Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health

Training Manual

Version 1

July 27, 2012

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Relevant Clinical Practice Guidelines (CPGs)

CPGs used in the tool kit:

- Traumatic Brain Injury (TBI)
  - Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guideline for Management of Concussion/Mild Traumatic Brain Injury (mTBI)
- Psychological Health
  - VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder (MDD), Ver. 2.0, May 2009
  - VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress (PTSD), Ver. 2.0, 2010
  - VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (SUD), Ver. 2.0, 2009
  - VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, Ver. 2.0, 2010

Other supporting clinical guidance:

- Deployment Health
  - Medically Unexplained Symptoms: Chronic Pain and Fatigue, Ver. 1.0
  - Post-deployment Health Evaluation Management, Ver. 1.2, Update
- Traumatic Brain Injury
  - Indications and Conditions for In-theater Post-injury Neurocognitive Assessment Tool (NCAT) Testing
  - Case Management of Concussion/Mild TBI
  - Clinical Guidance for Evaluation and Management of Concussion/mTBI-Acute/Subacute (CONUS)

Feedback

Feedback is vital for improving the quality of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) training manuals. Instructor feedback (written or verbal) on the course and course materials is greatly appreciated. Completed feedback should be directed to:

Education Directorate
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
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Table of Contents

1 Introduction

This training manual is designed primarily for instructor(s), but may also be beneficial to course sponsors, training leads or other individuals responsible for measuring performance related to training and/or education. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) clinical training manuals are designed to enhance consistent delivery of training while also providing instructors the flexibility to tailor materials to the needs of the audience. DCoE believes training is most effective when delivered by local instructors who can use examples relevant to the audience and reinforce education after the initial course is delivered. This manual:

- Incorporates adult learning principles
- Equips instructors with tools to motivate learners to actively participate in the learning process
- Consists of interchangeable modules, instructors to customize the course based on audience needs
- Includes tools that allow instructors and organizations to assess the impact of instruction on learner knowledge and behavior

DoD Documents Supporting DCoE Instruction Manual Effort

This manual is one of a series DCoE developed in support of:

- National Defense Authorization Act (NDAA) 110-181, TITLE XVI Sec 1621(c)(6) and 1622(c)(6): Coordinate best practices for training mental health professionals, with respect to psychological health, TBI, and other mental health conditions
- Mental Health Task Force (MHTF) 5.1.3.1, 5.1.3.3 and 5.1.3.4: Develop and implement core curricula on psychological health and TBI for DoD health care providers and leaders
- Public Law (P.L.) 110-181 Sec. 1615(a) Uniform training standard among military departments for training and skills of medical and non-medical providers of care.

2 Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health *Clinical Training Manual*

The purpose of this training manual is to demonstrate the use of the tool kit to initiate appropriate symptom management of mild traumatic brain injury (mild TBI) and co-occurring psychological health conditions when multiple diagnoses may be present, either resulting in resolution of symptoms or while awaiting specialty appointments. This tool kit was developed by DCoE and its centers to assist providers when managing this complex population of patients. The VA held a consensus conference in 2009 on concussion, posttraumatic stress disorder (PTSD), and pain with the goals of providing a consensus recommendation on the treatment of veterans with these co-morbid conditions. The five CPGs reviewed are concussion, PTSD, chronic opioid therapy, substance use disorders (SUD) and depression. The treatments

recommended in these CPGs are still recommended in the co-morbid population. However, there are areas within these CPGs that may present challenges should a patient present with multiple conditions. The tool kit helps to address these areas of conflict.

A training video was produced to accompany the tool kit. The first part of the training video highlights common definitions and illustrates the co-existing symptom domains. The second part addresses how to use the tool kit and provides guidance for the management of mTBI and co-occurring physical and psychological health conditions. The third part is clinical vignettes that further illustrate the complexity of this patient population.

The tool kit was not created to be a standard of care or an exclusive course of management. It does not replace clinical judgment or specialty consultation. The tool kit is designed to provide information and assist decision-making. Every health care professional making use of the tool kit is responsible for evaluating the appropriateness of applying the recommendations in the clinical setting. The tool kit does include pathways for real world consultation and resources are also located within the last appendix under “Provider Resources.” Icons are included throughout the manual to highlight key learning points or linkage to additional training materials (e.g., video vignette, role play scenario). The icons are represented in Appendix E.

The training manual is designed to facilitate effective training and encourage the use of customizable content to meet the needs of the instructor’s particular audience. Each instructor’s note page includes a picture of a slide, the instructor dialogue for content pertaining to that slide and a customizable area that allows the instructor to add reminders, additional content and notes. Any content within the training manual that exists in a customizable content area is a suggestion.

This course of instruction on how to use the Co-occurring Conditions Toolkit is intended for primary care providers who work in inpatient and ambulatory settings. However, other health care professionals may also benefit from this course. It may be used in a variety of settings to include but not limited to graduate medical education training, grand rounds and pre-deployment training. The majority of the content includes instructions on assessment, clinical decision making and treatment while encouraging familiarity with a variety of CPGs.

3 Slide Presentation

The slide presentation is divided into four sections. Instructors may incorporate any or all sections as individual needs require. For quick links to the various sections, please use the hyperlinks below.

SECTION A: SLEEP

This section includes the PowerPoint presentation and accompanying instructor notes. An overview of the content and associated SMART (specific, measurable, achievable, realistic, time-bound) objectives is included in the following table.

SMART Learning Objective(s)	Instructional Activity
▪ Differentiate between the most common diagnoses in a patient who: • experienced an mTBI, and • has sleep symptoms suggestive of a psychological condition	▪ Review a clinical vignette and utilize the sleep tabs of the tool kit to correctly differentiate between the most common diagnoses in a patient who experienced an mTBI and has sleep symptoms suggestive of a psychological health condition. ▪ Verbally discuss the assessment tools used to evaluate sleep symptoms and the recommended first and second step interventions.

Cover Slide: Sleep

Say:

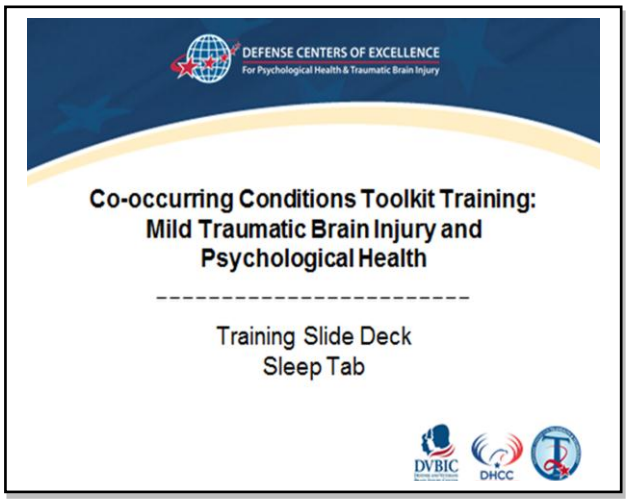
No slide notes

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health

Say:

The Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health was developed by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, or "DCoE."

[To next slide]

Do:

- Point to the specific tab of the tool kit that will be the focus of today's didactic, for instance, the sleep tab.

Additional Points (if any):

- None

Customizable Content (if any):

DCoE Centers

Say:

…and DCoE's centers:

- The Defense and Veterans Brain Injury Center or DVBIC
- The Deployment Health Clinical Center or DHCC
- The National Center for Telehealth and Technology or T2

Do:

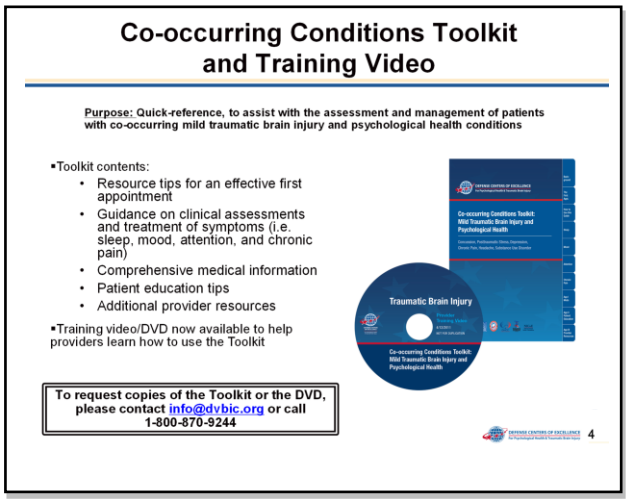
- Point to each component center's logo

Additional Points (if any):

- Instructor can mention where each component center is located:
  - DVBIC: multiple national and international sites
  - DHCC: Walter Reed National Military Medical Center, Bethesda, Md.
  - T2: Joint Base Lewis-McChord, near Tacoma, Wash.

Customizable Content (if any):

Co-occurring Conditions Toolkit and Training Video



Say:

The Department of Veterans Affairs hosted a consensus conference in 2009 on concussion, posttraumatic stress disorder, and pain, with the goal of providing a consensus recommendation on the treatment of veterans with these co-morbid conditions.

Five clinical practice guidelines were reviewed:

- Concussion
- PTSD
- Chronic opioid therapy
- Substance use disorders
- Depression

The treatments recommended in these CPGs are still recommended in the co-morbid population. However, there are areas within these CPGs that may present challenges should a patient present with multiple conditions. The tool kit attempts to address these areas of conflict.

A training video was produced to accompany the tool kit. If you have the chance to view the video, you will find that the first part of the video highlights common definitions and illustrates the co-existing symptom domains. The second part addresses how to use the tool kit and provides guidance for the management of mild TBI and co-occurring physical and psychological health conditions. The third part features clinical vignettes that further illustrate the complexity of this patient population and how to apply the tool kit to manage these patients.

Do:

- Point to the picture of the DVD on the slide if you intend to show the tool kit video.
- Emphazie how to order a copy of the tool kit and/or video.
- Show any part of the three-part video. For instance, if the instructor will conduct a basic review of mild TBI and psychological health issues, show section two of the video.

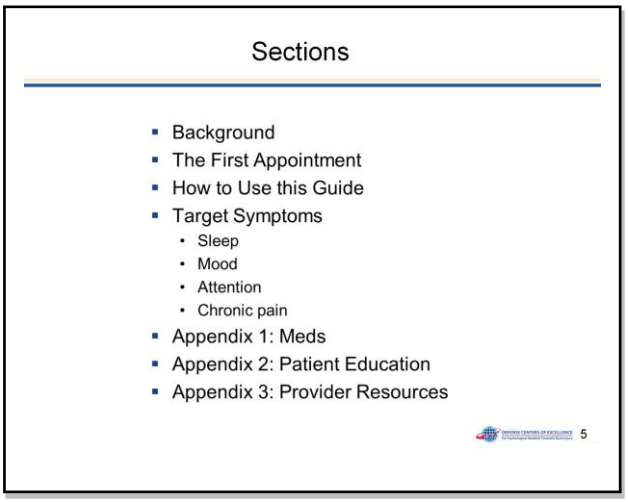
Customizable Content (if any):

Appendix B of the training manual contains evaluation tools for the content in the training video. The pre and post tests found in Appendix B are intended for participants in the training who have viewed the entire training video in its entirety.

Additional Points (if any):

- None

Sections



Say:

These are the main sections of the tool kit:

- Background
- The first appointment
- How to use this guide
- Target symptoms. The four target symptoms are: sleep, mood, attention and chronic pain. Each has its own tab containing tables that recommend tools and actions and treatment tips.
- Appendix I: medications
- Appendix II: patient education
- Appendix III: provider resources

Do:

- No activities

Additional Points (if any):

- Show the tool kit
- Mark the sections listed on this slide in advance; show each section of the tool kit to the class as you mention it.

Customizable Content (if any):

Provider resources websites are listed in Appendix III of the tool kit.

These are the provider assessment tools that will be discussed in detail in the training modules. The tools or references on where to find these original tools are found in Appendix III:

PHQ-2
PHQ-9
AUDIT-C
PTSD Checklist-Military (PCL-M)
Pain Assessment Tool (COT)
DAST-20
PSQI
DSM-IV & DSM-IV-TR definitions
TBI criteria

Understanding the Target Symptom Tabs

Say:

There are two tables within each of the four target symptom tabs.

Table 1 cross-walks characteristics of the symptoms with seven co-occurring conditions (concussion / mTBI, headache, PTSD, acute stress disorder, depression, chronic pain, and substance use disorder resulting in a diagnosis of one or more of those seven co-occurring conditions.

Table 1 is further described on the next slide.

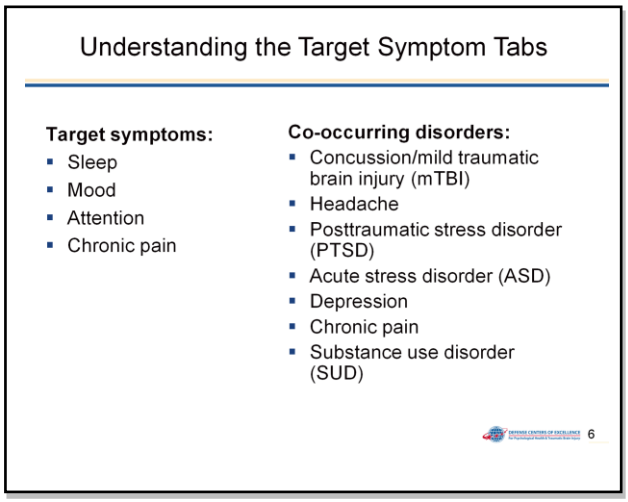
Table 2 provides treatment tips for the diagnosed co-occurring conditions.

Do:

- Point to the four target symptoms as they are mentioned
- If each participant has a copy of the tool kit, have each find one of the four tabs and open it to the two tables

Additional Points (if any):

- None



Customizable Content (if any):

Overview of Table 1

Say:

Bottom line up front: Utilization of Table 1 aids in determining a diagnosis of one or more of the seven co-occurring conditions.

There are three steps to understanding and using Table 1. Across the top banner, there are three columns labeled “symptoms,” “tool” and “action recommended.”

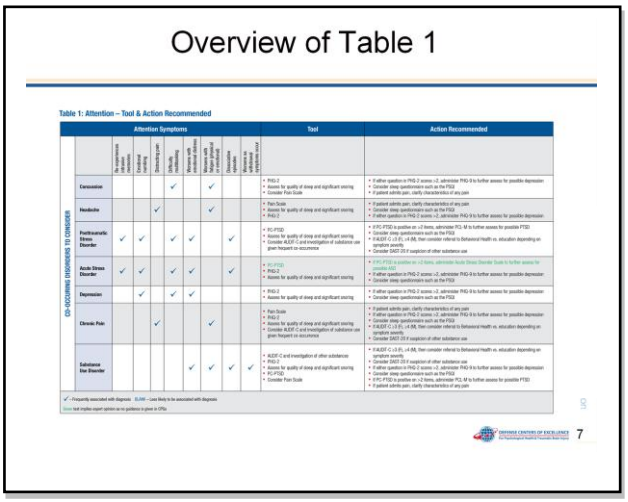
1. Symptoms column: The provider reviews the check-mark drawing to determine which potential diagnoses are associated with the characteristics of his/her patient’s symptoms
2. Tool column: Contains recommended screening and assessment tools based on the potential diagnosis identified in Table 1
3. Action recommended column: The results of the screening tools yield recommended actions, which help determine the etiology of the symptom(s)

Do:

- Point to “symptoms,” “tool” and “action recommended” when referring to these columns

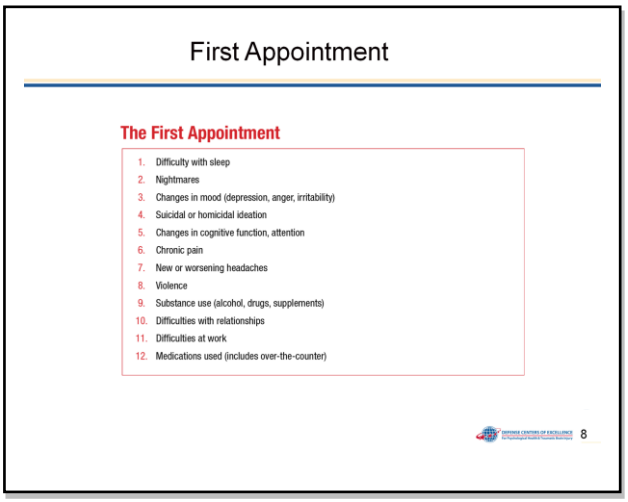
Additional Points (if any):

- Each of the tools mentioned in the tool column is either presented later on in the Tool kit or instructions are given on how to find and use them



Customizable Content (if any):

First Appointment



Say:

When seeing a service member with a concussion history and ongoing symptoms, a screening for potential co-occurring psychological health concerns should take place.

- There are several key areas of safety and symptoms that should be addressed
- (These 12 topics of concern are from page five of the tool kit)
- Given the time constraints of the primary care appointments, there will not likely be time to assess for the etiology of all symptoms. A focused interview that covers these main areas would be considered an adequate risk assessment and assist the provider in identifying the symptoms to address. The following slide includes some tips on structuring the clinical interview

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Tips for Structuring the Clinical Interview

Say:

There is not a one uniform presentation as the pattern of symptoms varies widely depending on the conditions present. Some tailoring of the provider communication style will be important to maximize effective patient interaction. Common cognitive symptoms that may affect patient interaction include memory problems, slowed thought process, problems with organization, dis-inhibition and altered self-awareness. Thus a longer appointment time may be required than most typical primary care appointments.

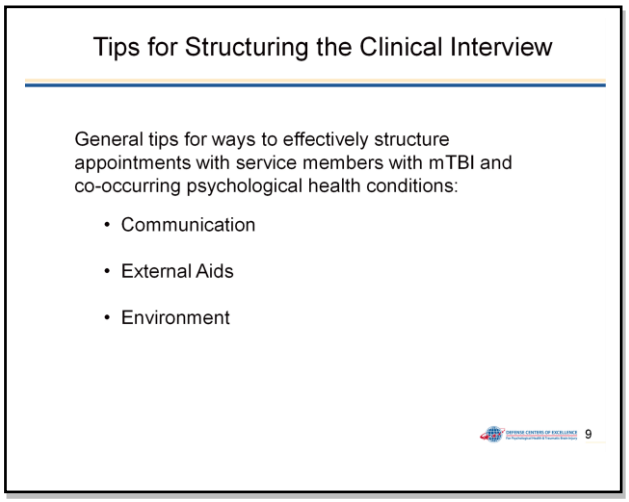
- **Communication** – use short, simple sentences, minimize the amount that is said at one time, speak slowly and clearly, use the same words when repeating information, summarize key points throughout the appointment, allow patient time to repond
- **External aids** – written notes, diagrams either by or for the patient, set session agendas
- **Environment** – more frequent yet shorter visits, set meeting time, structure, plan appointments during patients's best time of day, be open to contact between sessions, plan for longer duration of treatment, minimize distractions in visits and appointment environment

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Source of *Tips for Structuring the Clinical Interview* from the tool kit:

Kortte, KB, Briggs, F & Wegener, ST. (2005) Psychotherapy with Cognitively Impaired Adults. In GP Koocher, JC Norcross, & SS Hill, III (Eds.) The Psychologist's Desk Reference 2nd Edition (pp. 342-346), Oxford University Press.

Sleep

Say:

SMART objective:

- The participant will review a clinical vignette and utilize the sleep tabs of the tool kit to correctly differentiate between the most common diagnoses in a patient who experienced a mild TBI and has sleep symptoms suggestive of a psychological health condition.
- The participant will verbally discuss the assessment tools used to evaluate sleep symptoms and the recommended first and second step interventions.

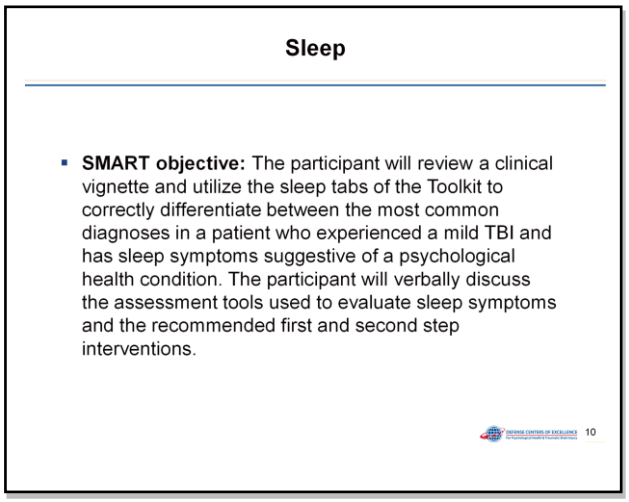
*SMART stands for specific, measurable, achievable, realistic and time-bound.

Do:

- Show the sleep tab of the tool kit.

Additional Points (if any):

- None



Customizable Content (if any):

Sleep

Say:

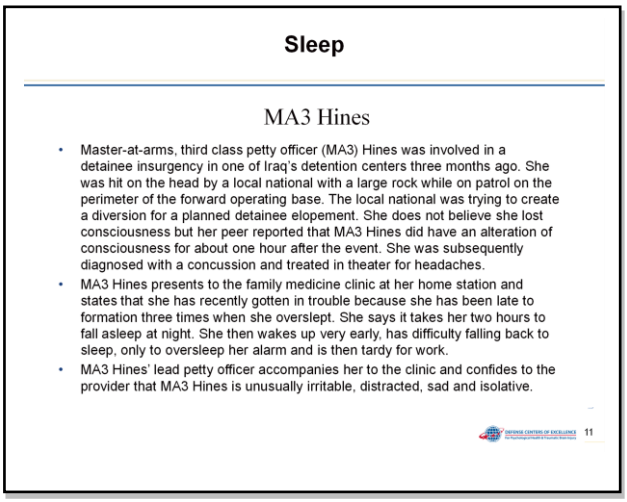
Master-at-arms, third class petty officer Hines was involved in a detainee insurgency in one of Iraq's detention centers three months ago. She was hit on the head by a local national with a large rock while on patrol on the perimeter of the forward operating base. The local national was trying to create a diversion for a planned detainee elopement. She does not believe she lost consciousness but her peer reported that Hines did have an alteration of consciousness for about one hour after the event. She was subsequently diagnosed with a concussion and treated in-theater.

Hines presents to the family medicine clinic at her home station and states that she has recently gotten in trouble because she has been late for formation three times when she overslept. She says it takes her about two hours to fall asleep at night. She then wakes up very early, has difficulty falling back to sleep only to oversleep her alarm and is then tardy for work.

