CASE MANAGEMENT OF CONCUSSION/MILD TBI
GUIDANCE DOCUMENT

1. REFERENCES: SEE APPENDIX B

2. PURPOSE
The purpose of this Guidance Document is to provide guidance for case management of Service members who have sustained concussion/mild traumatic brain injury (mTBI). The integration of case management services within the recovery process will facilitate the achievement of Service member wellness. Case management also serves to foster resiliency and assist both the Service member and his or her support system through the recovery process using established case management processes. The nationally recognized case management processes are: advocacy, assessment, planning, communication, education, resource management and service facilitation. This guidance assumes a basic understanding of nationally recognized case management standards and practices (References 1 and 5), as well as familiarity with Under Secretary of Defense Directive-Type Memorandum (DTM) 08-033 (Reference 2) "Interim Guidance for Clinical Case Management for the Wounded, Ill and Injured Service Member in the Military Health System (MHS)." This guidance focuses on case management for Service Members with mTBI and persistent symptoms.

3. AUTHORITY
Directive-Type Memorandum DTM-08-033, August 26, 2009, Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the MHS (Reference 2).

4. APPLICABILITY
This guidance may be utilized by all military treatment facility (MTF) case management staff within the MHS that encounter Service members, and their support systems, that have been identified as having sustained mTBI and are experiencing persistent post concussive symptoms beyond 4-6 weeks.

5. BACKGROUND

In 2000, prior to the beginning of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), there were 10,963 new cases of TBI. Each year since then, the number has risen. As of July 2010, the number of TBI cases since 2000 is 195,547. Of the total number there were 150,222 cases of mild TBI, the remainder were moderate, severe, penetrating or not classifiable.[1] The terms "concussion" and mild TBI (mTBI) are used interchangeably in this document. The Veteran's Administration/Department of Defense (VA/DoD) Clinical Practice Guideline for Concussion/Mild TBI April 2009 states: "the majority of Service members who sustain mTBI are recovered within several days to weeks and only a small subset of mild TBI patients experience post–injury symptoms of a long lasting nature" (Reference 3).

Case managers (CM's) supporting Service members with ongoing mTBI symptoms and treatment needs should have a clear understanding of mTBI including:

- Mechanism of injury

[1] Go to http://www.DVBIC.org/TBI-Numbers.aspx for more information

- Comparison to moderate and severe TBI
- Common symptom manifestations
- Normal clinical course of mTBI
- Ability for the patient to accomplish the mission and perform duties
- Medications indicated or contraindicated
- Conventional and complementary medical treatments
- Psychosocial issues such as behavior or substance abuse
- Referral sources that may be needed by the Service member and their family or other support system throughout the continuum of care
- How to educate the line leadership on limitations and their expected duration.

This document will serve to guide CM's to facilitate care for those Service members and families who require clinical and other support services due to mTBI sequelae. It is recommended that the CM be familiar with the VA/DoD Clinical Practice Guidelines for Concussion/mTBI, Version 1 April 2009 (Reference 3).

a. Concussion/Mild Traumatic Brain Injury Basics:

(1) Concussion/mTBI defined**:**

In October 2007, an Assistant Secretary of Defense Memorandum was published defining TBI as: "a traumatically induced structural injury and/or physiologic disruption of function as a result of the external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately after the event" (Reference 4):

- Any period of loss or a decreased level of consciousness
- Any loss of memory for events immediately before or after the injury
- Any alteration of mental state at the time of injury (confusion, disorientation, slowed thinking, etc.)
- Neurological deficit(s) (weakness, loss of balance, change in vision, praxis, paresis/plegia sensory loss, aphasia, etc.) that may or may not be transient
- An intracranial lesion

External forces may include any of the following events:

- The head being struck by an object
- The head striking an object
- The brain undergoing an acceleration/deceleration movement without direct external trauma to the head
- A foreign body penetrating the brain

- Forces generated from events such as a blast or explosion, or other force yet to be defined

(2) TBI Level Comparisons:

There are three levels or "categories" of TBI: concussive, or mild, moderate and severe as outlined in Table 1. The severity of the injury is determined at the time of injury as outlined in Table 1 (Reference 3). If a patient meets criteria in more than one category, the higher severity level is assigned. The initial category assignment does not necessarily reflect the patient's ultimate level of functioning (Reference 3). Mild TBI can also be present with other injuries and may go undiagnosed due to the clinical focus on more apparent injuries. Mild TBI also often goes unreported by Service members who either do not want to leave their units or simply dismiss their symptoms.

