Navy.aspx	(800) 342-9647 - 24/7
	Semper Fi Fund	www.semperfifund.org/	(760) 725-3680 Injured Marine Semper Fi Fund (703) 640-0181
	U.S.Marines Casualty Assistance	https://www.manpower.usmc.mil/portal/page/portal/M_RA_HOME/MR_OLD/PERSONNEL/Casualty	Comm: (703) 784-9512 DSN: 278-9512 Toll Free: (800) 847-1597
	Navy Casualty Assistance	http://www.public.navy.mil/bupers-npc/support/casualty/Pages/default2.aspx	Toll Free: (800) 368-3202 Comm: (901) 874-2501 DSN: 882-2501
Air Force	Air Force Wounded Warrior Program	www.woundedwarrior.af.mil/	(800) 581-9437
	Air Force-Military One Source	www.militaryonesource.com/MOS/AirForce.aspx	(800) 342-9647 - 24/7
	Air Force Suicide Prevention: Wingman Project	www.af.mil/suicideprevention.asp	(800) 273-TALK (8255)

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1335 East West Highway ★ 9th Floor, Suite 900 ★ Silver Spring, Maryland 20910 ★ 301-295-3257
www.dcoe.health.mil ★ Outreach Center: 866-966-1020 ★ www.realwarriors.org ★ www.afterdeployment.org

Sept 2011

Views expressed are not necessarily those of the Department of Defense. The appearance of external hyperlinks does not constitute endorsement by the Department of Defense of the linked websites, or the information, products or services contained therein.

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Quarterly Highlight

The Resilience and Prevention Directorate

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The directorate oversees the Real Warriors Campaign and the RAND Resilience and Prevention Study.

The directorate's main areas of focus are the Integrated Mental Health Strategy (IMHS) implementation on Chaplains, Resilience, Prevention and Families; the Defense Department Suicide Prevention Task Force Response and Coordination with Under Secretary of Defense for Personnel and Readiness; the Chairman of the Joint Chiefs of Staff (CJCS) strategic guidance on Total Force Fitness (TFF); and the Joint Mental Health Advisory Team-7 findings for overcoming stigma and seeking mental health care.

Resilience and Prevention Directorate Staff Members

Dr. Mark Bates
director

Maj. Todd Yosick
LCSW, deputy director

Ms. Tenia Burton
MBA, senior administrative assistant

Capt. Janet Hawkins
LCSW, prevention division chief

Dr. Colanda Cato
interpersonal violence subject matter expert

Cmdr. Susan Jordan
RD, health behaviors subject matter expert

Cmdr. Wanda Finch
LCSW, family and community program manager

Lt. Cmdr. David Barry
PsyD, substance abuse subject matter expert

Ms. Jessica Lei
research analyst

Cmdr. George Durgin
resilience division chief

Dr. Monique Moore
well-being subject matter expert

Dr. Vladimir Nacev
recovery care support subject matter expert

Cmdr. Sarah Arnold
MD, performance optimization program manager

Lt. Col. Gabrielle Bryen
LCSW, psychological health subject matter expert

Lt. Cmdr. Dana Lee
LCSW, reintegration and deployment health program manager

Dr. Evette Pinder
physical fitness and sleep subject matter expert

Dr. Jeffrey Rhodes
spiritual fitness program manager

Mr. Richard Keller
RN, help seeking subject matter expert

Mr. Colin Hegwood
research analyst

Available Resources from the Resilience and Prevention Directorate

- ★ Suicide Prevention and Risk Reduction Committee Fact Sheet
- ★ The Real Warriors Campaign Website
- ★ Overview of DCoE and DoD Suicide Prevention Efforts
- ★ The 2012 Warrior Resilience Conference Website and Proceedings
- ★ Suicide Risk and Protective Factors
- ★ CJCS Total Force Fitness Framework

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Spotlight

REAL WARRIORS ★ REAL BATTLES
REAL STRENGTH

The Real Warriors Campaign

by Lt. Cmdr. Dana Lee and Ruth Seeley

The Real Warriors Campaign is a multimedia public awareness campaign designed to encourage help-seeking behavior among service members, veterans and military families coping with psychological health concerns. The campaign is an integral part of the Defense Department's overall effort to eliminate the stigma associated with seeking psychological health care and support.