Hines' lead petty officer accompanies her to the clinic and confides to the provider that Hines is unusually irritable, distracted, sad and isolative.

Hines was treated for her concussion in-theater and no longer has the headaches that she experienced after the concussion. Because she no longer has the headaches, she feels as though she has fully recovered from the effects of her concussion. She is usually a very well-regarded sailor at her command and is not accustomed to getting in trouble with her chain of command. She reports that she thinks about the incident during which she was hit in the head much more than she would like and that when she tries to go to sleep, she is worried that she might have a dream about the local national who hit her. So far, that has not actually happened, but she worries about it.

[Continued on next page]



Sleep

MA3 Hines

- Master-at-arms, third class petty officer (MA3) Hines was involved in a detainee insurgency in one of Iraq's detention centers three months ago. She was hit on the head by a local national with a large rock while on patrol on the perimeter of the forward operating base. The local national was trying to create a diversion for a planned detainee elopement. She does not believe she lost consciousness but her peer reported that MA3 Hines did have an alteration of consciousness for about one hour after the event. She was subsequently diagnosed with a concussion and treated in theater for headaches.
- MA3 Hines presents to the family medicine clinic at her home station and states that she has recently gotten in trouble because she has been late to formation three times when she overslept. She says it takes her two hours to fall asleep at night. She then wakes up very early, has difficulty falling back to sleep, only to oversleep her alarm and is then tardy for work.
- MA3 Hines' lead petty officer accompanies her to the clinic and confides to the provider that MA3 Hines is unusually irritable, distracted, sad and isolative.

11

Customizable Content (if any):

Summary of MA3 Hines' vignette:

- Blow to head with rock three months ago
- Peer report of AOC
- Dx with concussion in-theater, treated for headaches which have resolved
- Present with:
  - Occupational troubles
  - Early and late insomnia
  - Collateral hx reveals she is irritable, distracted, sad and isolative
  - Endorses preoccupation with trauma event, worries that she will have dreams or nightmares, is late to work.

Hines doesn't need to wake up until 0630 hours, but seems to wake daily at 0430 hours after having a lot of trouble falling asleep and can't seem to fall back to sleep. Once she finally falls back to sleep, she ends up sleeping through her alarm.

The provider agrees that because her post-concussive headaches have resolved, it may seem like Hines has recovered from her concussion. However, it is unclear if the symptoms she presents with today are due to the concussion alone, due to something else or due to the concussion AND something else. The provider decides to utilize the Co-occurring Conditions Toolkit to further assist in differential diagnosis and treatment.

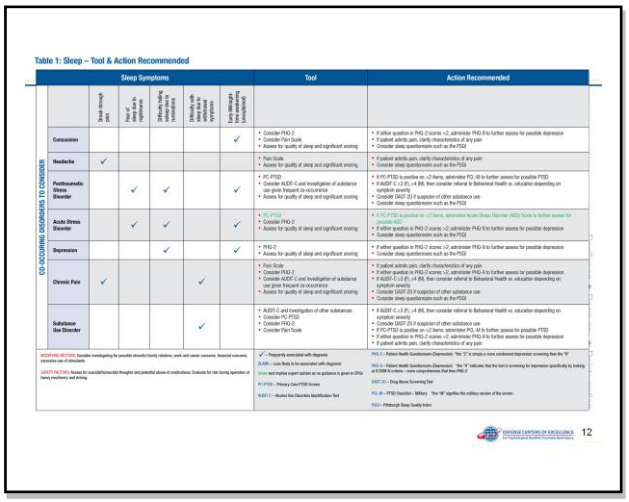
Do:

- No activities

Additional Points (if any):

- None

Table 1: Sleep – Tool & Action Recommended



Say:

When a patient, such as Hines, with mild TBI and co-occurring symptoms presents, the provider should identify which symptom tab (sleep, mood, attention or chronic pain) of the tool kit should be used based on current symptoms. In this case, Hines' target symptom seems to be sleep. Therefore, the provider flips to Table 1 of the sleep tab, which is on page 12 of the tool kit.

Before diving into Table 1, it is important to note the modifying and safety factors included in the bottom left corner:

- Modifying factors: consider investigating for possible stressful family relations, work and career concerns, financial concerns, excessive use of stimulants.
- Safety factors: assess for suicidal or homicidal thoughts and potential abuse of medications; evaluate for risk during operation of heavy machinery and driving.

Do:

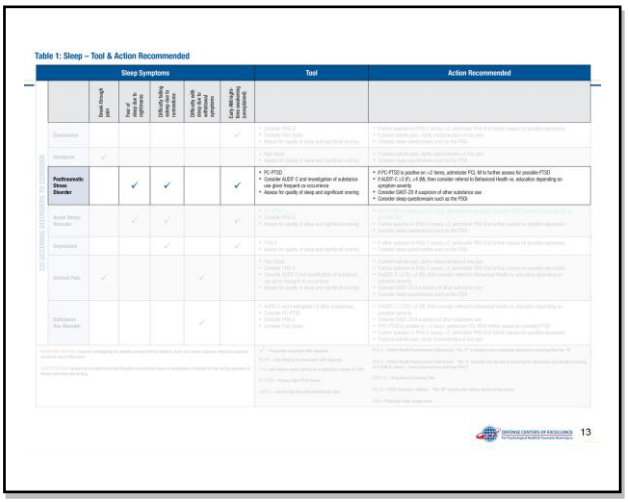
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Table 1: Sleep – Tool & Action Recommended **Cont'd**



Say:

Next, the provider reviews the characteristics of sleep symptoms at the top of the table. The characteristics of complaints related to sleep include: break-through pain, fear of sleep due to nightmares, difficulty falling asleep due to ruminations, difficulty with sleep due to withdrawal symptoms, early morning/nighttime awakening (unexplained).

In our example, Hines complains of difficulty falling asleep, worried about dreams and nightmares before falling asleep and early morning awakening.

The characteristics of Hines' symptoms, when matched with those at the top of the sleep tab, include:

- difficulty falling asleep due to ruminations
- early morning /nighttime awakening

Next, the provider determines the probable etiology of the specific symptoms. The "check-mark drawing" implies stronger association. Therefore, in our example, the provider looks to the PTSD, ASD, and depression rows as Hines' symptoms span these three diagnoses.

You will note that concussion does not become the focus on this patient scenario. This is due in large part to the resolution of the headaches, which eliminates pain as a source for sleep disturbances. Therefore, the concussion only has one common symptom (early morning/nighttime awakening - that is unexplained) that is correlated to it. This is unlike the rows in Table 1 for PTSD, acute stress disorder and depression that have a greater number of check-marks, leading the provider to suspect these as the source of Hines' problems.

The PTSD row is highlighted on this slide. This row includes the suggested assessment tools and the actions recommended for the management of PTSD.

Do:

- No activities

Customizable Content (if any):

Additional Points (if any):

- None

Table 1: Sleep – Tool & Action Recommended **Cont'd**

Say:

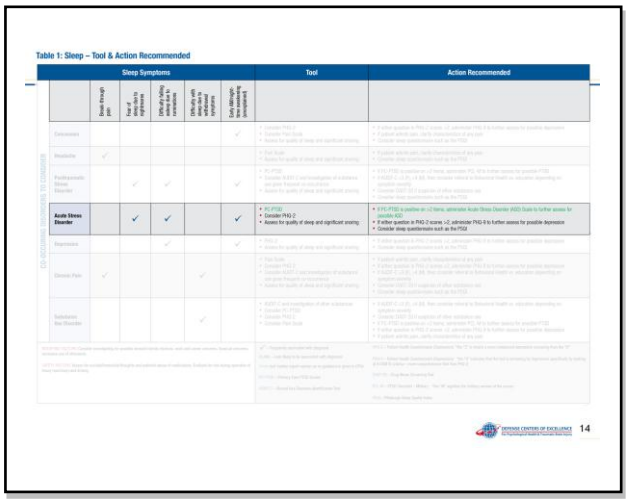
The acute stress disorder row is highlighted on this slide. This row includes suggested assessment tools and actions recommended for the management of acute stress disorder.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Table 1: Sleep – Too & Action Recommended Cont'd

Say:

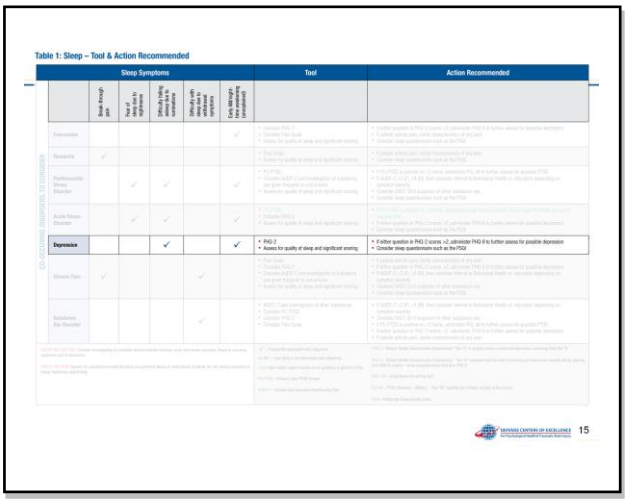
The depression row is highlighted on this slide. This row includes the suggested assessment tools and the actions recommended for managing depression.

Do:

- No activities

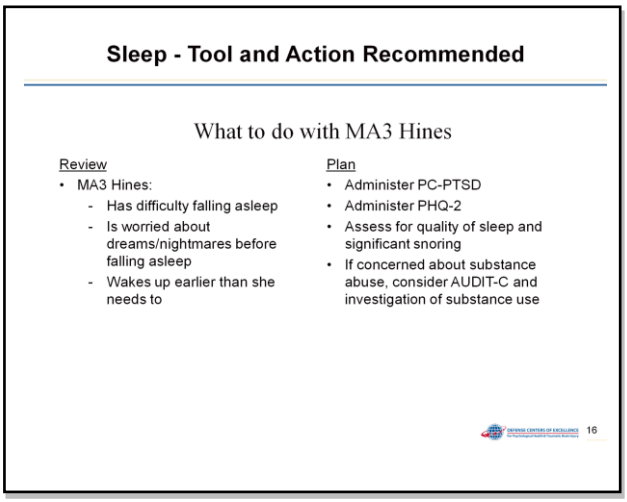
Additional Points (if any):

- None



Customizable Content (if any):

Sleep – Tool and Action Recommended



Say:

From the “tool” column on the PTSD, ASD and depression rows, here is the guidance for further assessing these symptoms:

- Administer the PC-PTSD
- Administer the PHQ-2
- Assess for quality of sleep and significant snoring using a tool such as the PSQI
- Consider administering the AUDIT–C and investigation of substance abuse given the frequent co-occurrence of PTSD and substance abuse. Note that the provider asked Hines several questions about substance abuse and given her responses, is not concerned that this is an issue. Therefore, the provider elects not to administer the AUDIT-C.

To illustrate what these tools look like, they are shown on the next few slides.

* It is important to note that there is a great deal of overlap in symptom presentation for the diagnoses of PTSD and acute stress disorder. The DSM-IV diagnostic criteria for both are found in the tool kit on pages 127-128 and a comparison of the two shows how similar the patient presentation can be. One of the main differences is that PTSD is not diagnosed until after at least 30 days, yet ASD may be diagnosed when the symptoms last AT LEAST two days and at a maximum of four weeks from the trauma event. Because the incident where Hines was attacked occurred more than four weeks ago, the provider rules out the potential for acute stress disorder.

Do:

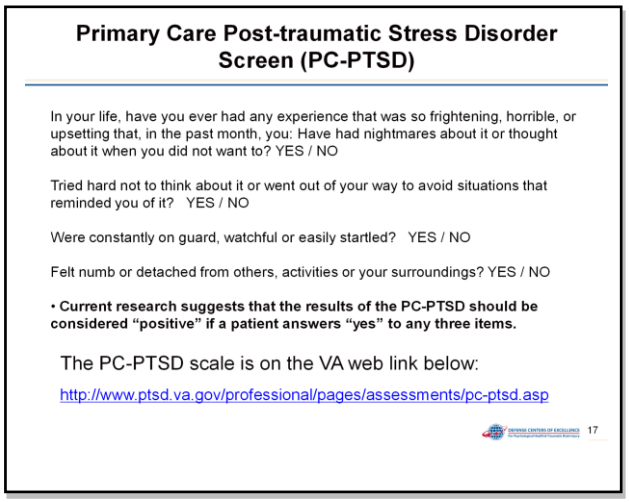
- No activities

Additional Points (if any):

- The location and instructions for use of the assessment tools mentioned here will be identified on the next slides.

Customizable Content (if any):

Primary Care Post-traumatic Stress Disorder Screen (PC-PTSD)



Say:

The Primary Care Post-traumatic Stress Disorder Screen (PC-PTSD) is a four-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items. For our purposes, we state in the tool kit that a screen is positive for a patient who answers **"yes" to more than 2 items** and administer the PCL-M to further assess for PTSD.

The PC-PTSD is located on the VA website link listed on this slide.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Patient Health Questionnaire 2 (PHQ-2)

Say:

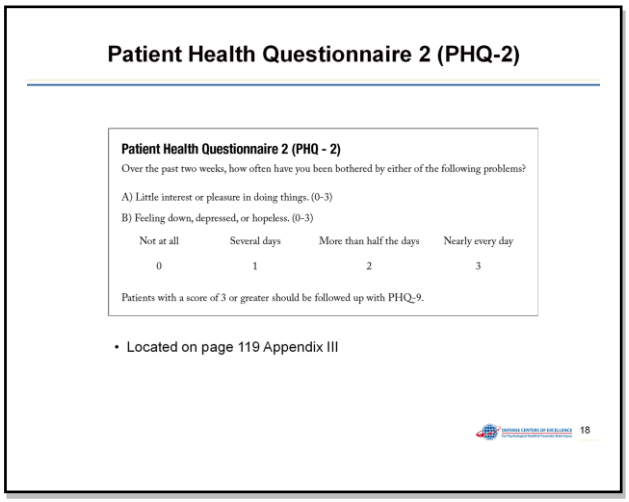
The Patient Health Questionnaire 2 is a tool for major depressive disorder that is effective in identifying patients with depression and can also be used to measure treatment outcomes. The authors state that patients with a PHQ-2 score of 3 or greater should be followed up with the PHQ-9 – as seen on this slide. For our purposes and for use in the tool kit, if the **PHQ-2 is > greater than 2** it is recommended for the provider to consider using the PHQ-9 to further assess for possible depression. The PHQ-2 is located on page 119 of the tool kit.

Do:

- No activities

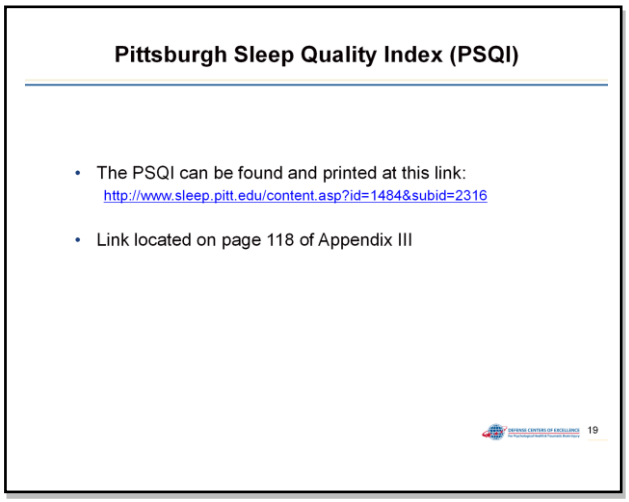
Additional Points (if any):

- None



Customizable Content (if any):

Pittsburgh Sleep Quality Index (PSQI)



Say:

The Pittsburgh Sleep Quality Index (PSQI) is a 19 item self-rated questionnaire and has five questions rated by a bed partner or roommate that assesses sleep disturbances during a one-month time interval. However, only the self-rated items are used in scoring the scale. All scores are combined according to the scoring criteria included with the form to produce a global PSQI score.

Each component is scored from 0 to 3, yielding a global PSQI score between 0 and 21, with higher scores indicating lower quality of sleep. The PSQI is useful in identifying good and poor sleepers. A global **PSQI score greater than 5** indicates that a person is a “poor sleeper” having severe difficulties in at least two areas or moderate difficulties in more than three areas.

The link to the PSQI is on page 118 of the tool kit under the heading “Additional Provider Tools”.

Do:

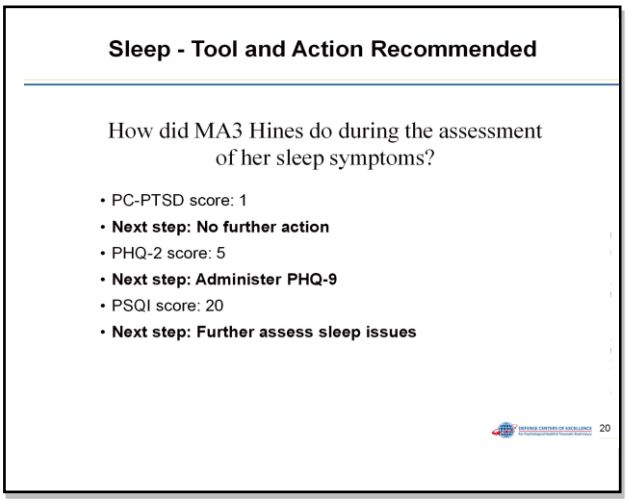
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Sleep – Tool and Action Recommended



Say:

Hines scored a 1 on the PC-PTSD, which indicates a negative score. No further action is necessary to assess for PTSD or acute stress disorder. A score is considered positive if a patient answers **"yes" to more than 2 items**. If the PC-PTSD was positive, the provider would administer the PCL-M to further assess for possible PTSD or the Acute Stress Disorder Scale to further assess for possible acute stress disorder.

Hines scored a 5 on the PHQ-2. If either question in the **PHQ-2 scores greater than 2**, the provider should next administer the PHQ-9 to further assess for possible depression.

Hines scored a 20 on the PSQI. The assessment of quality of sleep and significant snoring revealed she has early insomnia (can't get to sleep for two hours) and late insomnia (wakes up early unintentionally and can't get back to sleep), and does not snore. This prompted the provider to further assess Hines' sleep symptoms.

Do:

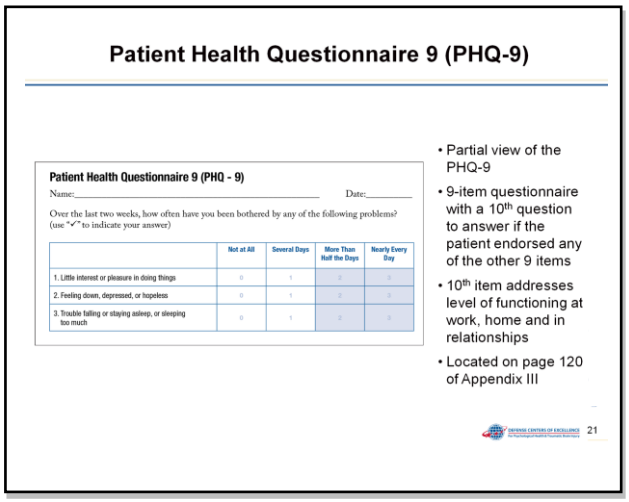
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Patient Health Questionnaire 9 (PHQ-9)



Say:

The Patient Health Questionnaire 9 (PHQ-9) is effective for assessing the presence and severity of depression. It is a nine-item questionnaire, with a 10th question for the patient to answer if they have endorsed any of the other nine items. The 10th question addresses levels of functioning at work, home and in relationships.

This is a partial view of the PHQ-9.

The PHQ-9 is located on page 120 of Appendix III and also includes interpretation information.

Do:

- No activities

Additional Points (if any):

- The first two items on the PHQ-9 are the same as the PHQ-2, thus shortening administrative time.

Customizable Content (if any):

***Patient Health Questionnaire 9 (PHQ-9)* Cont'd**

Say:

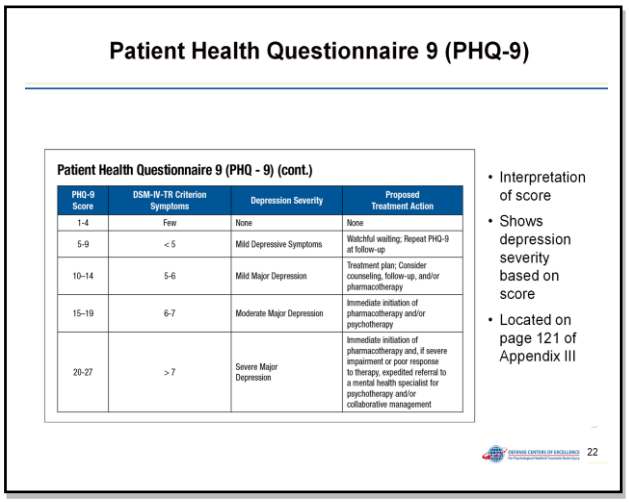
This table shows how the score on the PHQ-9 depicts the severity of depression and the proposed treatment action. This is found on page 121 of Appendix III.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Sleep – Tool and Action Recommended

Say:

Hines scored a 15 on the PHQ-9, which indicates that she has symptoms consistent with moderate depression.*

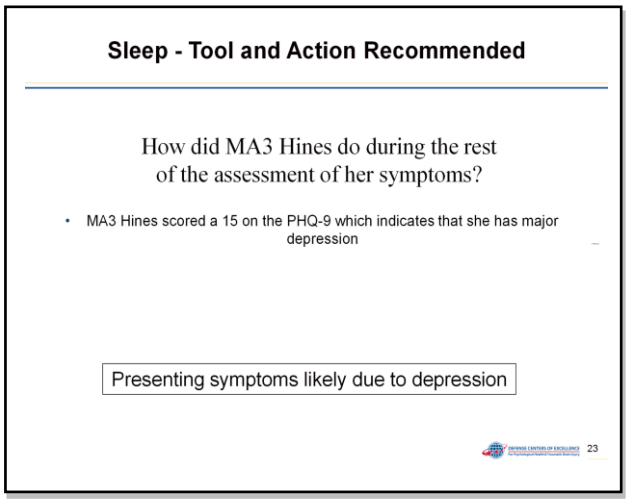
Diagnosis of depression would need to be confirmed by provider; these instruments are self-reports of symptoms, not diagnostic.