Table 1: TBI Severity

Closed Brain Injury	Alteration of Consciousness	Loss of Consciousness	Post-Traumatic Amnesia	Structural Imaging
Concussion/Mild TBI	≤ 24 hours	0-30 min	≤24 hours	Normal
Moderate TBI	>24 hours	>30 min <24 hours	>24 hours <7days	Normal / Abnormal
Severe TBI	>24 hours	≥24 hours	≥7days	Normal/ Abnormal

In the civilian population, the most common cause of TBI is falls (28%) (Reference 5). In the military population, since the beginning of OEF/OIF, the most common cause is blast injury related to improvised explosive devices (IEDs). In both the civilian and military populations, the vast majority of mTBI victims recover fully, usually within a few hours to days with no lasting effects. Approximately 10%, of the individuals have persistent symptoms beyond 4-6 weeks following mTBI (References 3 and 5). It is this subset of Service members with persistent symptoms that may benefit from case management for advance diagnostic evaluation and treatment.

Referrals to case management may be initiated by:

- Self referral by Service member
- Referral by family member/support person
- Referral from chain of command
- Referral from primary care provider
- Referral from nursing or other professional medical staff
- Referral from psychological health, behavioral health or substance abuse providers
- Referral from other case management staff

6. GUIDELINES

Case managers supporting Service members with mTBI should utilize the same guidelines and standards of practice (assessment, planning, communication, education, resource management, service facilitation and advocacy) established by the Case Management Society of America (CMSA) for case management in general (References 1 and 5). This section will cover certain symptom parameters and issues that might be identified during the assessment process that while not exclusive to mTBI patients, can create barriers to the Service member's successful return to duty (RTD). It is the CM's responsibility to identify these barriers and assist in developing a recovery care plan to facilitate the Service member's recovery and RTD or begin the process of transition from service. Documentation of all case management activities should be accomplished in the Armed Forces Health Longitudinal Technology Application (AHLTA). Please refer to DTM-08-033 (Reference 2) and your branch of Service/location for further documentation requirements.

a. Case Management of Service members with Persistent Concussion/mTBI Symptoms

Concussion/mTBI symptoms persisting after three months are sometimes referred to as persistent post-concussive symptoms (PPCS) (Reference 3). Symptoms can be physical, psychological and/or cognitive and are listed in Table 2.

Table 2: Post-Concussive Symptoms

Physical Symptoms	Cognitive	Psychological
Headache Fatigue Sensitivity to light/noise Insomnia & sleep disturbances Drowsiness Dizziness Nausea & vomiting Vision problems Transient neurological abnormalities Seizures Balance problems	Problems with memory Cognitive disorders Problems with concentration/ attention Functional status limitations	Problems controlling emotions Irritability Anxiety Depression

Case management interventions are primarily used for Service members with persistent symptoms of concussion/mTBI. Refer to section 9 tables 9.1.a and 9.1.b adapted from the VA/DoD Clinical Practice Guidelines for Concussion/mTBI (Reference 3). The case management interventions in the last column have been added for the purposes of this document to show the integration of case management interventions.

b. Case Management Assessments and Follow-Up Parameters:

Case management assessments, initial and follow up, typically follow a body systems/psychosocial needs approach or may be tailored to meet the needs of specific patient populations, such as pediatric, psychiatric and others. Each Service branch may have access to different avenues of documentation within various on-line systems. Assessment of the mTBI patient should be thorough and include

domains that encompass the military, physical, cognitive and behavioral issues associated with mTBI as well as psycho-social issues that may impact recovery. An example of a domain set used by the Regional Care Coordination (RCC) Program, administered through the Defense and Veteran's Brain Injury Center (DVBIC) (Reference 6) is listed in Table 3 below:

Table 3: RCC Assessment Domains

Domain
• Patient Name & Demographics (branch, rank, duty position • Contact Information • Caregiver/Alternative Contact Information • Family/Social Status (married, single, etc.) • Current Patient Location • Type of Referral (self/MTF/VA/family, etc.) • Injury Information (date, type, TBI severity, agent of injury) • Evaluation/Screening Status • Current Status (deceased, RTD, limited duty etc.) • Issues: Physical Symptoms • Cognitive/Behavioral Issues • Psycho Social Issues • Services: Rehab (CR/PT, OT, SLP/VT etc.) • Services: Medical (PCP, Med Monitor, SZ Control, Audiology, ENT, Ophthalmology, Imaging) • Behavioral: Psychology, Psychiatry, Social Work • Social Services: Housing, Transportation, Educational, Community, Support Groups • Access to Benefits/Entitlements, Financial Help • Other Services • Other CM's Involved (Army Wounded Warrior, Warrior Transition Units, Warrior Transition Brigades etc.) • Notes from Initial Intake Interview/Follow-up Attempts

c. Case Management Concussion/mTBI Interventions:

Just as symptoms of mTBI are not unique to the mTBI population, (Reference 4) case management interventions utilized in the support of Service members with concussion/mTBI are not necessarily unique to patients with concussion/mTBI and may be used in a variety of other neuro-related patient populations. There are however, certain interventions that are critical to the successful management of mTBI patients. Table 4 provides examples of critical case management mTBI interventions and corresponding rationale:

Table 4: Critical Case Management Interventions for mTBI

Critical Case Management Interventions for mTBI	Rationale
Provide or reinforce early education regarding mTBI, its course and recovery to both the Service member, family and military leadership	Early education helps manage patient expectations, may prevent development of symptoms, and/or reduce their number, duration and severity (Reference 3). Keeping military leaders aware of the Service member's condition may assist with appropriate duty assignments to mitigate stressors
Identify a "battle buddy" or support person to accompany Service member to appointments	Service member may present with memory issues such as focus and concentration. Service member may forget appointments
Write down instructions/follow up appointments for Service member, provide follow up reminder calls	Compensates for short term memory issues, gives Service member a tangible reminder
Assess for cognitive, psychological, behavioral and substance abuse symptoms—at initial and ongoing assessment intervals	Symptoms may develop overtime or be revealed by the Service member once a trust relationship is established with the CM
Facilitate use of anonymous or non-military evaluations/treatments/resources for mTBI when appropriate to minimize barriers to accessing care; reassure Service member that seeking help is strength, not weakness	Barriers to care may preclude Service member from wanting help from military providers. Maintains confidentiality and provides needed assistance to Service member
Provide education/communication for military line leadership, promote understanding of mTBI with the Service member's chain of command	This may assist command staff to assign Service member to duties appropriate to limitations while healing takes place, rather than placing Service member in a situation that may be overwhelming and cause negative behaviors that can result in disciplinary action

d. Case Management of mTBI with Co-Morbid Conditions:

Depending on diagnostic criteria (ICD-9 vs. DSM-IV) there are behavioral and personality changes that may be considered part of the post-concussion syndrome (Reference 4):

- Irritability
- Depression
- Anxiety
- Emotional lability
- Fatigue
- Insomnia
- Reduced alcohol tolerance
- Personality changes such as inappropriate social behavior, apathy or lack of spontaneity

Service members referred to case management for mTBI may also have post traumatic stress disorder (PTSD) and/or other related psychological health co-morbid conditions, which may have symptom presentations similar to persistent post-concussive symptoms of mTBI. Conditions such as major depressive disorder (MDD), anxiety disorders or substance abuse will require aggressive treatment regardless of whether the etiology is related to mTBI or not (Reference 3).