The campaign website, www.realwarriors.net, provides tools, tips and resources that health professionals and care providers can share with warriors and families to encourage the effective use of psychological health resources. Resources include:

- Video profiles and public service announcements featuring active duty, National Guard, reserve, or veteran service members of different ages, rank and military branches, who have sought support for psychological health concerns and maintained successful military or civilian careers.
- Free, downloadable educational materials, such as the "7 Tools That Reinforce Psychological Strength" mini brochure highlighting free tools and resources available for care and support.
- A weekly podcast series entitled, "Real Warriors, Real Advice" featuring warriors, veterans and military families who highlight the importance of seeking care for invisible wounds
- More than 100 articles discussing topics ranging from preparing for deployment to supporting your service member to coping with survivor guilt and grief.

The campaign also offers an array of information specifically tailored to health care providers. Review evidence-based clinical practice guidelines that include effective therapies, counseling and medications for the care of invisible wounds; learn in-depth specifics about military culture, including the signs and symptoms of psychological health concerns; access resources on how to become a TRICARE-accepting provider for those who are not already; and discover training and learning opportunities.

Additionally, the campaign's mobile site, m.realwarriors.net, offers users 24/7 access to psychological health resources from their smart mobile devices. Through the mobile site, service members, veterans, their families and health professionals can read campaign articles, watch the video profiles, and even receive 24/7 support from trained health resource consultants at the DCoE Outreach Center through the live chat feature or toll-free phone number, 866-966-1020.

To learn more, please visit the website at www.realwarriors.net, connect on Facebook at www.facebook.com/realwarriors and Twitter at www.twitter.com/realwarriors.

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NICoE Update:

The National Intrepid Center of Excellence Integrates Sleep Program into Interdisciplinary Care Model

By Joshua Stueve, NICoE public affairs officer

Over the past 10 years, the science of sleep has developed at a rapid pace. At NICoE there is a full integration of sleep assessment into its interdisciplinary care model, which includes appointments with a specialist, ongoing activity monitoring and overnight observation in a sleep lab. Every service member at NICoE meets with Dr. Anthony Panettiere, a former Navy neurologist who specializes in treating the sleep habits of those with traumatic brain injury and psychological health conditions.

NICoE photo by Joshua Stueve

The initial appointment occurs during the wounded warrior's first two days in the program, followed by spending a night in the sleep lab, attending an educational session about normal sleep and sleep abnormalities, and the wearing of a special sensor for four full days and nights to tracks motion. Through these activities, Panettiere can identify the sleep habits of each individual service member.

The two NICoE sleep labs are connected by a control room, which is manned by a technician and a Navy corpsman. Here, Panettiere reviews some scans from a patient's stay.

The NICoE sleep labs are similar to a hotel room, equipped with a bed and a bathroom. Patients arrive the evening of their stay and are connected to an EEG, an EKG and an oxygen sensor, which helps Panettiere determine when they are experiencing apnea. Additionally, service members in the sleep lab are attached to a monitor that tracks leg motion throughout the night.

Panettiere has identified sleep apnea in an overwhelming majority of the nearly 130 patients he has seen at NICoE. Identifying these patients' root sleep issues early on in the program allows patients to be treated right away and ensures that other diagnostic exams and tests will not affected by sleep deprivation. Panettiere shared that service members who are extremely tired tend to test poorly on neurological diagnostic evaluations conducted prior to sleep studies, however once they begin receiving treatment for a diagnosis of sleep apnea or other sleep conditions, the same service member will test much better.

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"Being tired affects more than just a service member's diagnostic evaluations," Panettiere said. "Exhaustion can affect cognition, cause headaches and increase pain in general. It also affects a service member's mood and even their ability to lose weight."