Do:

- No activities

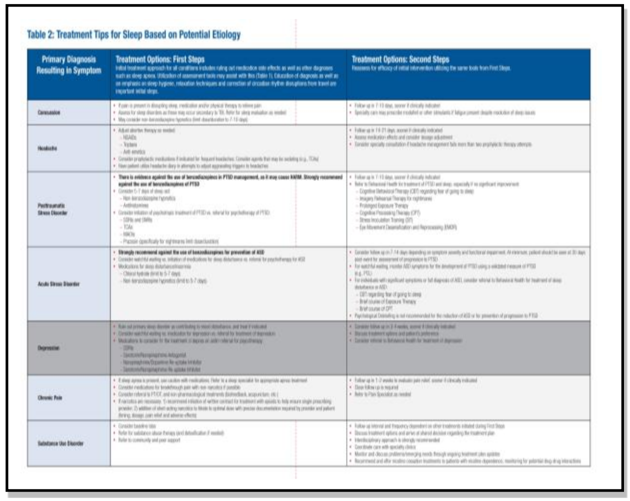
Additional Points (if any):

- None



Customizable Content (if any):

Table 2: Treatment Tips for Sleep Based on Potential Etiology



Say:

The provider next refers to Table 2 (page 15) of the sleep tab and looks to the depression row since that seems to be the etiology of Hines' symptoms based on the provider's assessments as noted in the previous slides.

Table 2 has two columns that discuss the first and second steps for treatment options.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

***Table 2: Treatment Tips for Sleep Based on Potential Etiology* Cont'd**

Say:

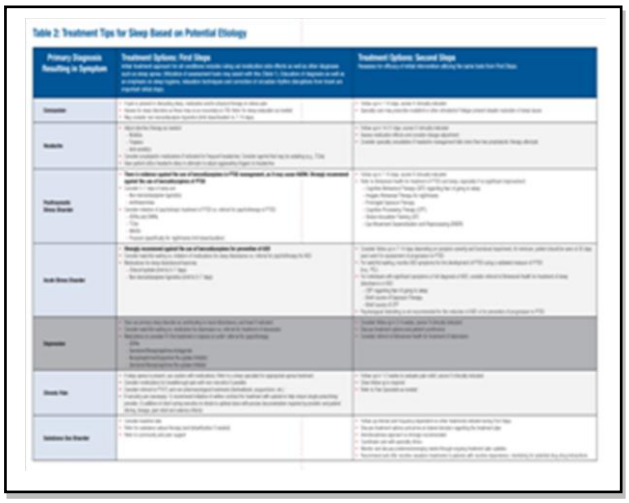
Here is the depression row. Let's look at the first step treatment options on the next slide.

Do:

- No activities

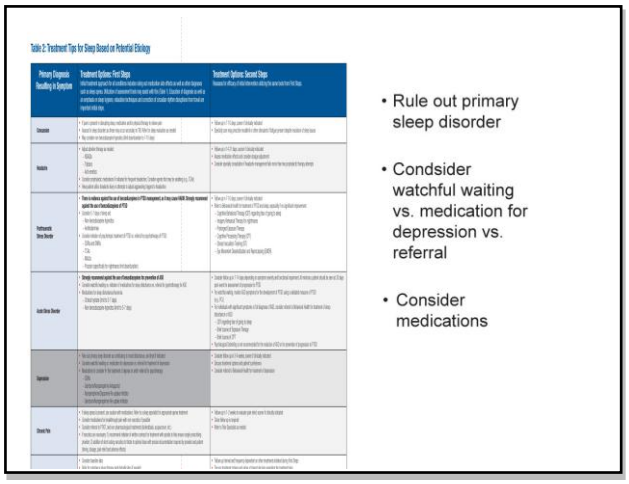
Additional Points (if any):

- None



Customizable Content (if any):

Sleep - Treatment Tips Based on Potential Etiology



Say:

According to the treatment options: first steps for depression, the provider would:

1) Rule out a primary sleep disorder as contributing to mood disturbance and treat if indicated
2) Consider watchful waiting versus medication for depression versus a referral for treatment for depression
3) Consider medications

-Selective serotonin re-uptake inhibitors (SSRIs)

-Serotonin/norepinephrine antagonists

-Norepinephrine/dopamine re-uptake inhibitor

-Serotonin/norepinephrine re-uptake inhibitor

The provider considers initiation of an SSRI for Hines. Let's look at where to find information on that in the tool kit

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

- Rule out primary sleep disorder
- Consider watchful waiting vs. medication for depression vs. referral
- Consider medications

Medication Considerations (example)

Say:

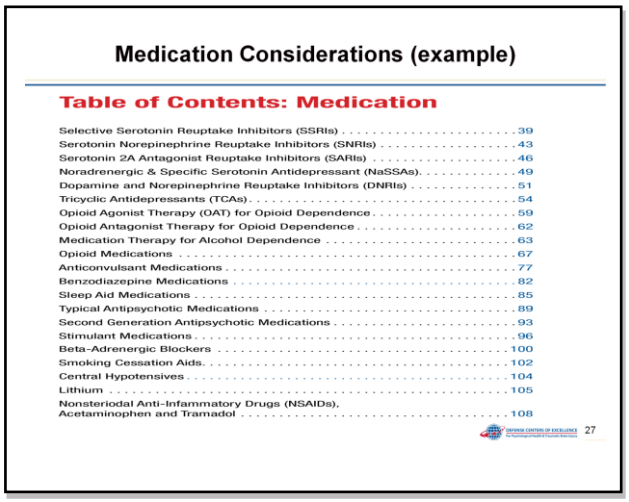
Page 36 of the tool kit includes the table of contents for the medications.

Do:

- No activities

Additional Points (if any):

- Appendix I contains medications that are potential pharmacological agents for use in co-occurring disordered patients.
- It includes this information for each medication:
  - The medication name (generic and brand name)
  - Adult starting dose (max per day)
  - Advantages/disadvantages
  - Pregnancy category
  - Safety margin
  - Efficacy
  - Table of adverse drug effects: (relative comparisons)
  - A table of pros and cons for the use of a specific class of medication acros the diagnoses of mild TBI, Headache, acute stress, PTSD, depression, chronic pain and substance use disorders
  - Black box warning if it exists for that class



Customizable Content (if any):

Medication Considerations (example)

Say:

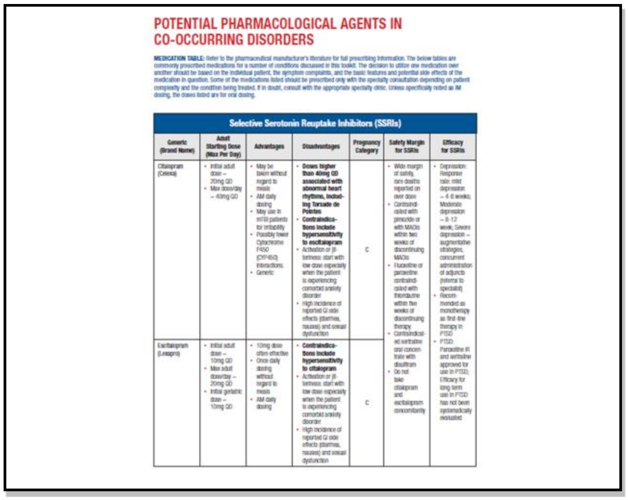
Here is a sample page of the SSRIs, which begin on page 39 of the tool kit.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Medication Considerations (example) **Cont'd**

Say:

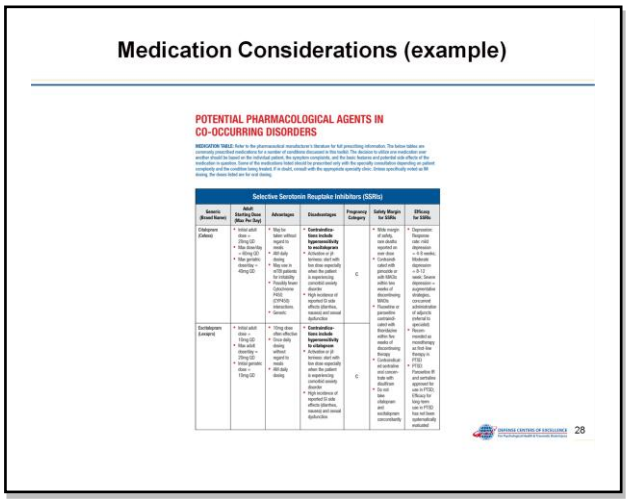
This slide of page 41 of Appendix 1 shows the information on Zoloft, which is the SSRI that the provider in this example is considering.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Medication Considerations (example)* Cont'd**

Say:

Page 42 shows the adverse drug effects with relative comparisons and the pros and cons of using SSRIs with the various co-occurring conditions.

The provider elects to start Hines on Zoloft, 50 mg QAM. The provider notes from the tool kit (page 41) that Zoloft is an SSRI that is helpful with managing insomnia, in addition to treating depressed mood. The provider is hopeful that it may target Hines' sleep complaints over time.

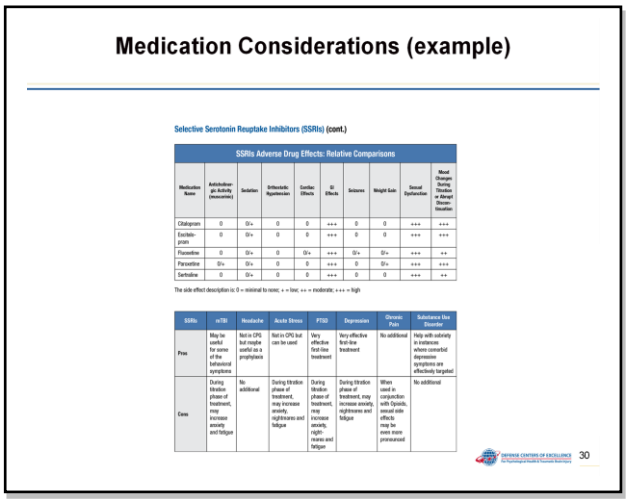
- The provider emphasizes that Hines must take the medication every day and that the full effect of the medication will not be appreciated for three to four weeks
- The provider goes over the side effects of the medication with Hines and answers all of her questions
- The provider also teaches Hines the principles of good sleep hygiene and recommends that she begin using those principles immediately
- The provider discusses a referral to behavioral health for treatment of depression and Hines agrees to the referral

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Sleep - Treatment Tips Based on Potential Etiology

Say:

According to Table 2, here are the treatment options: second steps for depression:

1) This follow up is at three to four weeks or sooner. Hines has had her initial evaluation by behavioral health and reports that she has “connected” with her behavioral health provider.
2) The provider assesses the efficacy of the Zoloft from the last visit.
3) Another thorough assessment of sleep symptoms and co-morbid diagnoses is essential to effective treatment. Hines reports improved sleep patterns.
4) The provider encourages Hines to maintain her behavioral health appointments and tells her to return to the clinic as needed for this or other general medical concerns.

Do:

- No activities

Additional Points (if any):

- None

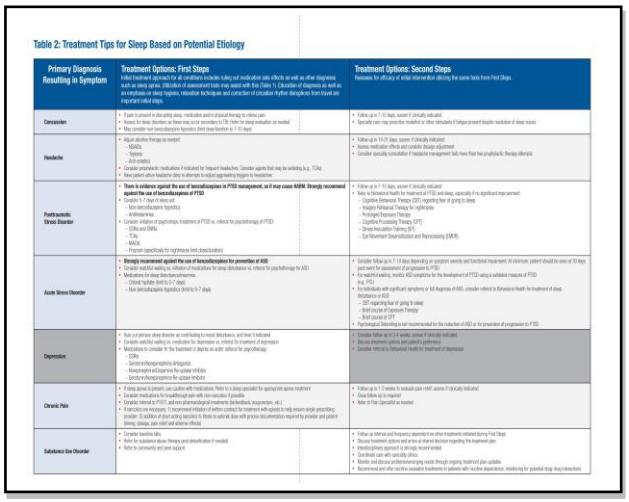
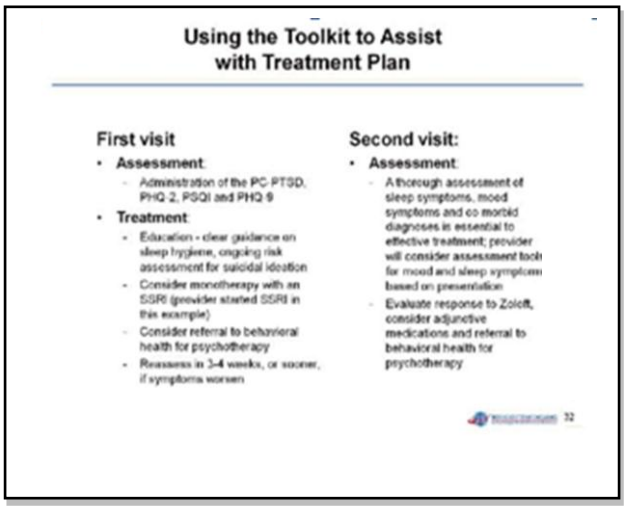


Table 2: Treatment Tips for Sleep Based on Potential Etiology

Primary Diagnosis Resulting in Symptom	Treatment Options: First Steps Initial treatment approach for all conditions includes sleep/wake and medication side effects as well as other diagnoses such as sleep apnea. Utilization of assessment tools may assist with this (Table 1). Education of diagnosis as well as an emphasis on sleep hygiene, relaxation techniques and correction of circadian rhythm disruptions from travel are important initial steps.	Treatment Options: Second Steps Reasons for efficacy of initial intervention utilizing the same tools from First Steps.
Concussion	• If pain is present in clinic-sitting sleep, medication and/or physical therapy to relieve pain • Assess for sleep disorders as these may occur secondary to TBI. Refer for sleep evaluation as needed. • May consider non-benzodiazepine hypnotics (limit dose/duration to 5 – 10 days)	• Follow up in 7 -10 days, assess if clinically indicated • Specialty care may prescribe modafinil or other stimulants if fatigue present despite resolution of sleep issues
Headache	• Adjust daytime therapy as needed: – NSAIDs – Tylenol – Anti-emetics • Consider prophylactic medications if indicated for frequent headaches. Consider agents that may be sedating (e.g., TCAs) • Have patient utilize headache diary in attempts to adjust aggravating triggers to headaches	• Follow up in 14-21 days, sooner if clinically indicated • Assess medication effects and consider dosage adjustment • Consider specialty consultation if headache management fails more than two prophylactic therapy attempts
Posttraumatic Stress Disorder	• **There is evidence against the use of benzodiazepines in PTSD management, as it may cause HARM. Strongly recommend against the use of benzodiazepines of PTSD** • Consider 5 – 7 days of sleep aid: – Non-benzodiazepine hypnotics – Antihistamines • Consider initiation of psychotropic treatment of PTSD vs. referral for psychotherapy of PTSD: – SSRIs and SNRIs – TCAs – NAOA; – Prazosin (specifically for nightmares limit dose/duration)	• Follow up in 7 -10 days, assess if clinically indicated • Refer to Behavioral Health for treatment of PTSD and sleep, especially if no significant improvement: – Cognitive Behavioral Therapy (CBT) regarding fear of going to sleep – Imagery Rehearsal Therapy for nightmares – Prolonged Exposure Therapy – Cognitive Processing Therapy (CPT) – Stress Inoculation Training (SIT) – Eye Movement Desensitization and Reprocessing (EMDR)
Acute Stress Disorder	• **Strongly recommend against the use of benzodiazepines for prevention of ASD** • Consider watchful waiting vs. initiation of medications for sleep disturbance vs. referral for psychotherapy for ASD • Medications for sleep disturbance/insomnias: – Chloral hydrate (limit to 5-7 days) – Non-benzodiazepine hypnotics (limit to 5-7 days)	• Consider follow up in 7-14 days depending on symptom severity and functional impairment. At minimum, patient should be seen at 30 days post-event for assessment of progression to PTSD • For watchful waiting, monitor ASD symptoms for the development of PTSD using a validated measure of PTSD (e.g., PCL) • For individuals with significant symptoms or full diagnosis of ASD, consider referral to Behavioral Health for treatment of sleep disturbances in ASD: – CBT regarding fear of going to sleep – Brief course of Exposure Therapy – Brief course of CPT • Psychological Debriefing is not recommended for the reduction of ASD or for prevention of progression to PTSD
Depression	• Rule out primary sleep disorder as contributing to mood disturbance, and treat if indicated • Consider watchful waiting vs. medication for depression vs. referral for treatment of depression • Medications to consider for the treatment in depression and/or referral for psychotherapy: – SSRIs – Serotonin/Norepinephrine Antagonist – Norepinephrine/Dopamine Re-uptake Inhibitor – Serotonin/Norepinephrine Re-uptake Inhibitor	• Consider follow up in 2-4 weeks, sooner if clinically indicated • Discuss treatment options and patient's preference • Consider referral to Behavioral Health for treatment of depression
Chronic Pain	• If sleep apnea is present, use caution with medications. Refer to a sleep specialist for appropriate apnea treatment • Consider medications for breakthrough pain with non-narcotics if possible • Consider referral to PT/OT, and non-pharmacological treatments (biofeedback, acupuncture, etc.) • If narcotics are necessary, 1) recommend initiation of written contract for treatment with opioids to help ensure single prescribing provider. 2) addition of short-acting narcotics to titrate to optimal dose with precise documentation required by provider and patient (timing, dosage, pain relief and adverse effects)	• Follow up in 1-2 weeks to evaluate pain relief, assess if clinically indicated • Close follow up as required • Refer to Pain Specialist as needed
Substance Use Disorder	• Consider baseline labs • Refer for substance abuse therapy (and detoxification if needed) • Refer to community and peer support	• Follow up interval and frequency dependent on other treatments initiated during First Steps • Discuss treatment options and arrive at shared decision regarding the treatment plan • Interdisciplinary approach in strongly recommended • Coordinate care with specialty clinics • Monitor and discuss problems/emerging needs through ongoing treatment plan updates • Recommend and offer nicotine cessation treatments to patients with nicotine dependence, monitoring for potential drug-drug interactions

Customizable Content (if any):

Using the Tool Kit to Assist with Treatment Plan



Say:

This is a concise view of the treatment plan for Hines that was recommended by following the tool kit guidance.

The provider used the tools recommended in Table 1 of the sleep tab to assess her symptoms and found that she endorsed many mood symptoms of depression as well. She scored high enough on the PHQ-9 to suggest a DSM-IV-TR diagnosis of depression which must be confirmed via clinician interview. The provider educated Hines on sleep hygiene and assessed her for suicidal or homicidal thoughts. The provider started monotherapy with an SSRI, offered a behavioral health referral for psychotherapy (which Hines agreed to) and made a follow-up appointment in three to four weeks.

At the second appointment, the provider re-evaluated Hines' mood and sleep symptoms and evaluated her response to the Zoloft.

That concludes the review of the Co-occurring Conditions Toolkit sleep tab.

Do:

- No activities

Additional Points (if any):

- Summarize what was stated in the SMART objective:
    - Participant reviewed a clinical vignette and used the sleep tabs of the tool kit to correctly differentiate between the most common diagnoses in a patient who experienced an mild TBI and has sleep symptoms suggestive of a psychological health condition
    - Participant verbally discussed the assessment tools used to evaluate sleep symptoms and the recommended first- and second-step interventions

Customizable Content (if any):

SECTION B: MOOD

This section includes the PowerPoint presentation and accompanying instructor notes. An overview of the content and associated SMART (specific, measurable, achievable, realistic, time-bound) objectives is included in the following table.

SMART Learning Objective(s)	Instructional Activity
▪ Correctly assess and differentiate between the most common diagnoses in a patient who: • Experienced a mTBI, and • Has co-occurring symptoms suggestive of ASD or PTSD	▪ Review a patient interview ▪ Utilize the mood tab of the tool kit ▪ Verbally discuss the assessment tools used to evaluate stress symptoms and first and second step interventions

Cover slide: Mood

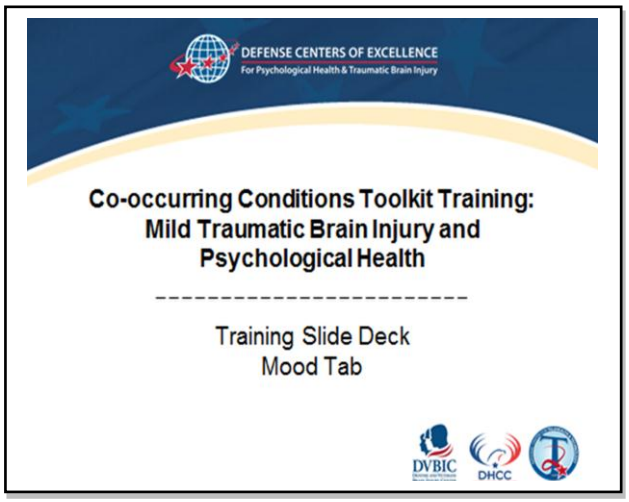
Say:
No slide notes

Do:

- No activities

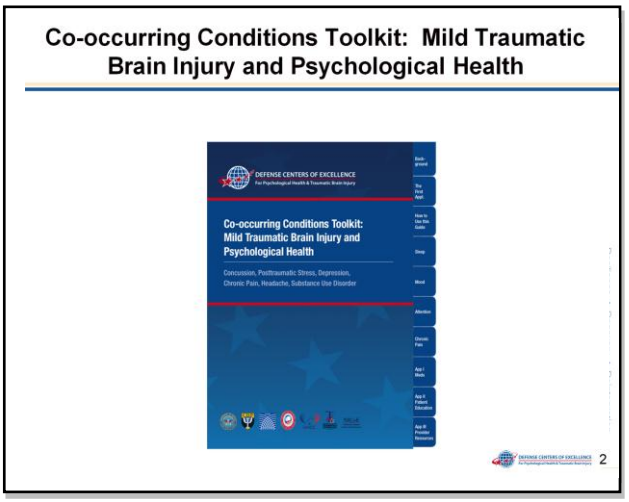
Additional Points (if any):

- None



Customizable Content (if any):

Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health



Say:

The Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury (mTBI) and Psychological Health was developed by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, or "DCoE."

[To next slide]

Do:

- Point to the specific tab of the tool kit that will be the focus of today's didactic, for instance, the mood tab.