A thorough review of the medical record, comprehensive case management assessment, multi-disciplinary team (MT) conference and interview with the Service member will help uncover co-morbidities so that an appropriate care plan can be determined. Some symptoms may not be obvious or may not be revealed until the Service member has established a trusted relationship with the CM and/or the care team with this information-particularly if the Service member is concerned about stigma or other career issues. Educating the Service member about mTBI persistent symptoms and resources such as anonymous websites that offer assessments and workshops may be beneficial to the Service member in taking the first step to recognizing the need for help. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) offers guidance and links to resources for co-morbid conditions at: www.dcoe.health.mil. DCoE also offers a 24/7 call center staffed by expert health care consultants and social workers at 1-866-966-1020.

e. Case Management Referral/Response Time Frames:

- There is no standard for TBI or other case management referral/response times. Case management processes from receipt of the referral to the initial assessment, contacting the patient and developing/implementing the recovery care plan in the acute inpatient setting may range from 1 to 7 (or more) days depending on the institution and type of patients served (References 5 and 7). In the outpatient setting it may range between a few days to weeks or even months. Factors to consider when determining response time frames include:

    - Inpatient or outpatient setting
    - Medical and psychological stability of Service member
    - Diagnoses
    - Referral volume
    - Staff availability
    - Acuity/functional level of the Service member
    - Availability of medical records
    - Location of the Service member-will they PCS soon, do they live on or near MTF?
    - Availability of resources such as support groups, family, transportation, housing, off base clinics and providers

f. Key Points to Consider for Case Management of Concussion/mTBI:

- No two mTBI injuries are the same no matter how similar the events
- Building a trust relationship with the Service member is essential for promoting compliance to the recovery care plan
- Knowledge of any co-morbid conditions is essential for holistic care
- Review all possible medical record sources for clinical/psychosocial information including the Post-deployment Health Assessment (PDHA) and Post-deployment Health Re-assessment (PDHRA)
- Recovery care plan for the Service member should encompass short-term, long-term and ongoing needs and goals and be developed with input from the (MT)

- Reinforcing education, timely multi-directional communication, patience and empathy are required to build trust and destroy perceptions of stigma so that the Service member will successfully return to work or experience a seamless transition to the VA system if separation from duty becomes necessary
- Ideally one CM should take the lead to ensure that clear, consistent multi-directional communication is accomplished between the MT, line commanders, Service member and family, other case management staff such as Federal Recovery Care Coordinators, DVBIC Regional Care Coordinators (RCC's) etc., to avoid duplication of services and confusion for the Service member and family
- Any active duty Service member who is diagnosed with mTBI and has symptoms refractory to six months of conventional therapy may be eligible to be referred to the **National Intrepid Center of Excellence** (NICoE) located in Bethesda, Maryland on the campus of the National Naval Medical Center for further outpatient mTBI diagnostic work up and treatment planning. Please refer to the DCoE website or Outreach Center (1-866-966-1020) for updates regarding referral criteria, process and admission start date. There is a Fisher House on campus for the families of Service members accepted into the NICoE program.

7. STAFFING REQUIREMENTS

Staffing needs will vary based on volume of Service members seen at the MTF's TBI clinic. The number of cases per CM has been established at 30 per DTM 08-033 (Reference 2). Please refer to DTM 08-033 for guidance on staffing, coding, case mix and acuity levels. This does not include administrative support staff or non-medical case management staff.

8. TRAINING

Per DTM 08-033, clinical CM's will complete required education and training modules as listed on MHS Learn (https://mhslearn.satx.disa.mil). Modules are listed under "Case Management." There may be additional training and education/continuing education that are branch specific and/or location specific.

9. PROCEDURES

This section details the procedures associated with case management of concussion/mTBI. Case management "procedures" are known as "interventions" and are provided in Tables 5 and 6 in association with the persistent physical or behavioral/cognitive symptoms respectively. Both tables are adapted from the VA/DoD Clinical Practice Guideline for Concussion/mTBI April 2009 (Reference 3). The last column, "Case Management Interventions" was added for the purposes of this guideline. The interventions in the last column are those that are deemed specific for Service members with concussion/mTBI that present with specific post concussion symptoms. All Service members with TBI share routine case management interventions regardless of diagnoses. These routine case management interventions include:

- Review of the medical record, identification of the TBI event, initial symptoms and information from the MACE evaluation if available, initial rest period, time to RTD, current medications
- Review current treatment and its efficacy or any changes with the Service member and MT
- Complete case management assessment (refer to domains listed in Table 3). Address issues identified within the assessment domains (Table 3)