"Sleep is addressed in their first week because abnormalities there cover most of what they come in with," he said. "If we can recognize the sleep disorder right away, it overarches all those other things, [which can then] be better treated and we can get a better assessment.

Diagnosis is only half of the battle. Panettiere also shared information on treatment options for people suffering from sleep apnea. One of the most common solutions, a Continuous Positive Airway Pressure (CPAP) machine is one of the three treatment options used at NICoE. This is a mask that patients wear when sleeping that delivers compressed air throughout the night. NICoE secures devices for patients covered by TRICARE North shortly after diagnosis, and works closely with a team at Walter Reed National Military Medical Center, Washington D.C., to ensure service members have a good fit and are comfortable working with the device. Additional types of treatment, including an oral appliance to help open the airway or surgery, are not available at NICoE, but are built into the customized treatment plan that service members receive upon graduation. Panettiere presented the NICoE sleep program at the February 2012 DCoE webinar, "Treating Sleep Problems in Posttraumatic Stress Disorder and TBI." Listen to the webinar and download slides to learn more about the program.

Connect with NICoE online on their website www.nicoe.capmed.mil or on social networks facebook.com/NationalIntrepidCenterofExcellence or Twitter@NICoEpage.

To refer a patient to NICoE, download the referral form and fax the completed form to NICoE Continuity Services at 301-319-3663.

NICoE photo by Joshua Stueve

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Spotlight

Defense and Veterans Brain Injury Center Neuro-rehabilitation Community Sites

by Capt. Carol Konchan, Defense and Veterans Brain Injury Center, Johnstown, Pa.

The mission of the Defense and Veterans Brain Injury Center (DVBIC) is to serve active-duty military, their beneficiaries and veterans with traumatic brain injuries (TBI) through state-of-the-art care, innovative clinical research initiatives and educational programs. DVBIC's multi-center network spans the entire continuum of TBI care: from initial injury in the war zone through to medical evacuation, acute care, rehabilitation and ultimately a return to community, family and work or continued duty.

DVBIC Neuro-rehabilitation Community Sites

The programs at DVBIC's two neuro-rehabilitation community reintegration centers located in Charlottesville, Va., and Johnstown, Pa., fill the gap in the care continuum between the hospital setting and the individual's return home or return to duty. The sites provide a real-home residence and comprehensive community embedded brain injury rehabilitation program for service members who have experienced TBIs and associated difficulties.

Benefits

The ability of the program to increase the level of independence and employability of service members while integrating service members back into their local communities is unique to the community reintegration model. It provides an increased probability of service members returning back to active duty or to their civilian jobs (e.g., reserve components) through supervised vocational placements with individual treatment plans adjusted according to the progress made on the "job". For the Defense Department and Department of Veterans Affairs, the sites provide an increased return to duty probability and reduction of functional disabilities and therefore a reduction in lifelong disability benefits through better rehabilitation outcomes.

Population Served

Active duty service members, to include reserve components, may participate in either the residential or outpatient programs that are offered at both Charlottesville and Johnstown.

Continued on page 8

DVBIC Johnstown Staff, photo courtesy of Melissa Kreutzberger

The neuro-rehabilitation programs address concurrent or co-morbid conditions such as posttraumatic stress disorder, combat stress, anxiety, depression, suicide prevention, pain management, sleep disorders, substance abuse, and family issues.

Services Offered

A full interdisciplinary clinical team approach is utilized to include: medical director, consulting psychiatrist, neuropsychologist, rehabilitation psychologist, behavioral counselor, speech and language pathologist, occupational therapist, physical therapist, case manager, admissions coordinator, vocational specialist, recreational therapist, nurses, house manager and community integration staff.

The program focuses on skill acquisition as a foundation for independent living, community engagement and work re-entry. Service members are taught:

- Compensatory techniques
- Use of adaptive equipment and technology
- Independent living skills
- Coping and anger management skills
- Social skills
- Vocational skills

While in the program, service members stay in community houses or, in the case of Johnstown, may also stay at the Hiram G. Andrews Center, a facility which is fully wheel-chair accessible. Outpatient services are also offered.