Additional Points (if any):

- None

Customizable Content (if any):

DCoE Centers

Say:

…and DCoE's centers:

- The Defense and Veterans Brain Injury Center or DVBIC
- The Deployment Health Clinical Center or DHCC
- The National Center for Telehealth and Technology or T2

Do:

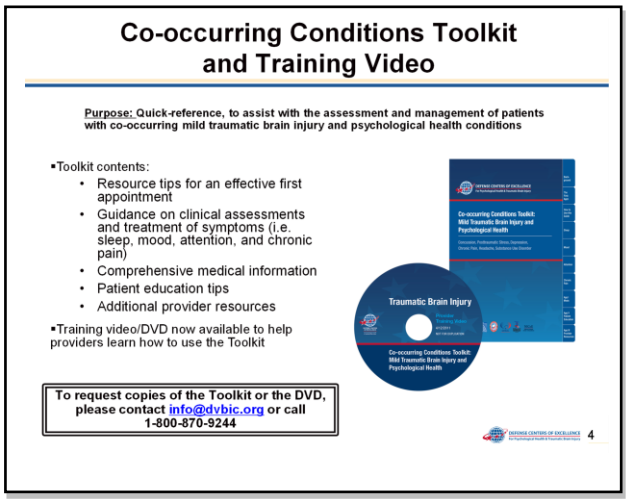
- Point to each of the component center logos

Additional Points (if any):

- Instructor can mention where each component center is located:
  - DVBIC: multiple national and international sites
  - DHCC: Walter Reed National Military Medical Center, Bethesda, Md.
  - T2: Joint Base Lewis-McChord, near Tacoma, Wash.

Customizable Content (if any):

Co-occurring Conditions Toolkit and Training Video



Say:

The Department of Veterans Affairs held a consensus conference in 2009 on concussion, posttraumatic stress disorder and pain, with the goal of providing a consensus recommendation on the treatment of veterans with these co-morbid conditions.

Five clinical practice guidelines were reviewed:

- Concussion
- PTSD
- Chronic opioid therapy
- Substance use disorders
- Depression

The treatments recommended in these CPGs are still recommended in the co-morbid population. However, there are areas within these CPGs that may present challenges should a patient present with multiple conditions. The tool kit attempts to address these areas of conflict.

A training video was produced to accompany the tool kit. If you have the chance to view the video, you will find that the first part of the video highlights common definitions and illustrates the co-existing symptom domains. The second part addresses how to use the tool kit and provides guidance for the management of mild TBI and co-occurring physical and psychological health conditions. The third part is clinical vignettes that further illustrate the complexity of this patient population and how to apply the tool kit to manage these patients.

Do:

- Point to the picture of the DVD on the slide if you intend to show the tool kit video
- Emphasize how to order a copy of the tool kit and/or video
- Show any part of the three-part video. For instance, if the instructor will conduct a basic review of mild TBI and psychological health condition, show section two of the video

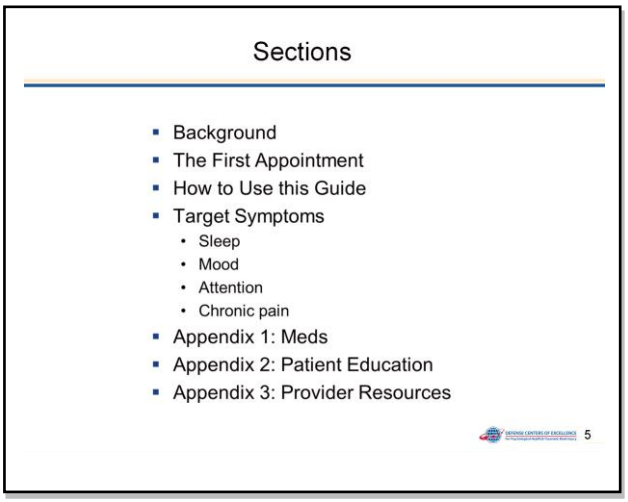
Customizable Content (if any):

Appendix B of the training manual contains evaluation tools for the content in the training video. The pre and post tests found in Appendix B are intended for participants in the training who have viewed the entire training video in its entirety.

Additional Points (if any):

- None

Sections



Say:

These are the main sections of the tool kit:

- Background
- The first appointment
- How to use this guide
- Target symptoms. The four target symptoms are: sleep, mood, attention and chronic pain. Each has its own tab containing tables that recommend tools and actions and treatment tips.
- Appendix I: medications
- Appendix II: patient education
- Appendix III: provider resources

Do:

- Show the tool kit
- Mark the sections listed on this slide in advance; show each section of the tool kit to the class as you mention it
- If each participant has a copy of the tool kit, have each find one of the four tabs and open it to the two tables

Additional Points (if any):

- None

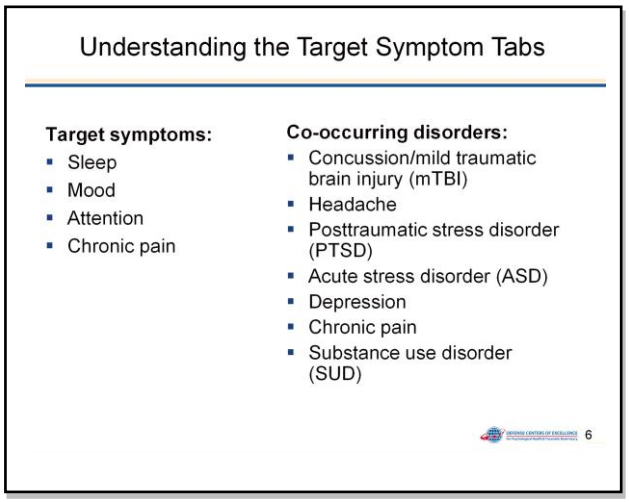
Customizable Content (if any):

Provider resources websites are listed in Appendix III of the tool kit.

These are the provider assessment tools that will be discussed in detail in the training modules. The tools or references on where to find these original tools are found in Appendix III:

PHQ-2
PHQ-9
AUDIT-C
PTSD Checklist-Military (PCL-M)
Pain Assessment Tool (COT)
DAST-20
PSQI
DSM-IV & DSM IV-TR Definitions
TBI Criteria

Understanding the Target Symptom Tabs



Say:

There are two tables within each of the four target symptom tabs.

Table 1 crosswalks characteristics of the symptoms with seven co-occurring conditions (concussion/ mild TBI, headache, PTSD, acute stress disorder, depression, chronic pain, and substance use disorder resulting in a diagnosis of one or more of those seven co-occurring conditions.

Table 1 is further described on the next slide.

Table 2 provides treatment tips for the diagnosed co-occurring conditions.

Do:

- Point to the four target symptoms as they are mentioned
- If each participant has a copy of the tool kit, have each find one of the four tabs and open it to the two tables

Additional Points (if any):

- None

Customizable Content (if any):

Overview of Table 1

Say:

Bottom line up front: Utilization of Table 1 results in a diagnosis of one or more of the seven co-occurring conditions.

There are three steps to understanding and using Table 1. Across the top banner, there are three columns labeled.

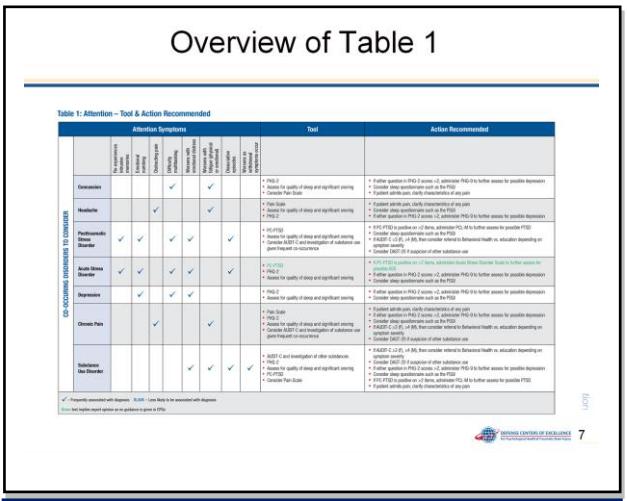
1. Symptoms column: The provider reviews the check-mark drawing to determine which potential diagnoses are associated with the characteristics of his/her patient's symptoms.
2. Tool column: Contains recommended screening and assessment tools based on the potential disorders identified in table 1.
3. Action recommended column: The results of the screening tools yield recommended actions, which help determine the etiology of the symptom(s).

Do:

- Point to "symptoms," "tool" and "action recommended" when referring to these columns
- Each of the tools mentioned in the tool column is either presented later on in the tool kit or instructions are given on how to find and use them

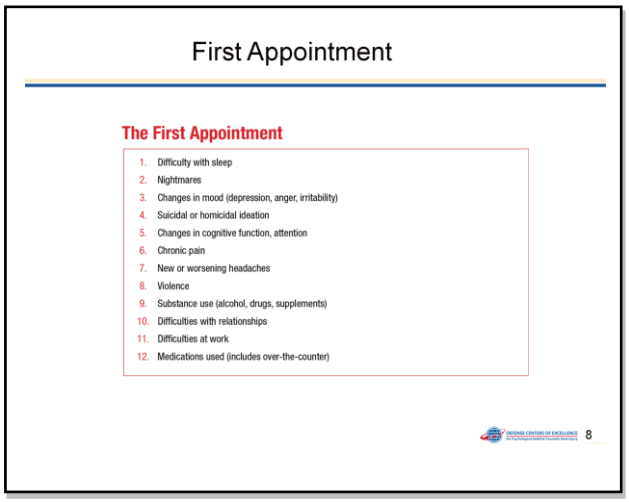
Additional Points (if any):

- None



Customizable Content (if any):

First Appointment



Say:

When seeing a service member with a concussion history and ongoing symptoms, a screening for potential co-occurring psychological health concerns should take place.

- There are several key areas of safety and symptoms that should be addressed.
- (These 12 topics of concern are from page five of the tool kit).
- Given the time constraints of the primary care appointments, there will not likely be time to assess for the etiology of all symptoms. A focused interview that covers these main areas would be considered an adequate risk assessment and assist the provider in identifying the symptoms to address. The following slide includes some tips on structuring the clinical interview.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Tips for Structuring the Clinical Interview

Say:

There is not a typical patient presentation as the pattern of symptoms varies widely depending on the conditions present. Some tailoring of the provider communication style will be important to maximize effective patient interaction. Common cognitive symptoms that may affect patient interaction include memory problems, slowed thought process, problems with organization, disinhibition and altered self-awareness. Thus an appointment, longer than most typical primary care appointments, is often required.

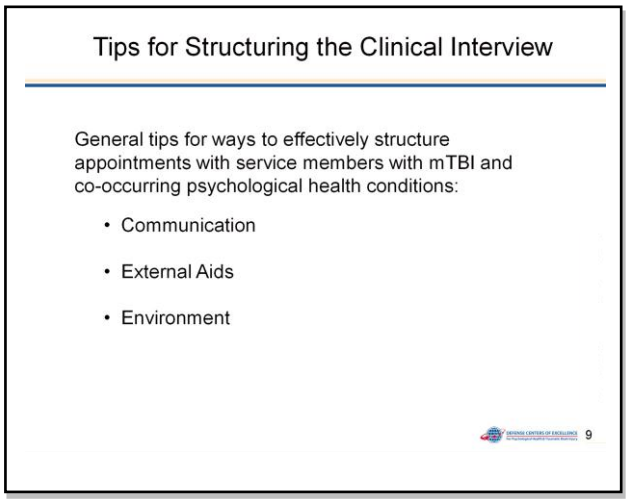
- **Communication** – use short, simple sentences, minimize the amount that is said at one time, speak slowly and clearly, use the same words when repeating information, summarize key points throughout the appointment, allow patient time to respond
- **External aids** – written notes, diagrams either by or for the patient, set session agenda
- **Environment** – more frequent yet shorter visits, set meeting time, structure, hold appointments on patient's best time of day, be open to contact between sessions, plan for longer duration of treatment, minimize distractions in visits and appointment environment

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Source of *Tips for Structuring the Clinical Interview* from the Toolkit:

Kortte, KB, Briggs, F & Wegener, ST. (2005) Psychtherapy with Cognitively Impaired Adults. In GP Koocher, JC Norcross, & SS Hill, III (Eds.) The Psychologist's Desk Reference 2nd Edition (pp. 342-346), Oxford University Press.

Mood

Say:

SMART objective:

- The participant will review a patient interview and utilize the mood tab of the tool kit to correctly assess the individual who presents with a history of concussion and co-occurring symptoms suggestive of ASD or PTSD.
- The participant will verbally discuss the assessment tools used to evaluate stress symptoms and first and second-step interventions.

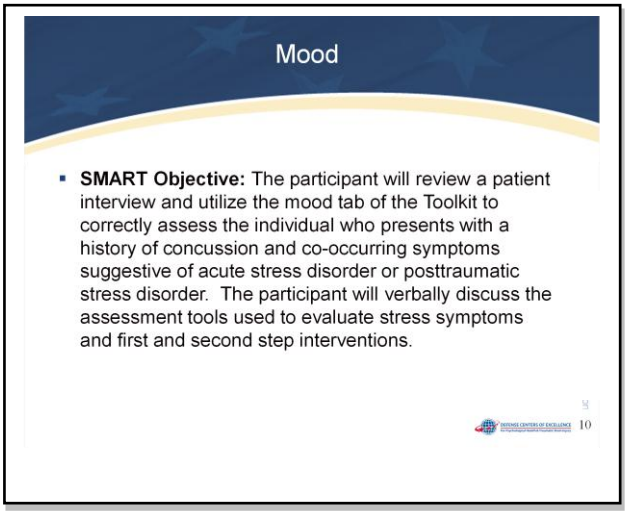
*SMART stands for specific, measurable, achievable, realistic and time-bound.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Mood

Say:

Sergeant First Class Taylor was exposed to an improvised explosive device blast four months ago during which he did not lose consciousness but had an alteration of consciousness for one hour after the event. He was subsequently diagnosed with a concussion and treated in-theater.

It should be noted that Taylor's platoon leader was killed by this blast.

Taylor presents to the family medicine clinic at his home station and still complains of occasional headaches but they are being effectively managed with low dose (25 mg) Elavil. Additionally, he reports that he and his wife are arguing constantly, he does not want to leave the house for social events because he feels "on edge" when in crowds, feels physically and emotionally exhausted all the time, has increased his alcohol consumption and becomes anxious when thinking about the blast.

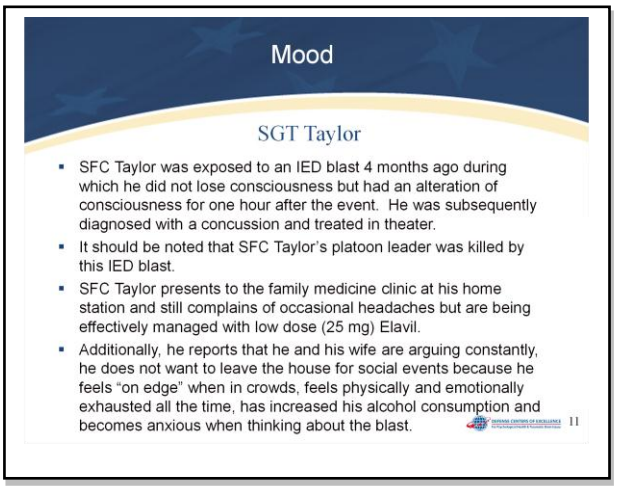
Taylor is already being seen for headache management and his provider knows him fairly well, but this is the first time he has heard these other complaints from him. The provider decides to utilize the Co-occurring Conditions Toolkit to further assist in differential diagnosis and treatment.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Summary of SFC Taylor's vignette:

- Exposed to IED blast 4 months ago
- No LOC
- AOC for one hour
- Diagnosed with concussion in-theater and treated
- His PLT LDR was killed in the blast
- Presents with:
  - Occasional headaches (H/A)
  - Use of PRN Elavil for H/A
  - Marital discord
  - Irritable in crowds
  - Feels physically and emotionally exhausted
  - Increased use of alcohol
  - Anxious when thinking of IED

Table 1: Mood – Tool & Action Recommended

Say:

When a patient, such as SFC Taylor presents, with mild TBI and co-occurring symptoms, the provider should identify which symptom tab (sleep, mood, attention or chronic pain) of the tool kit should be used based on current symptoms. In this case, Taylor's target symptom seems to be mood. Therefore, the provider flips to Table 1 of the mood tab, which is on page 18 of the tool kit.

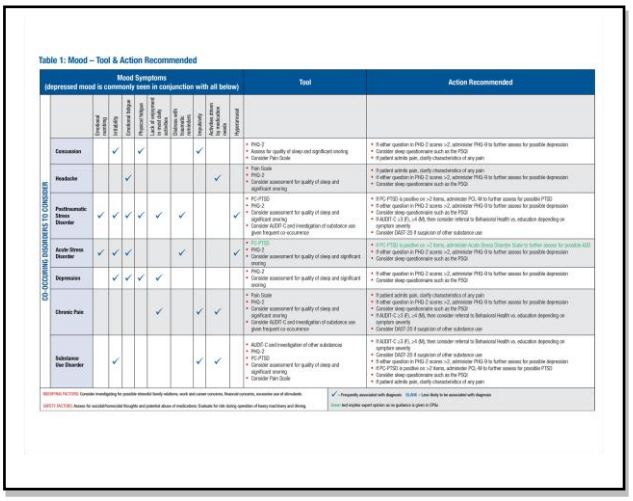


Table 1: Mood – Tool & Action Recommended

	Mood Symptoms (depressed mood is commonly seen in conjunction with all below)								Tool	Action Recommended
CO-OCCURING DISORDERS TO CONSIDER	Emotional swings	Irritability	Anxiety/Anger	Thoughts of Anger	Lack of enjoyment in daily activities	Distance with family members	Substance abuse for medication relief	Hypervigilance		
Concussion		✓		✓			✓		• PHQ-2 • Assess for quality of sleep and significant snoring • Consider Pain Scale	• If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI • If patient admits pain, clarify characteristics of any pain
Headache			✓					✓	• Pain Scale • PHQ-2 • Consider assessment for quality of sleep and significant snoring	• If patient admits pain, clarify characteristics of any pain • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI
Posttraumatic Stress Disorder	✓	✓	✓	✓	✓	✓		✓	• PC-PTSD • PHQ-2 • Consider assessment for quality of sleep and significant snoring • Consider AUDIT-C and investigation of substance use given frequent co-occurrence	• If PC-PTSD is positive on >2 items, administer PCL-M to further assess for possible PTSD • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI • If AUDIT-C ≥3 (F), >4 (M), then consider referral to Behavioral Health vs. education depending on symptom severity • Consider DAST-20 if suspicion of other substance use
Acute Stress Disorder	✓	✓	✓			✓		✓	• PC-PTSD • PHQ-2 • Consider assessment for quality of sleep and significant snoring	• If PC-PTSD is positive on >2 items, administer Acute Stress Disorder Scale to further assess for possible ASD • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI
Depression		✓	✓	✓	✓				• PHQ-2 • Consider assessment for quality of sleep and significant snoring	• If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI
Chronic Pain					✓		✓	✓	• Pain Scale • PHQ-2 • Consider assessment for quality of sleep and significant snoring • Consider AUDIT-C and investigation of substance use given frequent co-occurrence	• If patient admits pain, clarify characteristics of any pain • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI • If AUDIT-C ≥3 (F), >4 (M), then consider referral to Behavioral Health vs. education depending on symptom severity • Consider DAST-20 if suspicion of other substance use
Substance Use Disorder		✓					✓	✓	• AUDIT-C and investigation of other substances • PHQ-2 • PC-PTSD • Consider assessment for quality of sleep and significant snoring • Consider Pain Scale	• If AUDIT-C ≥3 (F), >4 (M), then consider referral to Behavioral Health vs. education depending on symptom severity • Consider DAST-20 if suspicion of other substance use • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • If PC-PTSD is positive on >2 items, administer PCL-M to further assess for possible PTSD • Consider sleep questionnaire such as the PSQI • If patient admits pain, clarify characteristics of any pain

Do:

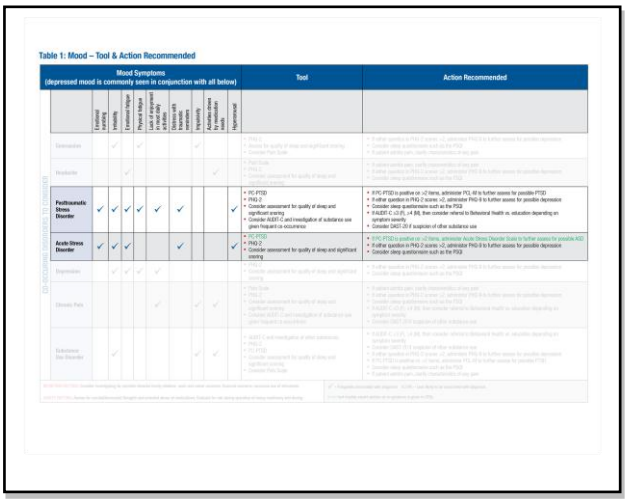
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Table 1: Mood – Tool & Action Recommended **Cont'd**



Say:

Next, the provider reviews the characteristics of mood symptoms at the top of the table. The characteristics of complaints related to mood include: emotional numbing, irritability, emotional fatigue, physical fatigue, lack of enjoyment in most daily activities, distress with traumatic reminders, impulsivity, activities driven by medication needs and hyperarousal.

In our example, Taylor complains of headaches, fatigue, increased alcohol consumption, irritability (arguing with spouse), he feels "on edge" in crowds, and distress when thinking about the IED blast.

The characteristics of Taylor's symptoms, when matched with those at the top of the mood tab, include: irritability, emotional fatigue, physical fatigue and hyperarousal.

Next, the provider determines the probable etiology of the specific symptoms. The "check-mark drawing" implies stronger association. Therefore, in our example, the provider looks to the PTSD and ASD rows as Taylor's symptoms span these two diagnoses.

The PTSD and ASD rows are highlighted on this slide. These rows include the suggested assessment tools, and the actions recommended for the management of PTSD and ASD.

Do:

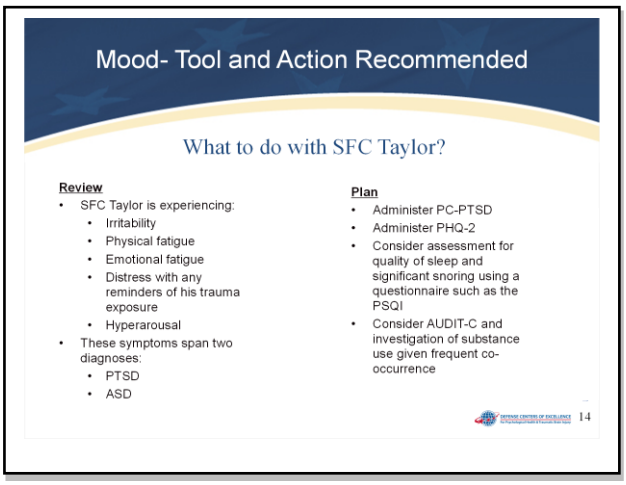
- Point out where the two rows for PTSD and ASD are located in table 1 on the slide.