- Educate the Service member and family/support system and chain of command regarding diagnoses, what to expect during recovery, treatments, medications, and provide approved educational materials, websites, and support groups
- Work to gain the trust of the Service member, be consistent, reinforce strengths in seeking help
- Communicate with chain of command any treatments or needs that may affect routine work/duty assignments
- Coordinate referrals and arrange transportation, if needed
- Follow up at periodic intervals of 1 month, 6 months and 12 months, or more often if needed
- Document in approved system, such as AHLTA

Table 5: Mild TBI Persistent Physical Symptom Identification, Treatment and Case Management Interventions

Common Physical Symptoms Following Concussion/ mTBI	Pharmacologic Treatment	Non-Pharmacologic Treatment	Referral After Failed Response to Initial Treatment	Case Management Interventions*
Headaches (most common symptom reported)	Non narcotic pain meds Non-steroidal anti-inflammatories (NSAIDs) Triptans (migraine type)	Sleep education Physical therapy Relaxation	Neurology Pain clinic	• Review with Service member his or her activities, is he or she following through with recommended physical therapy, relaxation techniques, required hours of sleep? • Ask Service member about effectiveness of pain medications, or side effects such as drowsiness, is it interfering with work? • Discuss need for functional assessment with the physician or MT • Discuss treatment changes or needs with primary care provider, line commander • Consider complementary and alternative medicine (CAM) therapies • Provide written instruction for follow up appointments, engage “battle buddy” to assist with reminders • Follow up on any new treatments prescribed to ensure compliance and evaluate effectiveness within 1-2 weeks
Feeling dizzy	Antibiotics, decongestants for infections and fluid		Dizzy : Ear Nose and Throat (ENT)/Neurology after ENT interventions	• Discuss symptoms with primary care provider, line commander, may need light, desk duty or off duty until symptoms resolve • Arrange referrals, transportation and “battle buddy” to drive and accompany Service member to appointments • Educate Service member on position changes ,safety precautions against driving or activities that increase symptoms, avoid drinking alcohol
Loss of balance Poor coordination		Physical therapy	Neurology	• Consider requesting referral for functional assessment, vestibular testing • Discuss with primary care provider, line commander, MT how loss of balance may impact job performance, require job accommodation or temporary re-assignment • If approved, arrange referrals, transportation & “battle buddy” to accompany and drive Service member • Discuss safety precautions with Service member, such as not driving, avoid alcohol

Table 5 Continued:

Common Physical Symptoms Following concussion/ mTBI	Pharmacologic Treatment	Non-Pharmacologic Treatment	Referral After Failed Response to Initial Treatment	Case Management Interventions
Nausea	Anti-emetics	Sleep education	Gastroenterology (GI)	• Review diet and medications for possible interactions, • Suggest dietary consult • Review sleep history, educate on sleep hygiene, provide written materials • Coordinate referral to dietician, GI specialist if ordered
Change in appetite			Consider Mental Health (MH)	• Review dietary habits, possible food-medication interactions, illicit substances or alcohol that can impact appetite • Suggest dietary consult Suggest MH consult
Sleep disturbances - Difficulty falling or staying asleep (insomnia)	Sleep medications	Sleep education	MH Physical Medicine and Rehabilitation (PM&R) Neurology	• Review sleep patterns, issues with Service member, identify barriers to sleep: timing of exercise, family issues, medications, caffeinated foods, drinks • Suggest MH or Neuro/sleep study consults if not done • Reinforce sleep hygiene measures such as avoiding caffeinated beverages or exercise just prior to sleep time • Suggest CAM for relaxation therapies such as massage, meditation
Vision problems - Blurring - Trouble seeing - Sensitivity to light		Sleep education Light desensitization Sunglasses	Optometry Ophthalmology **	• Consider functional assessment if not done, referrals to Optometry or Neuro-Ophthalmology or vision therapy if recommended by specialist. • Review sleep hygiene measures • Review specialist recommendations with line commanders if special equipment, computer screens or other adaptive equipment is needed, ensure equipment is ordered and delivered
Hearing difficulty - Sensitivity to noise		Environmental modifications	Audiology ENT Sensitivity to noise: Speech and Language Pathology	• Communicate to chain of command needs for adaptive equipment, quiet work space, ongoing therapy • Arrange for adaptive hearing equipment if indicated • Facilitate audiology consult, reassure Service member that symptoms usually improve or are treatable