Services address the following needs of patients: behavior, cognition, communication, function, medical, pain management, physical, psychological, recreation and leisure, social, spiritual, and vocational. The rehabilitation plan, goals and objectives concentrate on minimizing the effects of impairments, activity limitations, participation restrictions, and environmental needs while considering the personal preferences and goals of the patient.

Accreditation

Both sites are accredited by the Commission on Accreditation of Rehabilitation Facilities.

Program Capacity

- DVBIC Charlottesville currently has capacity for 13 patients in the residential program and three patients in the independent living program
- DVBIC Johnstown currently has a capacity for 20 patients in the residential program and up to three patients in the transitional and independent living programs

Admission Requirements

- History of brain injury with resultant functional limitations to include cognitive, behavioral, activities of daily living (ADLs) or IADLs, or psycho-social
- Medically stable such that status does not require: 24/7 skilled nursing care; IV medications; injectable medications that the service member cannot self-administer; ventilator; etc.
- Documentation of history and physical examination by physician within 30 days prior to admission
- PPD screening within 30 days prior to admission (Individuals screening positive must have negative chest x-ray or be on treatment). *DVBIC Charlottesville only*

Exclusion Criteria

- Active suicidality/homicidality within the recent past
- Specific medical conditions or treatments that would interfere with individual's rehabilitation as determined by the site medical director
- Active substance abuse

Points of Contact for Referrals

DVBIC Charlottesville

Admissions Coordinator, Debbie Henry,434-984-5218, ext. 201
Case Manager, Kate Bennett, MSW,434-984-5218, ext. 204
For more information about DVBIC Charlottesville, visit us online.

DVBIC Johnstown

Case Manager, Rose Noon, RN, 814-255-8132
For more information about DVBIC Johnstown, visit us online.

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Spotlight

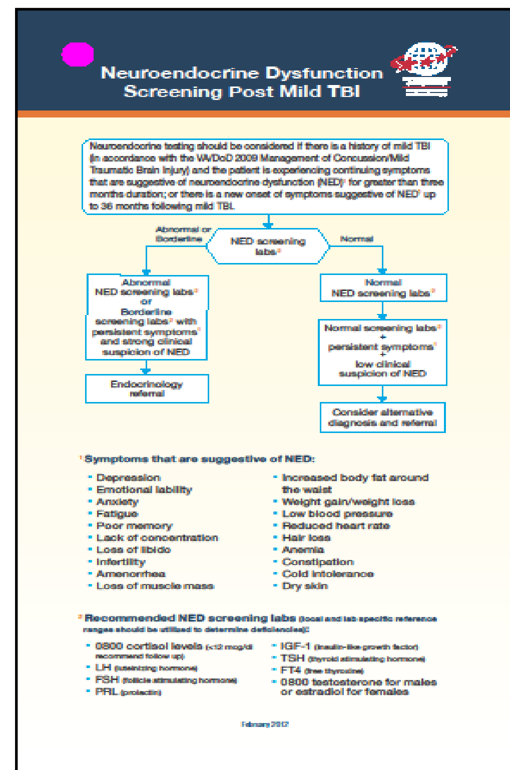
Subject Matter Expert

Neuroendocrine clinical recommendations for TBI

Courtesy of Capt. Rita Shapiro and Therese West, MSN, APN,C, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, TBI Clinical Standards of Care directorate

Approximately 85 percent of individuals with mild TBI have their symptoms resolve within three weeks or less. Current literature and expert consensus have identified that of the 15 percent of mild TBI patients whose symptoms do not resolve in the usual time frame, one or more co-occurring conditions may develop. Neuroendocrine dysfunction (NED) is a post-TBI sequelae that may be a contributing factor in the prognosis and recovery of mild TBI in 15-30 percent of those with unresolved symptoms after three months. DCoE initiated an expert panel to discuss NED as well as provide guidance and achieve expert consensus. DCoE developed the “Neuroendocrine Dysfunction Screening Post Mild Traumatic Brain Injury Clinical Recommendation and Supplemental Reference Card.” These tools are designed to offer guidance to primary care providers regarding indications for post-injury neuroendocrine screening. Visit dcoe.health.mil to see the new clinical recommendations and pocket card.