Additional Points (if any):

- None

Customizable Content (if any):

Mood - Tool and Action Recommended



Say:

From the “tool” column on both the PTSD and ASD rows, here is the guidance for further assessing these symptoms:

- PC-PTSD
- PHQ-2
- Consider assessment for quality of sleep and significant snoring

In addition, in the PTSD row, it is recommended to consider AUDIT-C and investigation of substance use given the frequent co-occurrence of PTSD and substance use.

* It is important to note that there is a great deal of overlap in symptom presentation for the diagnoses of PTSD and ASD. The DSM-IV diagnostic criteria for both are found in the tool kit on pages 127 and 128 and a comparison of the two shows how similar the patient presentation can be. One of the main differences is that PTSD is not diagnosed until at least 30 days after the traumatic event, yet ASD may be diagnosed when the symptoms last AT LEAST two days and at a maximum of four weeks from the traumatic event. Therefore, since the IED blast occurred four months ago, Taylor should be evaluated for PTSD.

Do:

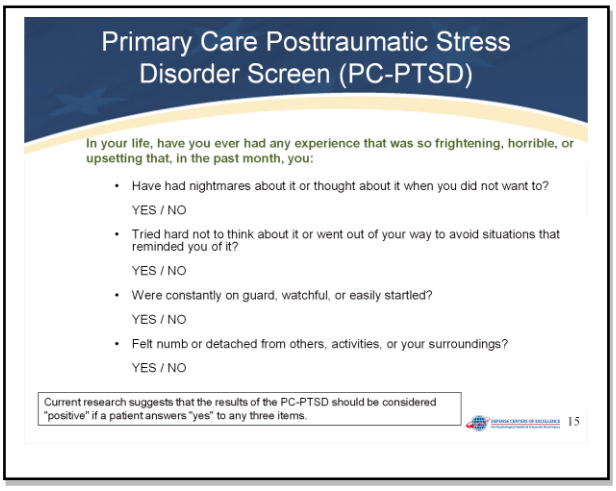
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Primary Care Posttraumatic Stress Disorder Screen (PC-PTSD)



Say:

The Primary Care Posttraumatic Stress Disorder Screen or PC-PTSD, is a four-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans in the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

The PC-PTSD can be accessed by performing an online search at: http://www.ptsd.va.gov/professional/pages/assessments/pc-ptsd.asp.

Do:

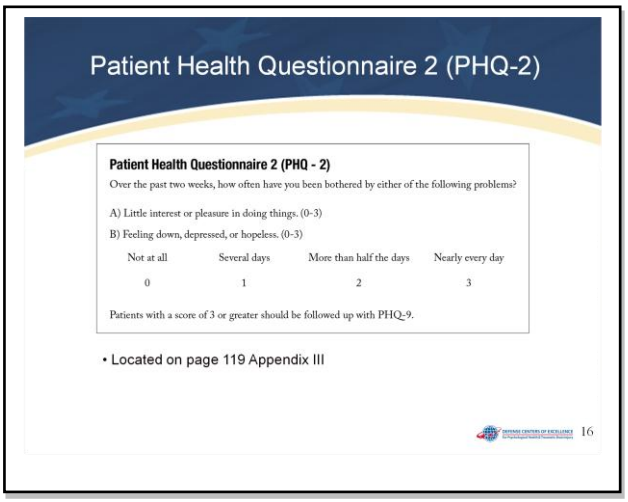
- No activities

Additional Points (if any):

- The four items on the screening tool are seen here on this slide

Customizable Content (if any):

Patient Health Questionnaire 2 (PHQ-2)



Say:

The Patient Health Questionnaire 2, PHQ-2, is a tool for major depressive disorder that is effective in identifying patients with depression and can also be used to measure treatment outcomes.

The authors state that patients with a PHQ-2 score of 3 or greater should be followed up with the PHQ-9 – as seen on this slide. For our purposes and for use in the tool kit, if the **PHQ-2 is greater than 2** it is recommended for the provider to consider using the PHQ-9 to further assess for possible depression.

Do:

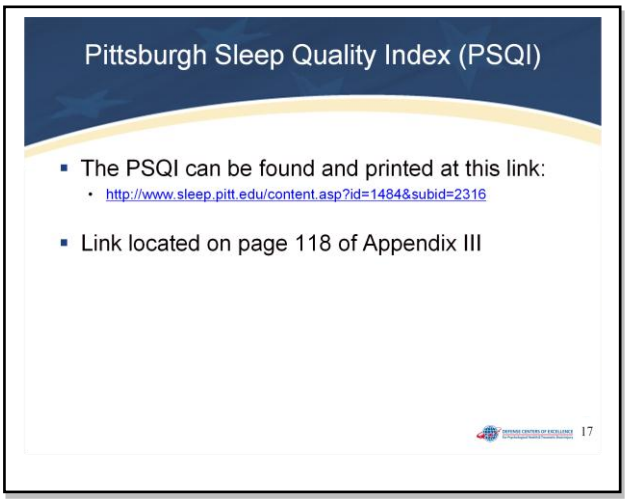
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Pittsburgh Sleep Quality Index (PSQI)



Say:

The Pittsburgh Sleep Quality Index is a 19 item self-rated questionnaire and has five questions rated by a bed partner or roommate that assesses sleep disturbances over a one-month time interval. However, only the self-rated items are used in scoring the scale. All scores are combined according to the scoring criteria included with the form to produce a global PSQI score.

Each component is scored from 0 to 3, yielding a global PSQI score between 0 and 21, with higher scores indicating lower quality of sleep. The PSQI is useful in identifying good and poor sleepers. A global **PSQI score greater than 5** indicates that a person is a “poor sleeper” having severe difficulties in at least two areas or moderate difficulties in more than three areas.

The link to the PSQI is on page 118 of the tool kit under the heading “Additional Provider Tools.”

Do:

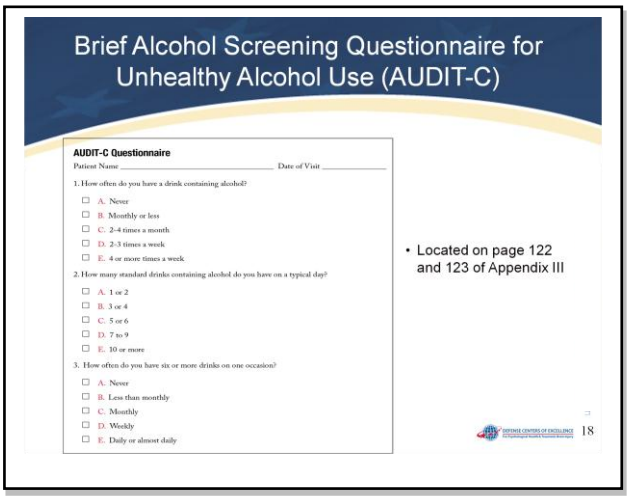
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Brief Alcohol Screening Questionnaire for Unhealthy Alcohol Use (AUDIT-C)



Say:

The Brief Alcohol Screening Questionnaire for Unhealthy Alcohol Use, or AUDIT-C, is a three-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10-question AUDIT instrument. In men, a score of 4 or more is considered positive – optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive.

The AUDIT-C is located in the tool kit on pages 122 and 123 of Appendix III.

Do:

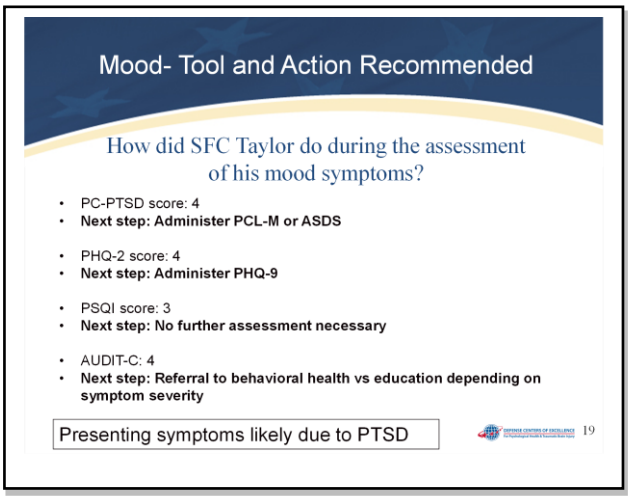
- No activities

Additional Points (if any):

- This slide depicts the actual three items used in the AUDIT-C screening tool. The scoring of the AUDIT-C is on page 122 of the tool kit and the tool itself is on page 123.

Customizable Content (if any):

Mood - Tool and Action Recommended



Say:

SFC Taylor scored a 4-out-of-4 on the PC-PTSD. According to Table 1 of the mood tab, if the PC-PTSD is positive on more than two items, the PCL-M should be administered to further assess for possible PTSD. If the provider is concerned that the diagnosis is more likely ASD, the Acute Stress Disorder Scale or other tools that assess ASD are indicated. However, it is important to remember one significant difference between ASD and PTSD. PTSD is not diagnosed until at least 30 days after the traumatic event. ASD may be diagnosed when the symptoms last AT LEAST two days and at a maximum of four weeks from the traumatic event. In this case, more than four weeks have elapsed since the traumatic event. Therefore, evaluation of the diagnosis of PTSD is further examined.

Taylor scored a 4 on the PHQ-2. Table 1 of the mood tab indicates that if the patient's PHQ-2 score is greater than 2, then the PHQ-9 should be administered to further assess for possible depression.

Taylor scored a 3 on the PSQI. A global PSQI score greater than 5 indicates that a person is a "poor sleeper" having severe difficulties in at least two areas or moderate difficulties in more than three areas. Therefore, no further assessment of his sleep is necessary at this time.

Finally, Taylor scored a 4 on the AUDIT-C. Table 1 of the mood tab indicates that for men, a score of 4 or higher on the AUDIT-C is considered positive for [and optimal for identifying] hazardous drinking or active alcohol disorders. The next step is to consider a referral for Taylor to behavioral health and also provide education about hazardous drinking and healthy drinking limits.

Based on these assessments, the provider focuses on PTSD as the primary cause of his symptoms.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

This slide depicts SFC Taylor's actual scores on the PC-PTSD, the PHQ-2, the PSQI and the AUDIT-C.

PTSD Checklist – Military Version (PCL-M)

Say:

The PTSD Checklist – Military Version (PCL-M) is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD. The PCL has a variety of purposes. There are three versions of the PCL and the one that is appropriate here is the PCL-M, for military, as it asks about symptoms in response to "stressful military experiences." It is often used with active duty service members and veterans.

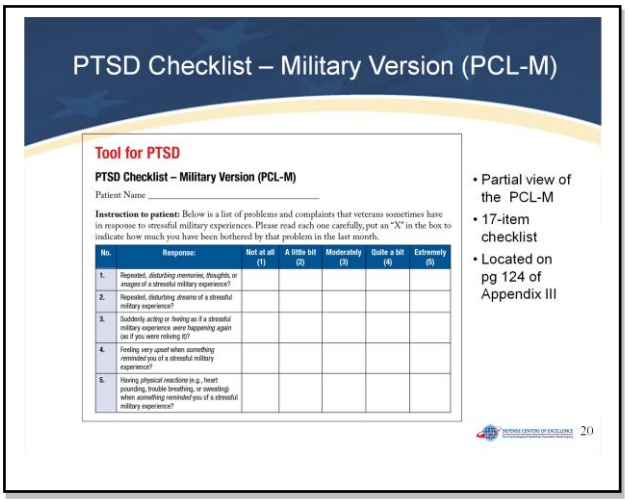
A copy of the PCL-M is located on page 124 of the tool kit.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

PTSD Checklist – Military Version (PCL-M) **Cont'd**

Say:

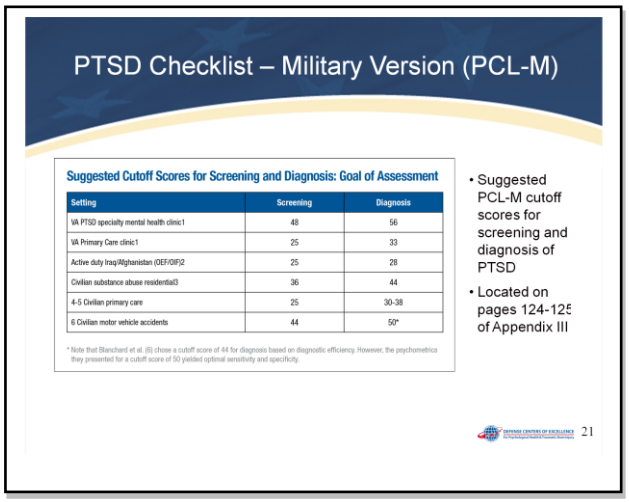
Note that the cutoff scores for the PCL-M for the screening and diagnosis of PTSD vary by the setting in which the patient is assessed. There is a helpful grid of suggested cutoff scores for screening and diagnosis in a variety of clinical settings. For instance, the cutoff for a PTSD diagnosis in a service member with service in Iraq or Afghanistan is 28. Please see the table and grid on pages 124-125 of Appendix III for screening and diagnosis cutoff scores in other populations.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Patient Health Questionnaire 9 (PHQ-9)

Say:

The Patient Health Questionnaire 9, or PHQ-9 is effective for assessing the presence and severity of depression. It is a nine-item questionnaire, with a 10th question for the patient to answer if he has endorsed any of the other nine items. The 10th question addresses level of functioning at work, home and in relationships.

This is a partial view of the PHQ-9.

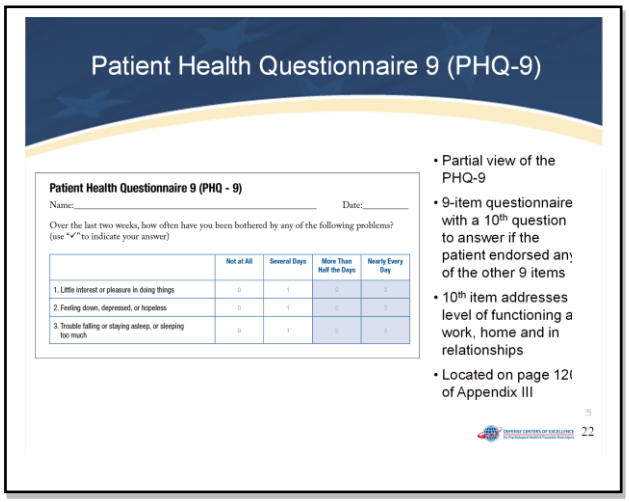
The PHQ-9 is located on page 120 of Appendix III.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Patient Health Questionnaire 9 (PHQ-9)

Say:

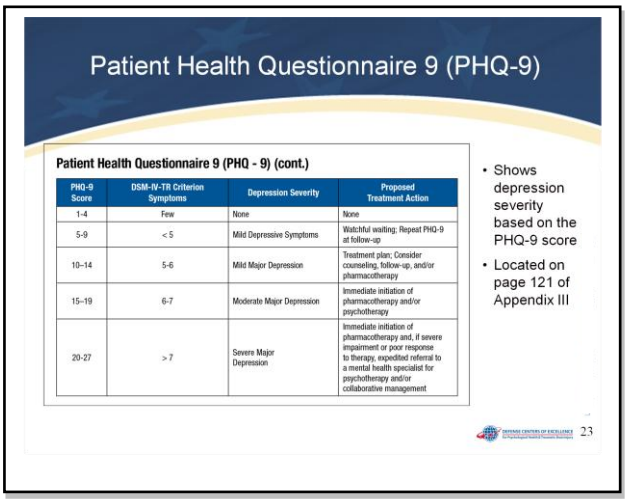
This table shows how the score on the PHQ-9 depicts the severity of depression and the proposed treatment action. This is found on page 121 of Appendix III.

Do:

- No activities

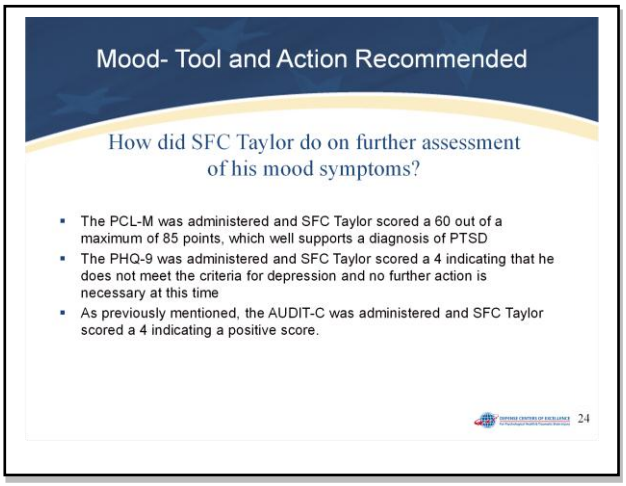
Additional Points (if any):

- None



Customizable Content (if any):

Mood - Tool and Action Recommended



Say:

How did SFC Taylor do on further assessment of his mood symptoms?

The PCL-M was administered and Taylor scored a 60 out of a maximum of 85 points, which well supports a diagnosis of PTSD.

The PHQ-9 was administered and Taylor scored a 4 indicating that he does not meet the criteria for depression and no further action is necessary at this time.

As previously mentioned, the AUDIT-C was administered and Taylor scored a 4 indicating a positive score. The next step is to refer Taylor to behavioral health or provide education about hazardous drinking behaviors depending on the severity of symptoms.

We have an emerging picture of the degree of Taylor's distress. He meets the criteria for a PTSD diagnosis and has shown, based on results of the AUDIT-C, that he has adopted hazardous drinking behaviors. Let's see what the provider can use as treatment choices within the tool kit.

Do:

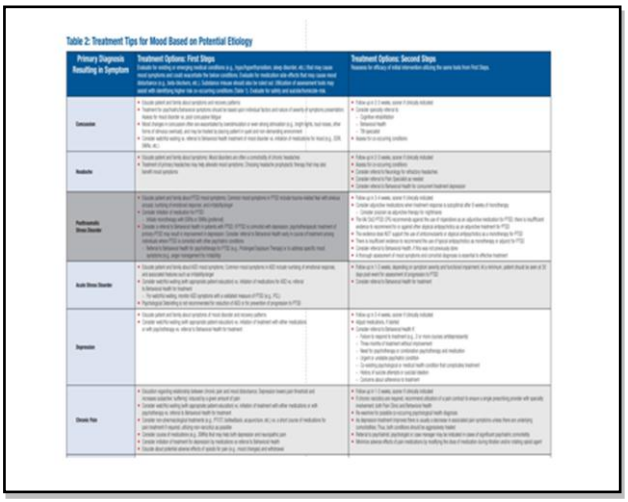
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Table 2: Treatment Tips for Mood Based on Potential Etiology



Say:

The provider next refers to Table 2 of the mood tab and looks to the PTSD row since that seems to be the etiology of SFC Taylor's symptoms based on the provider's assessments as noted in the previous slides.

Table 2 for mood has two columns that discuss the first and second steps for treatment options.

Do:

- No activities

Additional Points (if any):

- Table 2 is located on page 21 of the tool kit

Customizable Content (if any):

Mood- Treatment Tips Based on Potential Etiology

Say:

According to the treatment options: first steps, the provider would:

1) Emphasize to SFC Taylor that the common mood symptoms for military-related PTSD include: irritability or anger, numbing of emotions, avoidance of reminders of the trauma, anxious arousal and fear.
2) At this time the provider would consider a referral to a behavioral health provider for evidence-based psychotherapy based on Taylor's score on the PCL-M, his relationship problems and his recent changes in his drinking behaviors (AUDIT-C score of 4). (Taylor declines the referral to behavioral health at this time).
3) The provider may want to consider initiation of medication for PTSD – initiate monotherapy with selective serotonin reuptake inhibitors or serotonin and norepinephrine reuptake inhibitors (preferred). One rationale for waiting to start a new medication is the specialty referral to behavioral health. If the provider does not anticipate further follow up with Taylor, he would defer to the specialty provider.
4) In remote settings where perhaps the provider will be conducting the initial follow-up assessment, it may be prudent to start medication to address mood symptoms.
5) Emphasize to Taylor that he needs to abstain from alcohol because of alcohol's depressant effects on mood and existing relationship issues with his wife.

Do:

- No activities

Additional Points (if any):

- None

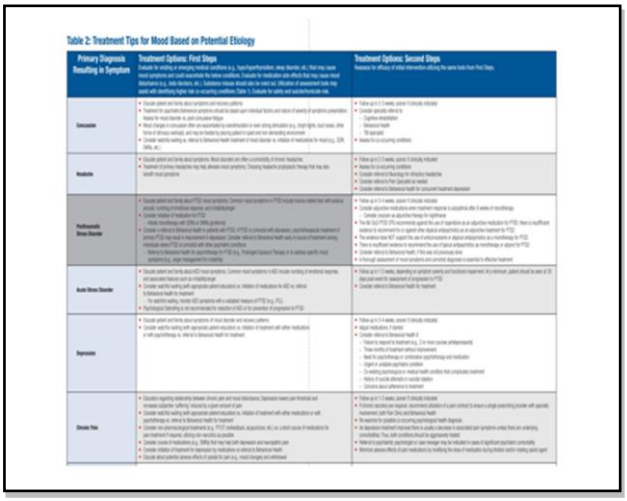


Table 2: Treatment Tips for Mood Based on Potential Etiology

Primary Diagnosis Resulting in Symptom	Treatment Options: First Steps	Treatment Options: Second Steps
Concussion		
Headache		
Posttraumatic Stress Disorder		
Acute Stress Disorder		
Depression		
Chronic Pain		

Customizable Content (if any):

***Mood - Treatment Tips Based on Potential Etiology* Cont'd**

Say:

The tool kit medication recommendations for PTSD are based on the VA/DoD CPG entitled, "Management of Post-Traumatic Stress." It is strongly recommend that patients diagnosed with PTSD should be offered SSRIs for which fluoxetine, paroxetine, or sertraline have the strongest support, or SNRIs, for which venlafaxine has the strongest support.

The provider is considering initiation of an SSRI for SFC Taylor. Let's look at where to find information on that in the tool kit.