***** Depending on the local resources, impaired vision may be referred in some facilities to neuro-ophthalmologists. Note that the impaired vision may be due to problems with oculomotility, as well as disorders of the retina and visual pathways

Table 6: Common Persistent Behavioral and Cognitive Symptoms and CM Interventions

Common Symptoms Following Concussion/mTBI	Pharmacologic Treatment	Non-Pharmacologic Treatment	Referral after failed response to Initial Intervention	Case Management Interventions
Fatigue -Loss of energy -Getting tired easily	Stimulant	Reassurance Encourage regular scheduled aerobic exercise Activity restriction adjustment	MH	• Review with Service member compliance to exercise regime, barriers to completion, may need to discuss with chain of command to allow time for balance exercise/relaxation times • Review sleep patterns, availability of quality sleep time (children/family may interfere with needed rest) • Review diet, hydration, vitamins or other supplements to diet • Assess for medication overuse
Cognitive difficulties -Concentration -Memory -Decision Making	Selective Serotonin Reuptake Inhibitor (SSRI) Stimulant*	Sleep hygiene education Sleep study	TBI specialist for cognitive rehabilitation (CR)or MH	• Assess for possible co-morbidities, ensure they are being addressed • Suggest functional assessment, cognitive rehabilitation testing/evaluation if not already done • Review treatments, plan of care with Service member with "battle buddy" or support person present, give written instructions. Encourage Service member to take his or her time, engage support person to assist as needed if Service member will allow • Provide instructions in writing, plan for appointment reminders such as phone calls
Feeling anxious -Emotional difficulties -Feeling depressed -Irritability -Poor frustration tolerance	Anti-epileptics SSRI		MH Social support	• Share information on resiliency-such as RESPECT-Mil at http://www.pdhealth.mil/respect-mil/index1.asp . Afterdeployment.org, de-emphasize stigma, and emphasize strength and patience. De-emphasize stigma with use of anonymous resources, web based or off MTF if needed • Discuss with primary care provider, line commander, or appropriate member(s) of multi-disciplinary team need for CR or MH referrals or duty adjustment • Be patient with Service member, allow extra time if possible for Service member to speak, try to focus on one item at a time.

APPENDICES

Appendix A: Acronyms and Terms

Acronym	Term
AHLTA	Armed Forces Health Longitudinal Technology Application
CAM	complimentary alternative medicine
CM	case manager
CCM	certified case manager (licensed staff)
CMSA	Case Management Society of America
CONUS	continental United States
CR	cognitive rehabilitation
CRNP	certified registered nurse practitioner
DCoE	Defense Centers of Excellence
DoD	Department of Defense
DVBIC	Defense and Veterans Brain Injury Center
ENT	ear nose and throat also known as otolaryngologist
LCSW	licensed clinical social worker
MH	mental health
mTBI	mild traumatic brain injury same as 'concussion'
MTF	military treatment facility
MT	multidisciplinary team
NICoE	National Intrepid Center of Excellence
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PCC	primary care clinician (MD, CRNP, PA)
PH	psychological health
PM&R	physical medicine and rehabilitation
POC	point of contact
RCP	recovery care plan (may be formal document or conceptual)
RCC	regional care coordinator: DVBIC program
RTD	return to duty
SSRI	selective serotonin re-uptake inhibitor
TBI	traumatic brain injury
tx	treatment
VA	Department of Veterans Affairs
WW	wounded warrior

Appendix B: References:

1. CMSA Standards of Practice for Case Management, Chapters 2-4, pages 6-10, Revised 2010.

2. Under Secretary of Defense Memorandum DTM-08-033, Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the MHS. August 26, 2009