An educational slide deck to accompany the NED clinical recommendations and pocket guide will be released soon. The slide deck will contain a general overview of mild TBI, pathophysiology of NED as it relates to mild TBI and an educational case study to help teach the content presented in the clinical recommendations. The slide deck will be available on the DCoE website upon release



Neuroendocrine Dysfunction Screening Post Mild TBI

Neuroendocrine testing should be considered if there is a history of mild TBI (in accordance with the VA/DoD 2009 Management of Concussion/Mild Traumatic Brain Injury) and the patient is experiencing continuing symptoms that are suggestive of neuroendocrine dysfunction (NED)[1] for greater than three months duration; or there is a new onset of symptoms suggestive of NED[1] up to 36 months following mild TBI.

NED screening labs[2]

Abnormal or Borderline

Abnormal NED screening labs[2] or Borderline screening labs[2] with persistent symptoms[1] and strong clinical suspicion of NED

Endocrinology referral

Normal

Normal NED screening labs[2]

Normal screening labs[2] + persistent symptoms[1] + low clinical suspicion of NED

Consider alternative diagnosis and referral

[1] Symptoms that are suggestive of NED:

- Depression
- Emotional lability
- Anxiety
- Fatigue
- Poor memory
- Lack of concentration
- Loss of libido
- Infertility
- Amenorrhea
- Loss of muscle mass
- Increased body fat around the waist
- Weight gain/weight loss
- Low blood pressure
- Reduced heart rate
- Hair loss
- Anemia
- Constipation
- Cold intolerance
- Dry skin

[2] Recommended NED screening labs (local and lab specific reference ranges should be utilized to determine deficiencies):

- 0800 cortisol levels (<12 mcg/dl recommend follow up)
- LH (luteinizing hormone)
- FSH (follicle stimulating hormone)
- PRL (prolactin)
- IGF-1 (insulin-like growth factor)
- TSH (thyroid stimulating hormone)
- FT4 (free thyroxine)
- 0800 testosterone for males or estradiol for females

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Subject Matter Expert

Electronic Resources for our Nations Wounded Warriors

by Christine Moyer, Computer/Electronic Accommodations Program (CAP), training and outreach web and social media analyst

The Computer/Electronic Accommodations Program (CAP) actively supports wounded service members during their recovery and rehabilitation. CAP equips service members with assistive technology devices, accommodations and training to help individuals with dexterity impairments, cognitive difficulties, vision loss and hearing loss recover, and assists transition to employment.

Through an individualized assessment process, CAP identifies and provides the assistive technology needed for a wounded service member. After being injured in May 2008, CAP provided Medal of Honor recipient Army Sgt. 1st Class Leroy Petry with voice recognition software, a digital voice recorder and a PDA to assist him with his recovery. Petry continued on active duty, re-enlisting for another eight years in the U.S. Army.

The CAP staff is dedicated to ensuring all resources and assistive devices are available to assist our nation's service members in their rehabilitation process, successful treatment outcomes and future employment opportunities.

For more information on how CAP supports wounded service members, visit www.cap.mil/wsm. For assistance by phone call 703-681-8813 or 703-681-3978 (TTY) 8 a.m. – 5 p.m. (EDT) or email cap@tma.osd.mil.

Assisted Listening Device from CAP. Photo courtesy of CAP website.