Do:

- No activities

Additional Points (if any):

- None

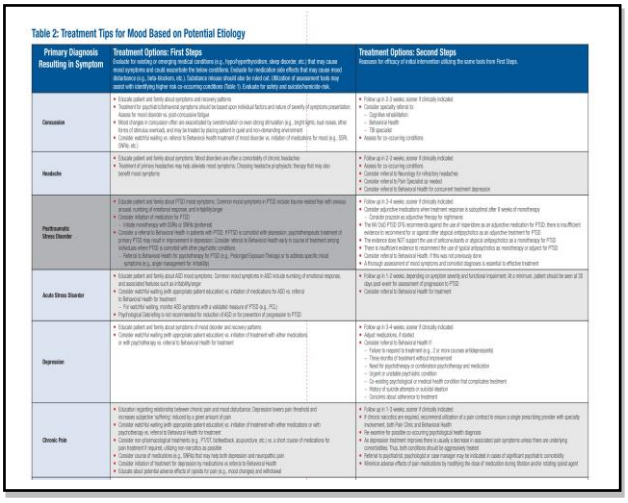


Table 2: Treatment Tips for Mood Based on Potential Etiology

Primary Diagnosis Resulting in Symptom	Treatment Options: First Steps	Treatment Options: Second Steps
Concussion		
Headache		
Posttraumatic Stress Disorder		
Acute Stress Disorder		
Depression		
Chronic Pain		

Customizable Content (if any):

Medication Considerations for (example) PTSD Symptoms

Say:

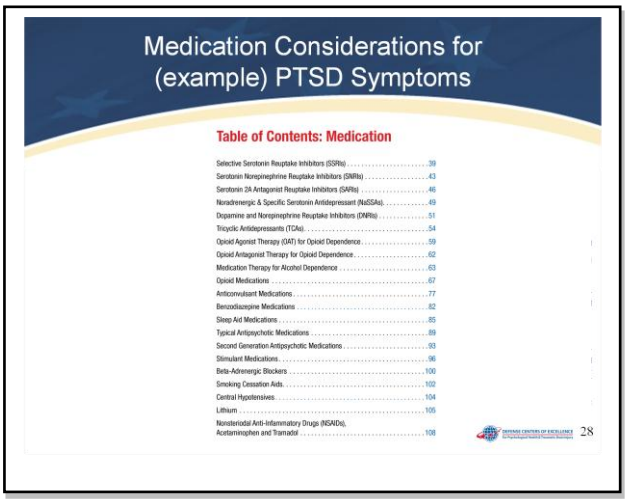
Page 36 of the tool kit includes the table of contents for the medications. SSRIs can be found on page 39 of the tool kit.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Medication Considerations for (example) PTSD Symptoms* Cont'd**

Say:

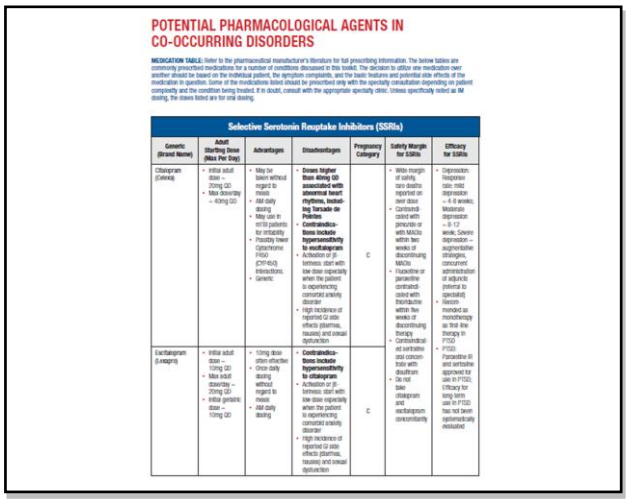
Here is a snapshot of the SSRIs that begin on page 39.

Do:

- No activities

Additional Points (if any):

- Appendix I contains the medications that are potential pharmacological agents for use in co-occurring disordered patients. It includes this information for each medication:
  - The medication name (generic and brand name)
  - Adult starting dose (max per day)
  - Advantages/disadvantages
  - Pregnancy category
  - Safety margin
  - Efficacy
  - Table of adverse drug effects: (relative comparisons)
  - Table of pros and cons for the use of a specific class of medication across the diagnoses of mild TBI, headaches, acute stress, PTSD, depression, chronic pain and substance use disorders
  - Black box warning if it exists for that class



POTENTIAL PHARMACOLOGICAL AGENTS IN CO-OCCURRING DISORDERS

MEDICATION TABLE: Refer to the pharmaceutical manufacturer's literature for full prescribing information. The below tables are commonly prescribed medications for a number of conditions discussed in this toolkit. The decision to utilize one medication over another should be based on the individual patient, the symptom complaints, and the basic features and potential side effects of the medication in question. Some of the medications listed should be prescribed only with the specialty consultation depending on patient complexity and the condition being treated. If in doubt, consult with the appropriate specialty clinic. Unless specifically noted as IM dosing, the doses listed are for oral dosing.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Generic (Brand Name)	Adult Starting Dose (Max Per Day)	Advantages	Disadvantages	Pregnancy Category	Safety Margin for SSRIs	Efficacy for SSRIs
Citalopram (Celexa)	• Initial adult dose – 20mg QD • Max dose/day – 40mg QD	• May be taken without regard to meals • AM daily dosing • May use in some patients for irritability • Possibly fewer Cytochrome P450 (CYP-450) interactions. • Generic	• **Doses higher than 40mg QD associated with abnormal heart rhythms, including Torsade de Pointes** • **Contraindications include hypersensitivity to escitalopram** • Activation or jitteriness: start with low dose especially when the patient is experiencing comorbid anxiety disorder • High incidence of reported GI side effects (diarrhea, nausea) and sexual dysfunction	C	• Wide margin of safety, rare deaths reported on over dose • Contraindicated with pimozide or with MAOIs within two weeks of discontinuing MAOIs • Fluoxetine or paroxetine contraindicated with thioridazine within five weeks of discontinuing therapy • Contraindicated w/ sertraline oral concentrate with disulfiram • Do not take citalopram and escitalopram concomitantly	• Depression: Response rate: mild depression – 4–8 weeks; Moderate depression – 8–12 weeks; Severe depression – augmentative strategies, concurrent administration of adjuncts; referral to specialist • Recommended as monotherapy as first-line therapy in PTSD • PTSD: Paroxetine IR and sertraline approved for use in PTSD; Efficacy for long term use in PTSD has not been systematically evaluated
Escitalopram (Lexapro)	• Initial adult dose – 10mg QD • Max adult dose/day – 20mg QD • Initial geriatric dose – 10mg QD	• 10mg dose often effective • Once daily dosing without regard to meals • AM daily dosing	• **Contraindications include hypersensitivity to citalopram** • Activation or jitteriness: start with low dose especially when the patient is experiencing comorbid anxiety disorder • High incidence of reported GI side effects (diarrhea, nausea) and sexual dysfunction	C		

Customizable Content (if any):

***Medication Considerations for (example) PTSD Symptoms* Cont'd**

Say:

Page 42 shows the adverse drug effects with relative comparisons and the pros and cons of using SSRIs with various co-occurring conditions.

After reviewing the medication information, the provider starts SFC Taylor on citalopram (Celexa) 20 mg and emphasizes that Taylor must take the medication every day and that the full effect of the medication will not be appreciated for three to four weeks. The provider reviews the side effects of the Celexa with Taylor and answers all his questions. The provider is aware that Taylor is currently taking Elavil, a tricyclic anti-depressant or TCA, for his headaches and notes the clinical pearl listed on page 41 of the tool kit. A TCA can be added to an SSRI. However, if you add an SSRI to a TCA, then there is the potential for increased TCA levels. After consulting with his colleague in behavioral health, the provider decides that because Taylor is on such low doses of both the Elavil and the citalopram (Celexa), the concern for increased TCA levels is small.

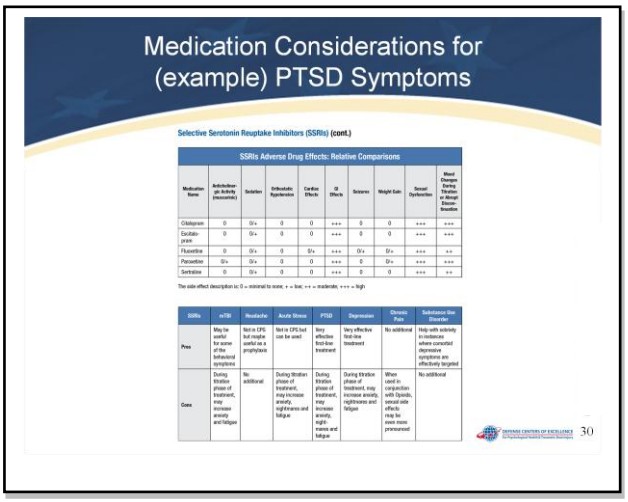
The provider also recommends that Taylor stop drinking alcohol. He discusses a referral to behavioral health for psychotherapy for PTSD and SFC Taylor defers for now. The provider schedules SFC Taylor's follow-up appointment for four weeks from today. SFC Taylor can follow up sooner should he need to.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Other SSRIs may be considered from the tool kit instead of citalopram (Celexa).

Mood - Treatment Tips Based on Potential Etiology

Say:

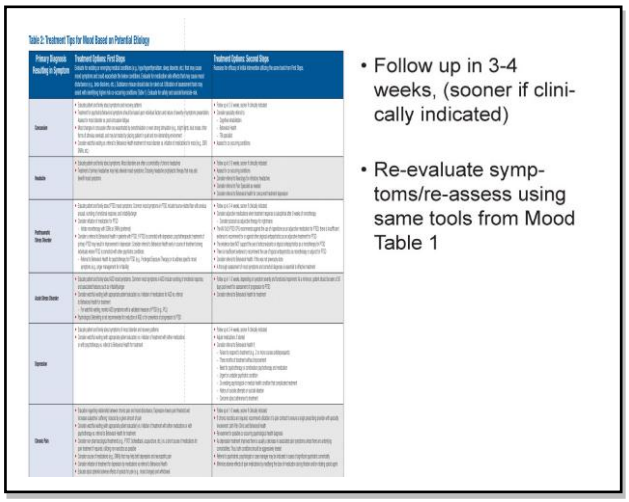
At SFC Taylor's follow-up visit (four weeks from the original visit), the provider assesses the efficacy of the celexa 20 mg from the last visit. Another thorough assessment of mood symptoms and co-morbid diagnoses is essential to effective treatment. The provider follows up on his headache pain and overall mood symptoms. Taylor continues to be upset about thoughts of his trauma exposure, which now seem to creep into his daily thoughts. The provider encourages him to continue his medications and again offers a referral to behavioral health so that he may receive therapy for PTSD. Taylor agrees to the behavioral health referral.

Do:

- No activities

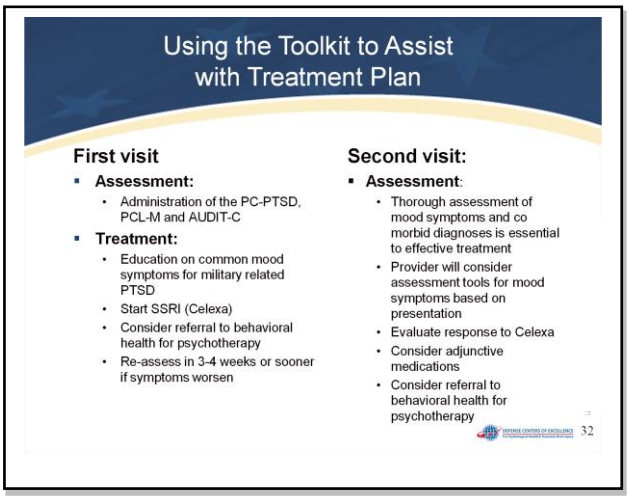
Additional Points (if any):

- None



Customizable Content (if any):

Using the Tool kit to Assist with Treatment Plan



Say:

This is a concise view of the treatment plan for SFC Taylor that was recommended by following the tool kit guidance.

The provider used the tools recommended in Table 1 for mood to assess his symptoms and found that he endorsed many PTSD symptoms and was drinking alcohol hazardously. The provider educated Taylor about his mood symptoms related to his trauma exposure. He started monotherapy with an SSRI, encouraged him to stop drinking alcohol, offered a behavioral health referral for psychotherapy and made a follow-up appointment for three to four weeks or sooner if symptoms worsened.

At the second session, the provider re-evaluated his mood symptoms, assessed his headaches, evaluated his response to celexa and offered a behavioral health referral for psychotherapy, which Taylor agreed to.

That concludes the review of the Co-occurring Conditions Toolkit mood tab.

Do:

- No activities

Additional Points (if any):

- Summarize what was stated in the SMART objective:
  - Participant reviewed a clinical vignette and utilized the mood tabs of the tool kit to correctly differentiate between the most common diagnoses in a patient who experienced a mild TBI and has mood symptoms suggestive of a psychological health condition such as ASD or PTSD.
  - Participant verbally discussed the assessment tools used to evaluate stress and mood symptoms and the recommended first and second step interventions.

Customizable Content (if any):

SECTION C: ATTENTION

This section includes the PowerPoint presentation and accompanying instructor notes. An overview of the content and associated SMART (specific, measurable, achievable, realistic, time-bound) objectives is included in the following table.

SMART Learning Objective(s)	Instructional Activity
▪ Correctly assess and differentiate between the most common diagnoses in a patient who: • Experienced a mTBI, and • Has co-occurring symptoms suggestive of problems or diagnoses related to attention and memory	▪ Review a clinical vignette of a patient with a memory problem and headache ▪ Verbally discuss the assessment tools used to evaluate attention symptoms and the recommended interventions

Cover Slide – Attention

Say:

No slide notes

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health

Say:

The Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health was developed by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, known as DCoE.

[To next slide]

Do:

- Point to the specific tab of the tool kit that will be the focus of today's didactic, for instance, the attention tab.

Additional Points (if any):

- None

Customizable Content (if any):

DCoE's Centers

Say:

…and DCoE's centers:

- The Defense and Veterans Brain Injury Center or DVBIC
- The Deployment Health Clinical Center or DHCC
- The National Center for Telehealth and Technology or T2

Do:

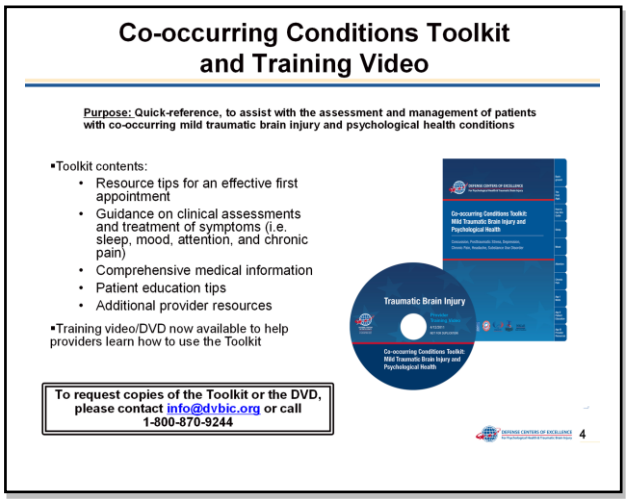
- Point to each of the component center logos.

Additional Points (if any):

- Instructor can mention where each component center is located:
  - DVBIC: multiple national and international sites
  - DHCC: Walter Reed National Military Medical Center, Bethesda, Md.
  - T2: Joint Base Lewis-McChord, near Tacoma, Wash.

Customizable Content (if any):

Co-occurring Conditions Toolkit and Training Video



Say:

The Department of Veterans Affairs held a consensus conference in 2009 on concussion, posttraumatic stress disorder, and pain, with the goal of providing a consensus recommendation on the treatment of veterans with these co-morbid conditions.

Five clinical practice guidelines, or CPGs, were reviewed:

- Concussion
- PTSD
- Chronic opioid therapy
- Substance use disorders
- Depression

The treatments recommended in these CPGs are still recommended in the co-morbid population. However, there are areas within these CPGs that may present challenges should a patient present with multiple conditions. The tool kit attempts to address these areas of conflict.

A training video was produced to accompany the tool kit. If you have the chance to view the video, you will find that the first part of the video highlights common definitions and illustrates the co-existing symptom domains. The second part addresses how to use the tool kit and provides guidance for the management of mild TBI and co-occurring physical and psychological health conditions. The third part is clinical vignettes that further illustrate the complexity of this patient population and how to apply the tool kit to manage these patients.

Do:

- Point to the picture of the DVD on the slide if you intend to show the tool kit video.
- Emphasize how to order a copy of the tool kit and/or video.
- Show any part of any of the three-part video. For instance, if the instructor will conduct a basic review of mild TBI and psychological health issues, show section two of the video.

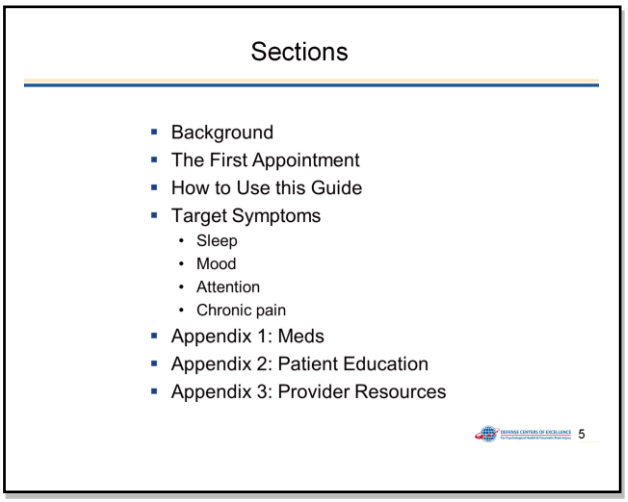
Customizable Content (if any):

Appendix B of the training manual contains evaluation tools for the content in the training video. The pre and post tests found in Appendix B are intended for participants in the training who have viewed the entire training video in its entirety.

Additional Points (if any):

- None

Sections



Say:

These are the main sections of the tool kit:

- Background
- The first appointment
- How to use this guide
- Target symptoms. The four target symptoms are: sleep, mood, attention and chronic pain. Each has its own tab containing tables that recommend tools and actions and treatment tips.
- Appendix I: medications
- Appendix II: patient education
- Appendix III: provider resources

Do:

- Show the tool kit
- Mark the sections listed on this slide in advance; show each section of the tool kit to the class as you mention it

Additional Points (if any):

- None

Customizable Content (if any):

Provider resources websites are listed in Appendix III of the tool kit.

These are the provider assessment tools that will be discussed in detail in the training modules. The tools or references on where to find these original tools are found in Appendix III:

PHQ-2
PHQ-9
AUDIT-C
PTSD Checklist-Military (PCL-M)
Pain Assessment Tool (COT)
DAST-20
PSQI
DSM-IV & DSM-IV-TR definitions
TBI Criteria

Understanding the Target Symptom Tab

Say:

There are two tables within each of the four target symptom tabs.

Table 1 crosswalks characteristics of the symptoms with seven co-occurring conditions (concussion/ mTBI, headache, PTSD, acute stress disorder, depression, chronic pain, and substance use disorder) in a diagnosis of one or more of those seven co-occurring conditions.

Table 1 is further described on the next slide.

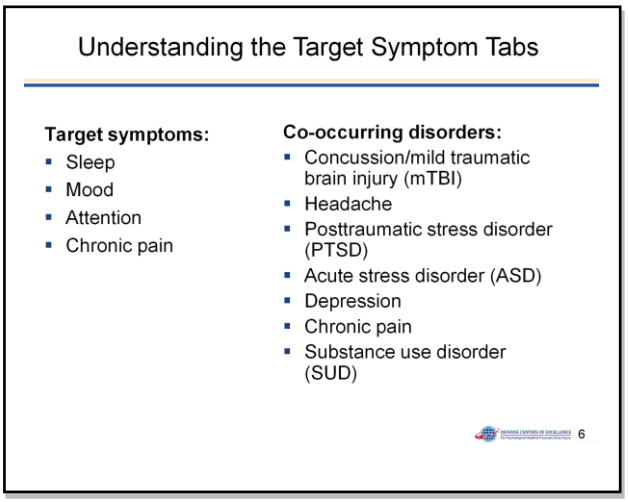
Table 2 provides treatment tips for the diagnosed co-occurring condition.

Do:

- Point to the four target symptoms as they are mentioned.
- If each participant has a copy of the tool kit, have each find one of the four tabs and open it to the two tables.

Additional Points (if any):

- None



Customizable Content (if any):

Overview of Table 1

Say:

Bottom line up front: Utilization of Table 1 results in a diagnosis of one or more of the seven co-occurring conditions.

There are three steps to understanding and using Table 1. Across the top banner, there are three columns labeled, “symptom,” “tools” and “action recommended.”

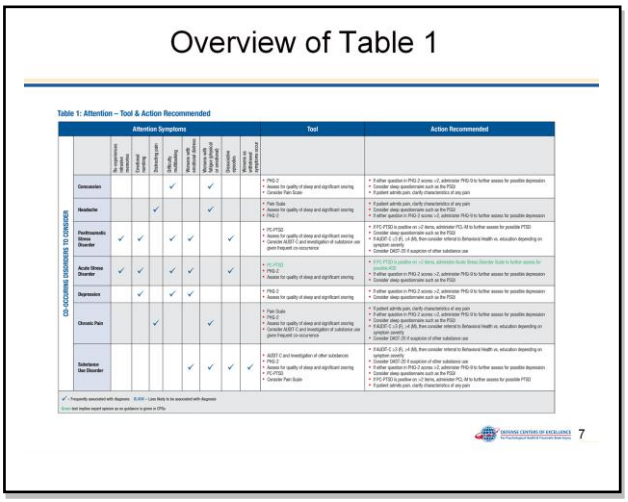
1. Symptoms column: The provider reviews the check-mark drawing to determine which potential diagnoses are associated with the characteristics of his/her patient’s symptoms.
2. Tool column: Contains recommended screening and assessment tools based on the potential disorders identified in Table 1.
3. Action recommended column: The results of the screening tools yield recommended actions, which help determine the etiology of the symptom(s).

Do:

- Point to “symptoms,” “tool” and “action recommended” when referring to these columns.