3. VA/DoD Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury, Version 1.0-April 2009

4. Assistant Secretary of Defense Memorandum, "Traumatic Brain Injury: Definition and Reporting," October 1, 2007.

5. BUMEDINST 6300.17 BUMED-M00WII: Subject Navy Medicine Clinical Case Management pages 7-12, 23 November 2009

6. Defense and Veteran's Brain Injury Center Regional Coordinator Intake and Follow-up Forms, December 2007

7. Fort Bragg WOMACK Army Medical Center Excerpt from the Case Management Department's Internal SOP.

Appendix C: Helpful Resources

TBI RESOURCES	RESOURCE TYPE	WEBSITE
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury	Call Center: 1-866-966-1020, website, hardcopy materials, videos, blogs	http://www.dcoe.health.mil
Defense and Veterans Brain Injury Center	National Locations, RCC Program, research, surveillance	http://www.dvbic.org
Deployment Health Clinical Center	Information, articles and directives for Services regarding TBI	http://pdhealth.mil/TBI.asp
National Resource Directory	Web-based information on a variety of medical topics	https:// www.nationalresourcedirectory.gov
Real Warriors Campaign	Web-based information for Warrior psychological health	http://realwarriors.net
VA/DoD Clinical Practice Guidelines	Listing of most recent CPG's, downloadable in PDF format	http://www.healthquality.va.gov
U.S. Dept. of Veterans Affairs	On-line information about Veterans rights and benefits, VA locations	http://www.va.gov
Commission for Case Management Certification	Information on criteria for CM certification.	http://www.ccmcertification.com
The Case Management Resource Guide	website	http://www.cmrg.com

Helpful Resources Continued:

TBI RESOURCES	RESOURCE TYPE	WEBSITE
Case Management Society of America	National and State information on CM resources, legislative updates, education, CEU's	http://www.cmsa.org
The Case Manager's Survival Guide	Manual	Winning Strategies for Clinical Practice Second Edition Toni G. Cesta, Hussein A. Tahan. Mosby 2003.
U.S. Navy CM Tool Kit	Excellent example of required CM basics for the military	http://www.med.navy.mil/sites/sample/bumed/CaseManagement/Pages/default.aspx
U.S. Army Telehealth for MH Article	Mobile Phone CM Support to improve Warrior outcomes	http://behavioralhealthcentral.com
Navy Medicine	website	http://www.med.navy.mil
U.S. Department of Army Medicine	website	http://www.armymedicine.army.mil
Wounded Warrior Regiment U.S. Marine Corps	Website and Call Center	http://www/woundedwarriorregiment.org SGT. Merlin German WWR Call Center: 1-877-487-6299
Air Force Surgeon General	website	http://www.sg.af.mil

GLOSSARY

This section provides the definitions for terms used within this Guidance Document.

Table 7: Case Management for Concussion/mTBI Guidance Document Definitions

Term	Definition
Case Manager for TBI (TBI Case Manager) (CM)	Case manager (RN or LCSW) assigned at an MTF or TBI clinic with the clinical background and/or training required to expertly assess, plan, implement, monitor and evaluate the ongoing care of Service members with TBI. May be civilian or military.
Certified Case Manager (CCM)	Certified case manager: Licensed secondary degree level professional(typically and RN or LCSW) who has met the certification criteria for case manager as set forth by the Commission for Case Management Certification (CCMC) and obtained the certification after passing a written examination administered by the CCMC.
Federal Recovery Care Coordination Program	Program under Congressional authority that provides non-medical case management services to Service members with catastrophic illness or injuries
Multi-disciplinary Team (MT)	Multidisciplinary team consisting of but not limited to: the primary care clinician, CM, RN's, consultants (medical/psychiatric/psychological/diagnostic), home care, rehabilitation therapists, social worker, Service members and family.
Primary Care Clinician/ Coordinator	Primary care clinician: Physician certified registered nurse practitioner, physician assistant, medic or corpsman.
Recovery Care Plan (RCP)	Documentation (separately or on-line tool) by the CM and MT based on assessments of identified medical/physical/mental/behavioral/social/spiritual and other problems or deficits and their planned interventions, referrals, short and long term goals with time frames, intervals for reassessments and success measurements and ongoing needs. May also be called "care plan."
Regional Care Coordination Program	Program under the Defense and Veterans Brain Injury Center that provides non-medical case management for Service members who have sustained traumatic brain injury during OEF/OIF.

The Case Management Process