Education

Web-based Case Studies

The following web-based case studies are now available on MHS Learn:

- Diagnosing mTBI
- Assessing the Individual with Persistent Symptoms
- Use, Administration and Interpretation of the Military Acute Concussion Evaluation (MACE)
- Assessing the Individual with Persistent Headaches
- Cognitive and Behavioral Symptom Management of mTBI
- Management of Hearing and Vision Problems following mTBI
- Return to Duty/Activity after mTBI
- Assessing and Treating Dizziness and Disequilibrium
- Defense Department ICD-9 CM Coding Guidance for Traumatic Brain Injury
- Assessing and Managing Fatigue and Sleep Dysfunction

Learn more about TBI web-based case studies and how to earn continuing education credits, or log on to the MHS learn system.

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Marriage and Family Retreats

"Getting It Back: Reclaiming your Relationship"

The Charlie Norwood VA Medical Center together with the Warrior Care Project and VA VISN 7 leadership is sponsoring several free "Marriage Enrichment Retreats" during the remainder of 2012. Retreats are open to all veterans, active-duty and reserve components. The retreat for June 8-10, 2012, will be at Hickory Knob in McCormick, South Carolina. The August 17-19, 2012 retreat will be at WinShape in Rome, Georgia. Registration should be postmarked no later than 10 days prior to the retreat start date. To obtain a registration form, contact Chaplain Ed Waldrop at 706-733-0188, ext. 6172 or Edward.Waldrop@va.gov.

DCoE Monthly Webinar Schedule

Date	Topic
June 28	Intimate Partner Violence: What Health Care Providers Need to Know
July 26	MACE Training and Deployed Guidelines
Aug. 23	Psychological Health 101: Education for the Civilian Health Care Provider Treating Service Members
Sept. 27	Managing Suicide Behaviors
Oct. 25	Learning from Real Cases; Military Medicine Supplement
Nov. 15	Emerging Technologies to Address PTSD/TBI

Register or learn more about DCoE monthly webinars on the DCoE website.

Upcoming Conferences

Army Wounded Warrior Program Symposium

Date: June 10-15, 2012
Location: Orlando, Fla.
Online Information

CMSA Annual Conference

Date: June 19-22, 2012
Location: Moscone Center West, San Francisco, Calif.
Online Information

DoD/VA Suicide Prevention Conference

Date: June 20-22, 2012
Location: Renaissance Hotel, Washington, D.C.
Online Information

Brain Injury Association of Pennsylvania

Date: June 25-26, 2012
Location: Lancaster, Pa.
Online Information

National Neurotrauma Society Annual Meeting

Date: July 22-25, 2012
Location: Phoenix, Ariz.
Online Information

DVBIC Annual TBI Summit

For Invited DoD/VA health care providers who treat service members and veterans and care for families that experience TBI.
Date: August 22-24, 2012
Location: National Harbor, Md.
www.dvbic.org

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Question(s) from the Field

by Sue Kennedy, RN, BSN, CCM

Question(s):
Is there a list of skilled nursing facilities, long-term care facilities for service members? What should I look for in choosing a facility? How do I find a transitional care or assisted living facility for a recovering service member?

Answer:

Time spent in acute care settings can be short. Discharge from acute care does not mean that the patient is fully well and capable of caring for him or herself. Some wounded warriors will have ongoing needs for medical and/or psychological care that a family or support system may not be able to provide. The question then is how does the case manager facilitate care for service members who are in need of skilled nursing, transitional or assisted living levels of care?

Here are some of my thoughts and resources:

- Each VA Polytrauma Center has a transitional care unit; there are five of these in in the United States. For additional information about the Polytrauma Centers, visit www.polytrauma.va.gov.

- Many VA Medical Centers have long-term care facilities. Each Veterans Integrated Service Network (VISN) has multiple facilities and services.

- Community sites for inpatient and outpatient transitional care are at Charlottesville, Va. and Johnstown, Pa., (see article by Capt. Carol Konchan in this issue).

Service members may choose to go to TRICARE or out of network non-military facilities. The role of the case manager expands when assisting a service member and/or family in selecting an appropriate facility.

Here are some things to consider:

- Choose a facility that contracts with TRICARE and if possible, any secondary insurances that the service member may have. Ensure that the service member and family are aware of any additional financial obligations (such as deductibles and co-pays).