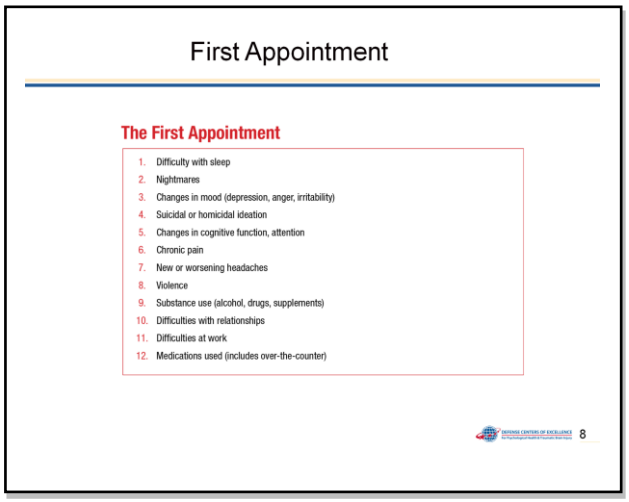
Additional Points (if any):

- Each of the tools mentioned in the “tool” column is either presented later on in the tool kit or instructions are given on how to find and use them.



Customizable Content (if any):

First Appointment



Say:

When seeing a service member with a concussion history and ongoing symptoms, a screening for potential co-occurring psychological health concerns should take place.

- There are several key areas of safety and symptoms that should be addressed.
- (These 12 topics of concern are from page five of the tool kit.)
- Given the time constraints of the primary care appointments, there will not likely be time to assess for the etiology of all symptoms. A focused interview that covers these main areas would be considered an adequate risk assessment and assist the provider in identifying the symptoms to address. The following slide includes some tips on structuring the clinical interview.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Tips for Structuring the Clinical Interview

Say:

There is not a typical patient presentation as the pattern of symptoms vary widely depending on the conditions present. Some tailoring of the provider communication style will be important to maximize effective patient interaction. Common cognitive symptoms that may affect patient interaction include memory problems, slowed thought process, problems with organization, disinhibition and altered self-awareness. Thus a longer appointment time is often required than most typical primary care appointments.

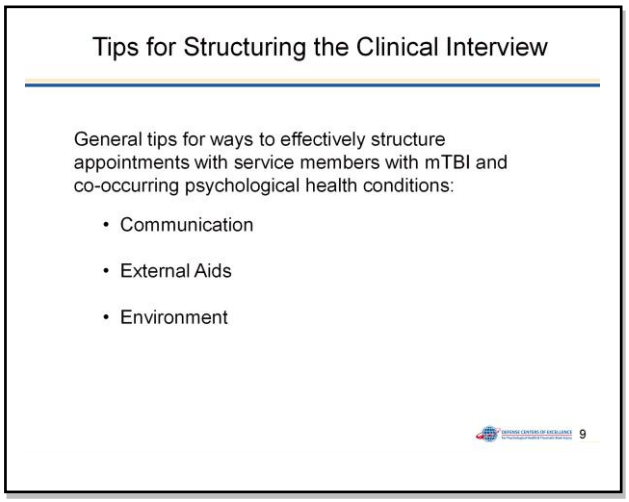
- **Communications** – use short, simple sentences, minimize the amount that is said at one time, speak slowly and clearly, use the same words when repeating information, summarize key points throughout the appointment, allow patient time to respond
- **External aids** – written notes, diagrams either by or for the patient, set session agendas
- **Environment** – more frequent yet shorter visits, set meeting time, structure, hold appointments on patient's best time of day, be open to contact between sessions, plan for longer duration of treatment, minimize distractions in visits and appointment environment

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Source of *Tips for Structuring the Clinical Interview* from the Toolkit:

Kortte, KB, Briggs, F & Wegener, ST. (2005) Psychotherapy with Cognitively Impaired Adults. In GP Koocher, JC Norcross, & SS Hill, III (Eds.) The Psychologist's Desk Reference 2nd Edition (pp. 342-346), Oxford University Press.

Attention

Say:

SMART objective:

- The participant will review a clinical vignette of a patient with a memory problem and headache and correctly identify the first and second interventions within the attention tab of the tool kit.
- The participant will verbally discuss the assessment tools used to evaluate attention symptoms and the recommended interventions.

*SMART stands for specific, measurable, achievable, realistic and time-bound.

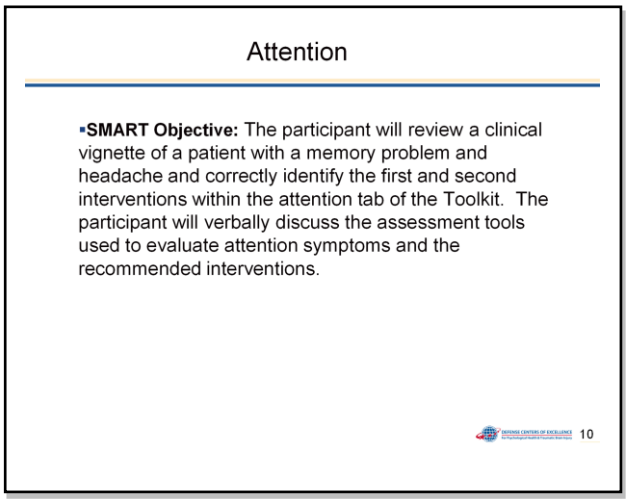
The clinical vignette follows.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Attention

Say:

LT Owens presents to the family medicine clinic and describes her occupational therapy work* in the hospital education office.

*Note that it is common for service members to have a job arranged by the occupational therapy department to work within a medical facility or their company area, in which they can practice being in the workplace, even if that job has little to do with the job in which they have been trained.

Owens has spent the last two weeks assisting with updating slide decks used to train orthopedic technicians who come to her military treatment facility for training on clinical techniques. She also assists by answering phones, managing the hospital education calendar on the intranet and updating the education director's outlook calendar appointments.

Lately she has made two errors while entering the director's appointments into the calendar by placing them in the wrong month, which caused the director to miss two important meetings. Owens is frustrated by her errors and is worried about the perception of her poor performance. In addition, she missed her follow-up neurology appointment on the day she made the errors at work. Her headaches have increased in intensity and are worse when she is tired. Her main complaint is her inability to pay attention and she wants assistance with her concentration and memory.

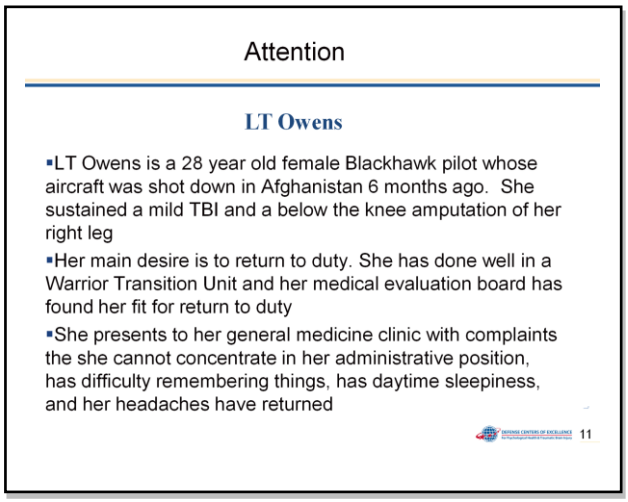
The provider decides to utilize the Co-occurring Conditions Toolkit to further assist in differential diagnosis and treatment of this complicated patient.

Do:

- No activities

Additional Points (if any):

- None

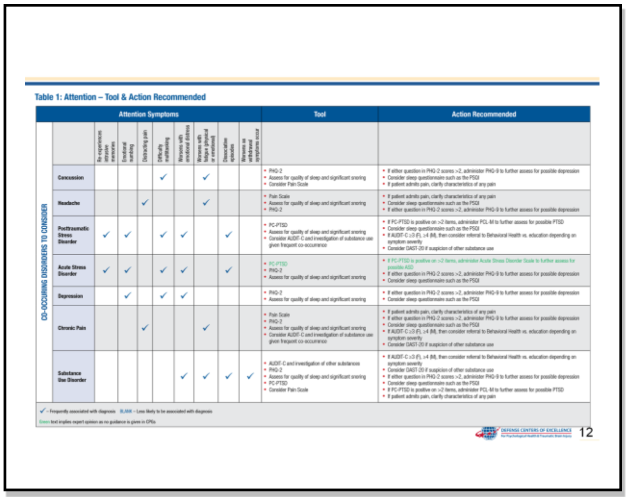


Customizable Content (if any):

Summary of LT Owens' vignette:

- 28 yo female shot down in Afghanistan six months ago
- R BKA
- mTBI
- Main desire to return to duty
- MEB – fit for duty
- Did well in Warrior Transition Unit until recently
- Presents with:
  - Decreased concentration
  - Poor memory
  - Daytime sleepiness
  - Headaches returned

<u>Table 1: Attention – Tool & Action Recommended</u>



Say:

When a patient with mild TBI and co-occurring symptoms, such as LT Owens, presents, the provider should identify which symptom tab (sleep, mood, attention or chronic pain) of the tool kit should be used based on current symptoms. In this case, Owens' target symptom seems to be attention. Therefore, the provider flips to Table 1 of the attention tab, which is on page 24 of the tool kit.

Do:

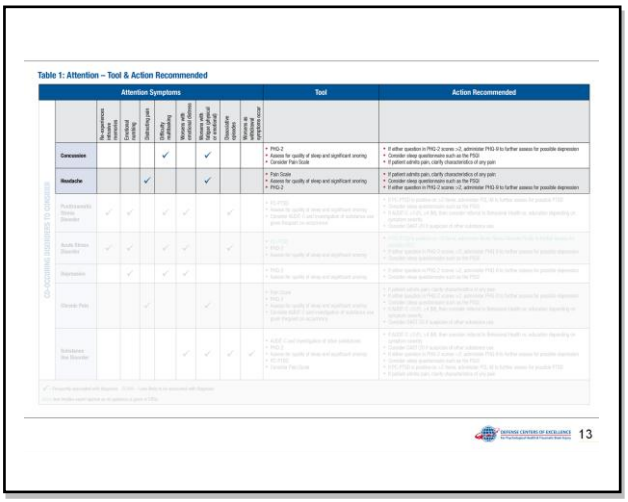
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

***Table 1: Attention – Tool & Action Recommended* Cont'd**



Say:

Next, the provider reviews characteristics of attention symptoms at the top of the table. The characteristics of symptoms related to attention include: re-experiences intrusive memories, emotional numbing, distracting pain, difficulty multitasking, worsens with emotional distress, worsens with fatigue (physical or emotional), dissociative episodes and worsens as withdrawal symptoms occur.

In our example, LT Owens complains of an inability to pay attention and wants assistance with improving her concentration and memory. In addition, she reports daytime sleepiness and a return of her headaches.

The characteristics of Owens' symptoms, when matched with those at the top of the attention tab, include: difficulty multitasking, worsens with fatigue (physical or emotional), and distracting pain.

Next, the provider determines the probable etiology of the specific symptom. The "check-mark drawing" implies stronger association. Therefore, in our example, the provider looks to the concussion and headache rows. It is noted that the chronic pain row could also apply. However, in this example, because Owens' chronic pain is headache, we defer to that row.

The concussion and headache rows are highlighted on this slide. These rows include the suggested assessment tools, and the actions recommended for the management of concussion and headaches.

Do:

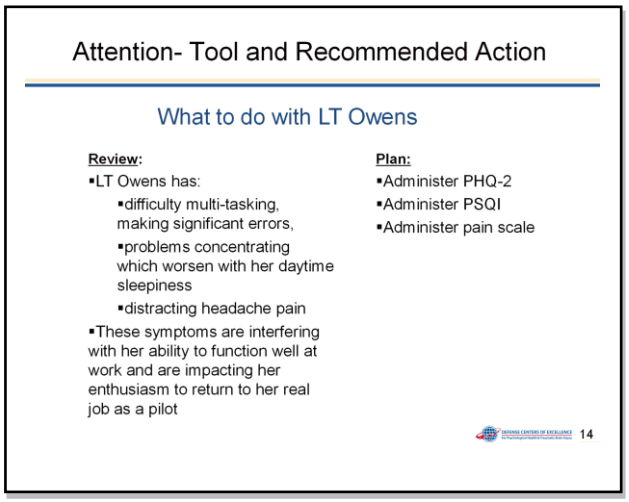
- No activities

Additional Points (if any):

- The concussion and headache rows are the first two rows on the table on this slide.

Customizable Content (if any):

Attention - Tool and Recommended Action



Say:

From the "tool" column on both the concussion and headache rows, here is the guidance for further assessing these symptoms:

- Administer the PHQ-2
- Assess for quality of sleep and significant snoring using a tool such as the PSQI
- Consider using the pain scale

To illustrate what these tools look like, they are shown on the next few slides.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Patient Health Questionnaire 2 (PHQ-2)

Say:

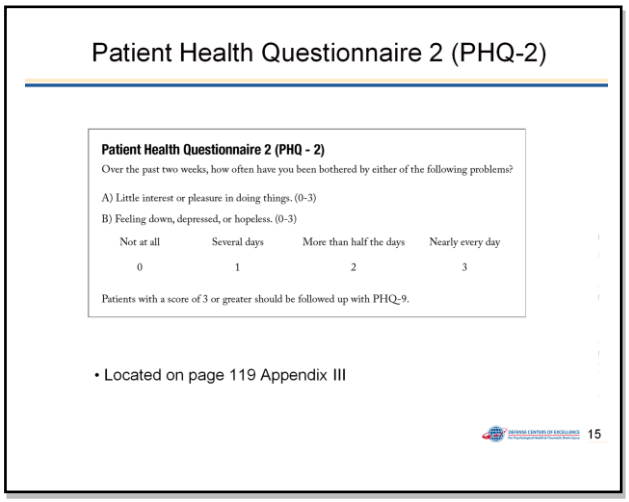
The Patient Health Questionnaire 2 is a tool for major depressive disorder that is effective for identifying patients with depression and can also be used to measure treatment outcomes. The authors state that patients with a PHQ-2 score of 3 or greater should be followed up with the PHQ-9 as seen on this slide. For our purposes and for use in the tool kit, if the **PHQ-2 is greater than 2**, it is recommended for the provider to consider using the PHQ-9 to further assess for possible depression.

Do:

- No activities

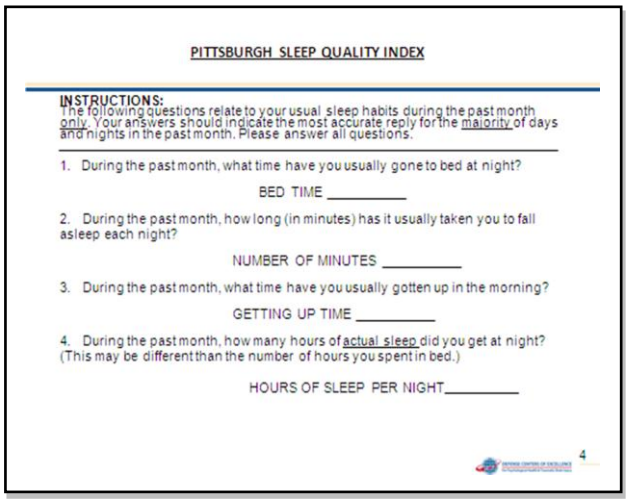
Additional Points (if any):

- It is very easy to incorporate the PHQ-2 questionnaire into a primary care assessment because it only has two screening items



Customizable Content (if any):

Pittsburgh Sleep Quality Index (PSQI)



PITTSBURGH SLEEP QUALITY INDEX

INSTRUCTIONS:
The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

BED TIME _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

3. During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME _____

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT_____

4

Say:

The Pittsburgh Sleep Quality Index (PSQI) is a 19 item self-rated questionnaire and has five questions rated by a bed partner or roommate that assesses sleep disturbances over a one-month time interval. However, only the self-rated items are used in scoring the scale. All scores are combined according to the scoring criteria included with the form to produce a global PSQI score.

Each component is scored from 0 to 3, yielding a global PSQI score between 0 and 21, with higher scores indicating lower quality of sleep. The PSQI is useful in identifying good and poor sleepers. A global PSQI score is greater than 5 indicates that a person is a “poor sleeper” having severe difficulties in at least two areas or moderate difficulties in more than three areas.

The link to the PSQI is on page 118 of the tool kit under the heading “Additional Provider Tools”.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Numeric Rating Pain Scale

Say:

The pain scale recommended in the tool kit is the Numeric Rating Pain Scale. It is located on page 126 and is often used in chronic opioid therapy.

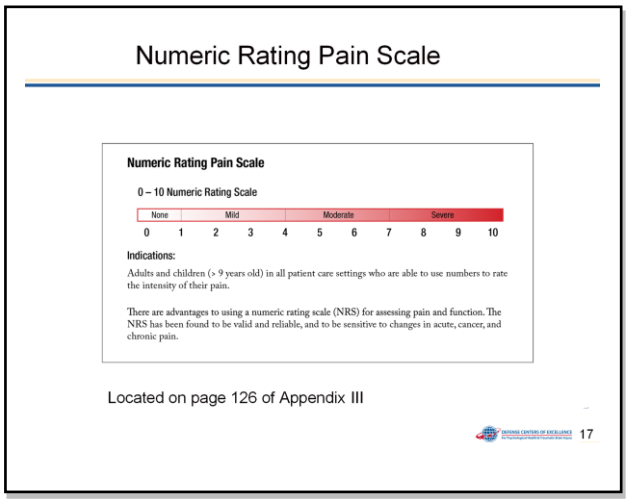
The indications for the pain scale are for adults and children older than nine in all patient care settings who are able to use numbers to rate the intensity of their pain. The scale rates the intensity and quality of the pain.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Numeric Rating Pain Scale* Cont'd**

Say:

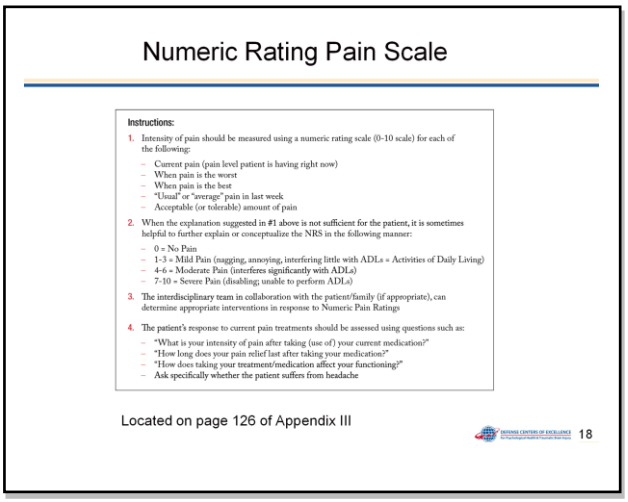
These are the questions that assess the quality and intensity of the patient's pain.

Do:

- No activities

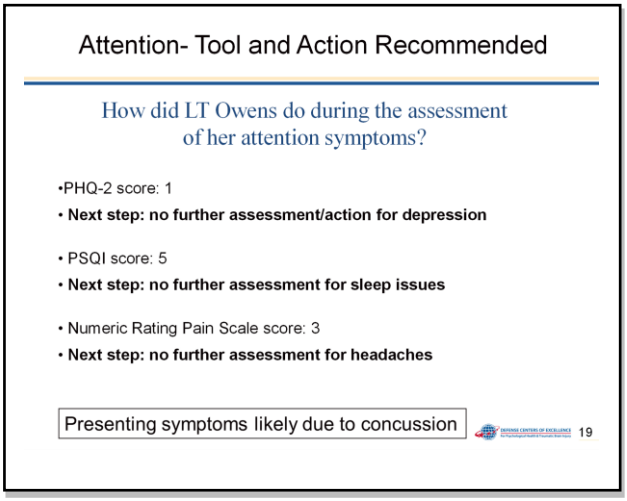
Additional Points (if any):

- None



Customizable Content (if any):

Attention - Tool and Action Recommended



Say:

How did LT Owens do during the assessment of her attention symptoms?

On the PHQ-2 she only scored a 1, stating that she rarely or ever felt like she did not want to do things that were pleasurable. In fact, she was motivated to do fun things, but on one or two days in the past two weeks she was feeling slightly hopeless about returning to work. Based on her PHQ-2 score, evaluation for MDD is not warranted.

The provider noted the PSQI sleep scale rating of 5 indicates that Owens does not have clinically meaningful disturbed or poor sleep, eliminating the need for further evaluation of a sleep disorder. However, keep in mind that she complained of daytime fatigue.

Her pain scale rating for her headaches is a 3 on a few occasions and a 1 during the assessment itself. Overall, she states the headache is annoying, but interferes very little with her activities of daily living.

Her main complaint throughout the assessment was her ability to attend to the important aspects of her job. Based on these assessments, the provider focuses on concussion as the primary cause of her symptoms.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Attention - Treatment Tips Based on Potential Etiology

Say:

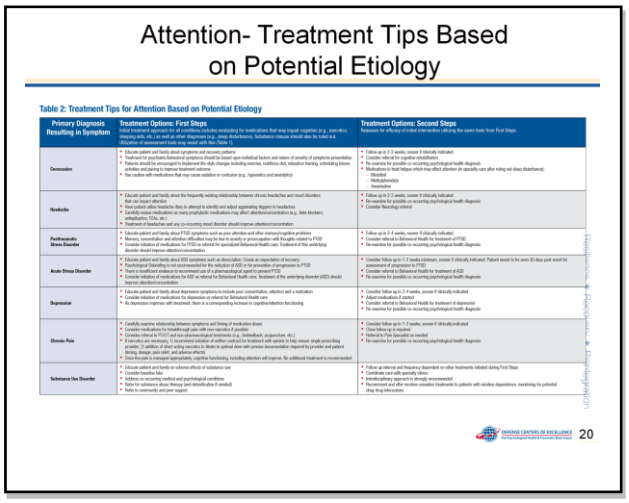
This is Table 2 for attention, found on page 27 of the tool kit. It reviews the first and second options for treatment tips for attention based on potential etiology.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Attention - Treatment Options: First Steps

Say:

According to the treatment options, one of the first steps is for the provider to educate Owens about her symptoms and recovery patterns. The emphasis here is on managing multiple tasks at once. Even in a relatively easy work environment for her, managing multiple tasks can be stressful.

Next, according to the tool kit, she should be encouraged to implement some easy to master life-style changes like regular exercise, balanced nutrition, relaxation techniques and scheduling leisure time in each week.

Finally, according to the tool kit, the provider could consider medications at this point to help her sleep, but may want to first go over the principles of sleep hygiene to see if that improves her sleep.

A follow-up appointment would be scheduled for two weeks to re-assess.

Do:

- No activities

Additional Points (if any):

- Table 2 for attention is found on page 27 of the tool kit.

Customizable Content (if any):

Attention - Treatment Options: Second Steps

Say:

The provider should refer to Table 2, Treatment Options: Second Steps for the follow-up visit.