- Verify what services are covered at the facility by insurance. Some services outside of room and board may not be considered medically necessary or may be a contract exclusion/limitation and therefore not covered by insurance. Laundry service is one such item that may not be covered.

- Verify the facility has the correct level of nursing care for the patient's medical needs. Many nursing homes, assisted living facilities and transitional care do not have 24/7 RN coverage, but instead use LPN's or medication aides. Regulations vary by state. Facilities with Commission on Accreditation of Rehabilitation Facilities (CARF) (or Medicare credentialing are held to a minimum standard of quality. For more on CARF, visit www.carf.org.

- Stay as close as possible to the patient's family/support system geographically.
- Check the state's nursing home, transitional care or assisted living registry for violations. Most facilities will have some minor violations that should have dates of resolution listed. Avoid facilities with major infractions involving patient care or facility structure/cleanliness. Contracting with insurance companies is not a guarantee of quality care.
- When possible, conduct an unannounced on-site visit to the facility. If possible, have the family do this; encourage them to talk with the facility staff and residents. Reputable facilities will not mind unannounced visits and will encourage such dialogue. Avoid facilities that require appointments for tours. View as much of the facility as possible. (One facility I worked for had "showrooms" at the front of the facility, to show prospective clients, while the actual patient rooms in the middle and back of the facility lacked some of the amenities in the "showrooms").
- Do not rely on internet marketing virtual tours or brightly colored brochures. These are made for marketing and show the facility in the best possible light, which may not be reality.
- Present several options to the service member and family, encourage them to visit the facilities and encourage them to make the final choice.
- Family members who are unable to provide direct care to their loved ones are many times experiencing guilt as well as feeling overwhelmed. There can be many reasons such as holding down a job or not having the space in the home. Re-assure the family they can still be involved in the care of the service member.
- By the time someone is ready for discharge to a lower level of care, patients and families have gotten used to acute inpatient care — nurses and doctors available 24/7, nursing assistants available to assist when called. The reality of lower levels of care is that the patients have usually progressed to a point of not requiring an acute level of care. This should be explained to the family, so that their expectations are realistic.
- "Where would you put your family member?" Case managers should be cautious about "recommending" any facility, be it skilled nursing, rehabilitation, transitional care or assisted living. As a rule, we probably should not put our personal recommendation on any facility. This potentially opens a case manager to liability and can also undermine credibility with the family and service member, making future case management difficult. Case managers are not involved in the day to day care of such facilities, may have not set foot in them, and while we can look up facility and staff credentials, we can't ensure the quality of care delivered. Even anecdotal information from someone who may have had a family member in one can be subject to bias, and staff that may have been there when the person who received quality care was there may not be there anymore. It is better to say what we know — such as: staffing, violations, location, visiting hours, therapies, activities offered or other services provided.

- Continue to encourage a family member or friend, or the patient if they are able, to visit the facility, and talk to the staff and residents before making a decision. **Nothing can truly take the place of a boots on the ground unannounced walk through.**

- Once a decision has been made, encourage the family to remain in close contact and as involved as they are able. Reputable facilities welcome family involvement with residents.

Some online tools I found helpful are:

- www.snapforseniors.com
  CMSA affiliated search engine
- www.seniorliving.com
  Lists many area facilities of all levels.
- www.assistedliving.com
  Provides zip code search tools, virtual tours and descriptions of a facility. A quick tutorial is also provided to illustrate how to look up a specific facility violation in your state.
- www.memberofthefamily.net
  This website lists state-by-state registry of nursing home and transitional care with state links to explain the violations for nursing homes and transitional care.

Latest TBI Numbers

Courtesy of the Defense and Veterans Brain Injury Center and the Armed Forces Surveillance Center

As of 4th Quarter 2011 . . .

. . . **233,425** service members have sustained a traumatic brain injury since the year 2000. This number includes both deployed and non-deployment associated TBI. Of this number, **178,961** are classified as mild.

Please don’t forget to complete our ICE Survey!