At the second visit, LT Owens is about the same, her symptoms are unchanged and her objective self report measures are the same.

The provider would re-examine for possible co-occurring psychological health diagnoses such as MDD. If her PHQ-2 score is higher than on previous assessment, administer the PHQ-9.

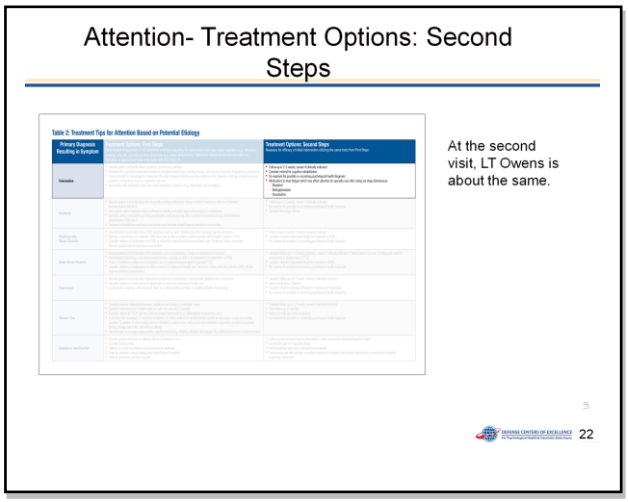
The provider observes that in the second steps for treatment options, medications are considered to address her fatigue. The provider decides to explore options for stimulant medications to address her fatigue, which may be contributing to her attention and memory issues.

Do:

- No activities

Additional Points (if any):

- Table 2 for attention is found on page 27 of the tool kit



Customizable Content (if any):

Medication Considerations for Fatigue Symptoms (example - stimulants)

Say:

Page 36 of the tool kit includes the table of contents for the medications. Discussion of stimulants begins on page 96 and is seen on the next slide.

Do:

- No activities

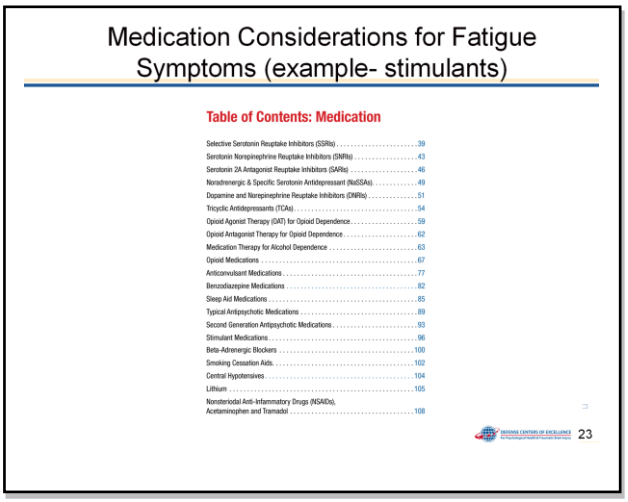
Additional Points (if any):

- The table of contents for Appendix I, Medication, begins on page 36 of the tool kit.
- The tables that discuss stimulant medications begin on page 96.

Appendix I contains the medications that are potential pharmacological agents for use in co-occurring disordered patients.

It includes this information for each medication:

- Medication name (generic and brand name)
- Adult starting dose (max per day)
- Advantages/Disadvantages
- Pregnancy category
- Safety margin
- Efficacy
- Table of adverse drug effects (relative comparisons)
- A Table of pros and cons for the use of a specific class of medication across the diagnoses of mild TBI, headache, acute stress, PTSD, depression, chronic pain and substance use disorders
- Black box warning if it exists for that class



Customizable Content (if any):

Attention - Treatment Tips Based on Potential Etiology

Say:

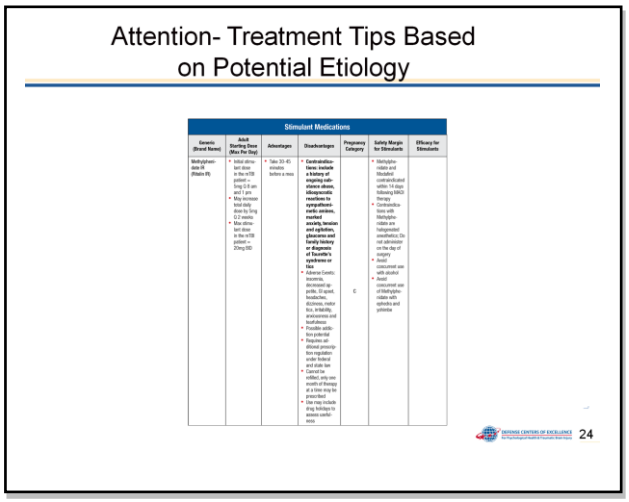
The provider has treated patients with concussion and fatigue issues in the past and is familiar with the use of stimulants. However, he understands the risks of interrupting her sleep patterns by using a stimulant and looks further into the tool kit tables in the medication appendix, page 96, for additional guidance on stimulant medications.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Attention - Treatment Tips Based on Potential Etiology* Cont'd**

Say:

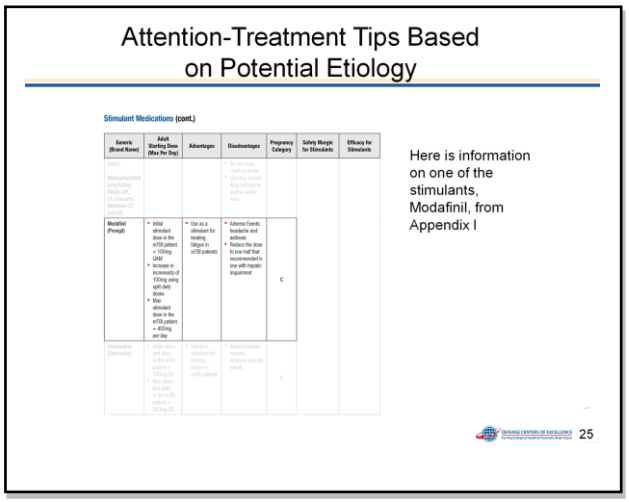
One of the stimulant medications that the provider is considering is modafinil. This is a view of page 98 of the tool kit (in Appendix I: Medications) that provides information on modafinil.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Attention - Treatment Tips Based on Potential Etiology* Cont'd**

Say:

When considering the use of stimulants such as modafinil in patients with mild TBI, it is important to appreciate the pros and cons as seen in this table from Appendix 1 on page 99.

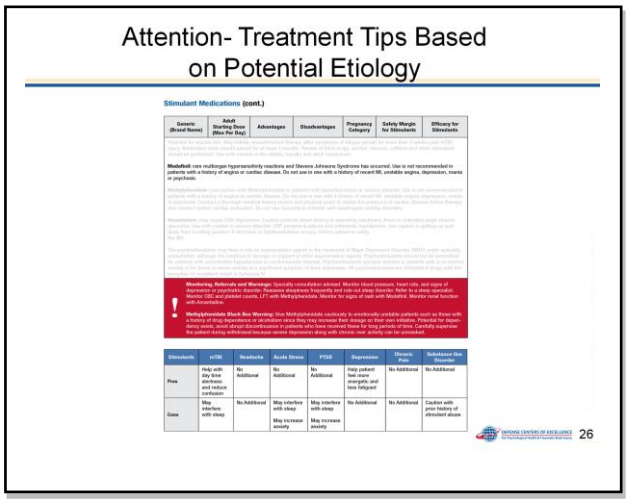
According to the tool kit, it is important to rule out a sleep disturbance before initiating a stimulant and consider consultation with a sleep specialist.

Do:

- No activities

Additional Points (if any):

- Mention the helpful black box warning for methylphenidate that is on this page of the tool kit. Any medication with a black box warning will be addressed in the pros and cons of that drug class.



Customizable Content (if any):

Using the Tool Kit to Assist with Treatment Plan

Say:

This is a concise view of the treatment plan for LT Owens that was recommended by following the tool kit guidance.

The provider delays starting a stimulant and will first discuss the case with the sleep clinic to rule out a sleep disorder to further evaluate the patient's sleep complaints and assist with the consideration of a stimulant. The provider also refers her to the TBI multi-disciplinary team or neuropsychologist for an assessment for cognitive rehabilitation.

The headache is not the focus of this scenario and therefore it's not a major part of the treatment plan. As noted on slide 19: The PSQI sleep scale rating was 5 and her pain scale rating was 3 for her headaches on a few occasions and a 1 during the assessment itself. Overall, she states the headache is annoying, but interferes very little with her activities of daily living. Her main complaint throughout the assessment was her inability to attend to the important aspects of her job. If the headache had been a larger concern for LT Owens, the scenario would have investigated more aggressive treatment of the headache as the primary symptom.

That concludes the review of the Co-occurring Conditions Toolkit attention tab.

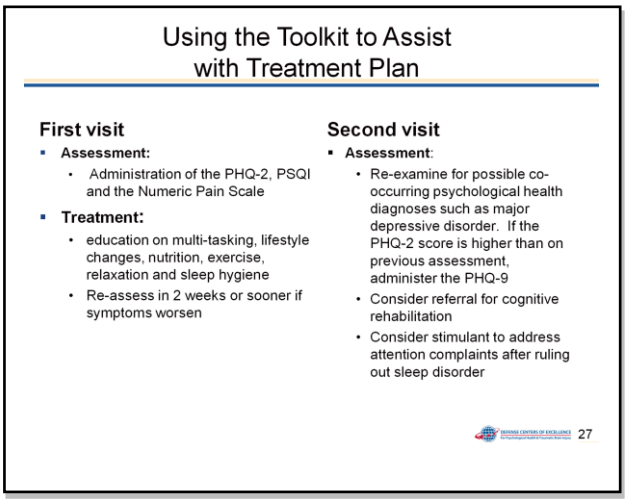
Do:

- No activities

Additional Points (if any):

- Summarize what was stated in the SMART objective:
- The participants correctly assessed and differentiated between the most common diagnoses in a patient who experienced a mild TBI and has co-occurring symptoms suggestive of problems or diagnoses related to attention and memory.

The participants reviewed a clinical



Customizable Content (if any):

vignette of a patient with a memory problem and a headache. They verbally discussed the assessment tools used to evaluate attention symptoms and the recommended first and second step interventions.

SECTION D: CHRONIC PAIN

This section includes the PowerPoint presentation and accompanying instructor notes. An overview of the content and associated SMART (specific, measurable, achievable, realistic, time-bound) objectives is included in the following table.

SMART Learning Objective(s)	Instructional Activity
▪ Correctly differentiate between the common diagnoses for chronic pain symptoms in the individual who presents with a history of: ▪ Concussion, and ▪ Co-occurring psychological health condition	▪ Review a clinical vignette and utilize the chronic pain tables of the tool kit ▪ Verbally discuss the assessment tools used to evaluate chronic pain symptoms and the first and second step treatment interventions.

Cover Slide – Chronic Pain

Say:

No slide notes

Do:

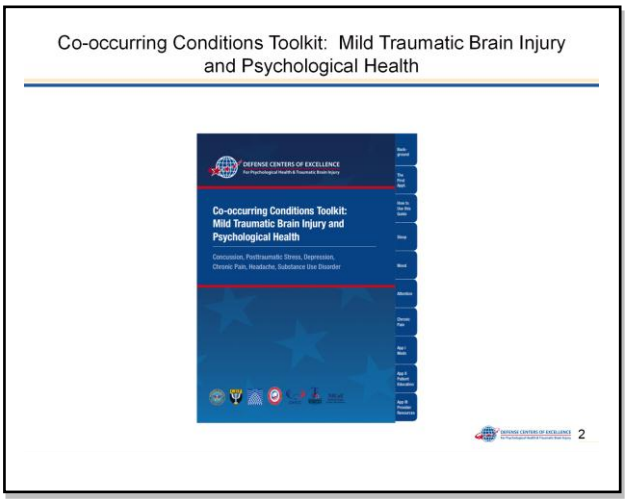
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health



Say:

The Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health was developed by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, or DCoE.

[To next slide]

Do:

- Point to the specific tab of the tool kit that will be the focus of today's didactic, for instance, the pain tab**.**

Additional Points (if any):

- None

DCoE Component Centers

Say:

…and DCoE's centers:

- The Defense and Veterans Brain Injury Center or DVBIC
- The Deployment Health Clinical Center or DHCC
- The National Center for Telehealth and Technology or T2

Do:

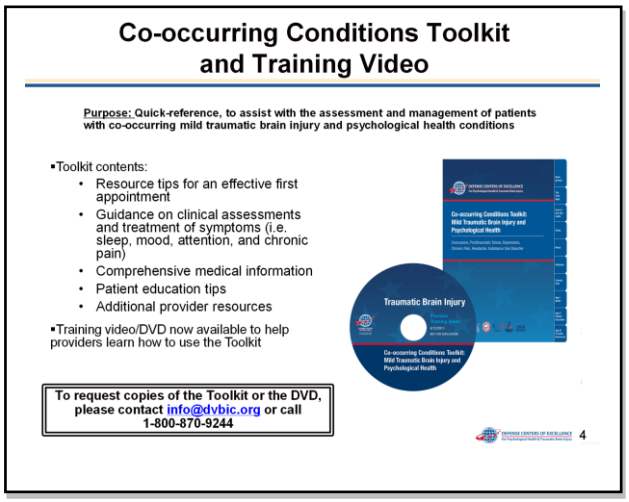
- Point to each of the component center logos.

Additional Points (if any):

- Instructor can mention where each component center is located:
  - DVBIC: multiple national and international sites
  - DHCC: Walter Reed National Military Medical Center, Bethesda, Md.
  - T2: Joint Base Lewis-McChord, near Tacoma, Wash.

Customizable Content (if any):

Co-occurring Conditions Tool Kit and Training Video



Say:

The Department of Veterans Affairs held a consensus conference in 2009 on concussion, posttraumatic stress disorder, and pain, with the goal of providing a consensus recommendation on the treatment of veterans with these co-morbid conditions.

Five clinical practice guidelines (CPGs) were reviewed:

- Concussion
- PTSD
- Chronic opioid therapy
- Substance use disorders or SUDs
- Depression

The treatments recommended in these CPGs are still recommended in the co-morbid population. However, there are areas within these CPGs that may present challenges should a patient present with multiple conditions. The tool kit attempts to address these areas of conflict.

A training video was produced to accompany the tool kit. If you have the chance to view the video, you will find that the first part of the video highlights common definitions and illustrates the co-existing symptom domains. The second part addresses how to use the tool kit and provides guidance for the management of mild TBI and co-occurring physical and psychological health conditions. The third part is clinical vignettes that further illustrate the complexity of this patient population and how to apply the tool kit to manage these patients.

Do:

- Point to the picture of the DVD on the slide if you intend to show the tool kit video.
- Emphasize how to order a copy of the tool kit and/or video.
- Show any part of any of the three-part video. For instance, if the instructor will conduct a basic review of mild TBI and psychological health issues, show section two of the video.

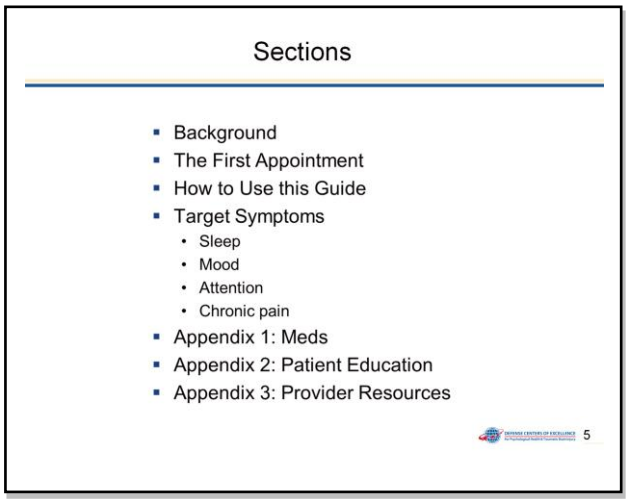
Customizable Content (if any):

Appendix B of the training manual contains evaluation tools for the content in the training video. The pre and post tests found in Appendix B are intended for participants in the training who have viewed the entire training video in its entirety.

Additional Points (if any):

- None

Sections



Say:

These are the main sections of the tool kit:

- Background
- The first appointment
- How to use this guide
- Target symptoms. The four target symptoms are: sleep, mood, attention and chronic pain. Each has its own tab containing tables that recommend tools and actions and treatment tips.
- Appendix I: medications
- Appendix II: patient education
- Appendix III: provider resources

Do:

- Show the tool kit.
- Mark the sections listed on this slide in advance; show each section of the tool kit to the class as you mention it.

Additional Points (if any):

- None

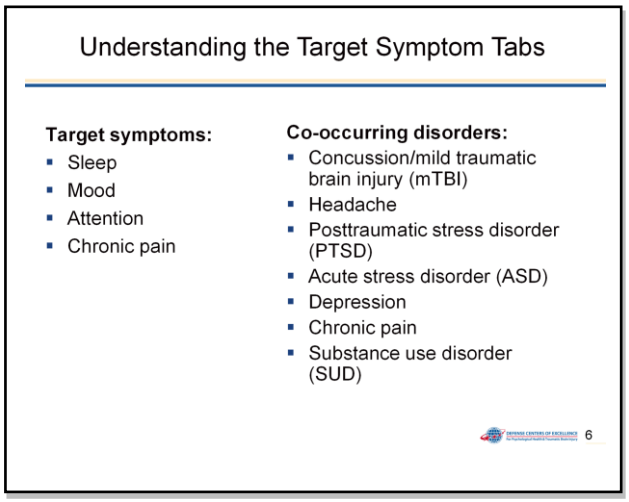
Customizable Content (if any):

Provider resources websites are listed in Appendix III of the tool kit.

These are the provider assessment tools that will be discussed in detail in the training modules. The tools or references on where to find these original tools that are found in Appendix III:

PHQ-2
PHQ-9
AUDIT-C
PTSD Checklist-Military (PCL-M)
Pain Assessment Tool (COT)
DAST-20
PSQI
DSM-IV & DSM-IV-TR definitions
TBI criteria

Understanding the Target Symptom Tabs



Say:

There are two tables within each of the four target symptom tabs.

Table 1 crosswalks characteristics of the symptoms with seven co-occurring conditions (concussion/ mild TBI, headache, PTSD, acute stress disorder, depression, chronic pain, and substance use disorder resulting in a diagnosis of one or more of those seven co-occurring disorders.

Table 1 is further described on the next slide.

Table 2 provides treatment tips for the diagnosed co-occurring condition.

Do:

- Point to the four target symptoms as they are mentioned.
- If each participant has a copy of the tool kit, have each find one of the four tabs and open it to the two tables.

Additional Points (if any):

- None

Customizable Content (if any):

Overview of Table 1

Say:

Bottom line up front: Utilization of Table 1 results in a diagnosis of one or more of the seven co-occurring conditions.

There are three steps to understanding and using Table 1. Across the top banner, there are three columns labeled “symptoms,” “tool” and “action recommended”:

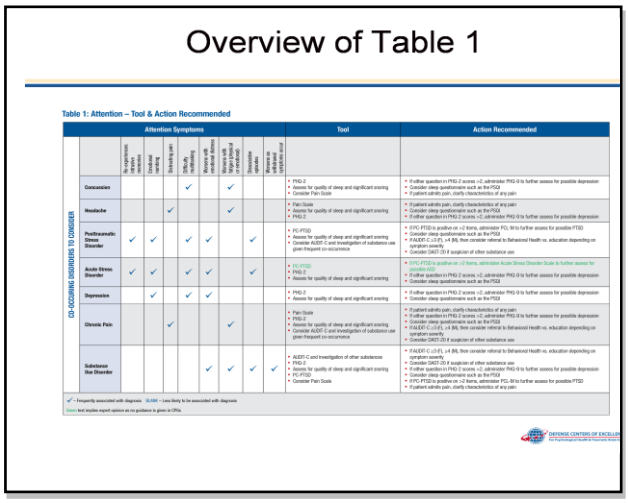
1. Symptoms column: The provider reviews the check-mark drawing to determine which potential diagnoses are associated with the characteristics of his/her patient’s symptoms.
2. Tool column: Contains recommended screening and assessment tools based on the potential disorders identified in Table 1.
3. Action recommended column: The results of the screening tools yield recommended actions, which help determine the etiology of the symptom(s).

Do:

- Point to “symptoms,” “tool” and “action recommended” when referring to these columns.
- Each of the tools mentioned in the tool column is either presented later on in the tool kit or instructions are given on how to find and use them.

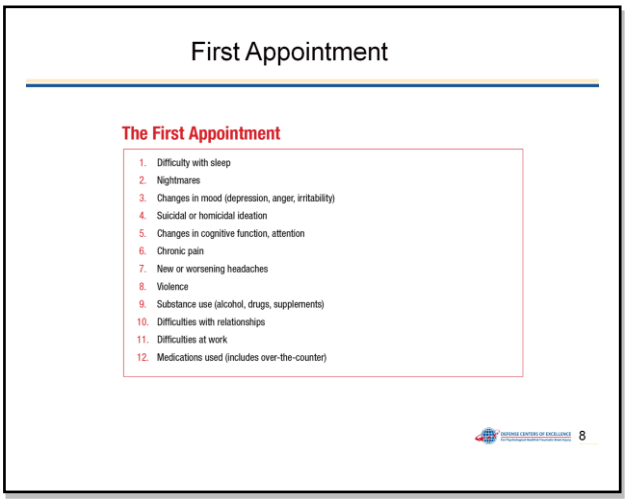
Additional Points (if any):

- None



Customizable Content (if any):

First Appointment



Say:

When seeing a service member with a concussion history and ongoing symptoms, a screening for potential co-occurring psychological health concerns should take place.

- There are several key areas of safety and symptoms that should be addressed.
- (These 12 topics of concern are from page five of the tool kit).
- Given the time constraints of the primary care appointments, there will not likely be time to assess for the etiology of all symptoms. A focused interview that covers these main areas would be considered an adequate risk assessment and assist the provider in identifying the symptoms to address. The following slide includes some tips on structuring the clinical interview.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Tips for Structuring the Clinical Interview

Say:

There is not a typical patient presentation as the pattern of symptoms vary widely depending on the conditions present. Some tailoring of the provider communication style will be important to maximize effective patient interaction. Common cognitive symptoms that may affect patient interaction include memory problems, slowed thought process, problems with organization, disinhibition and altered self-awareness. Thus a longer appointment time may be required than most typical primary care appointments.

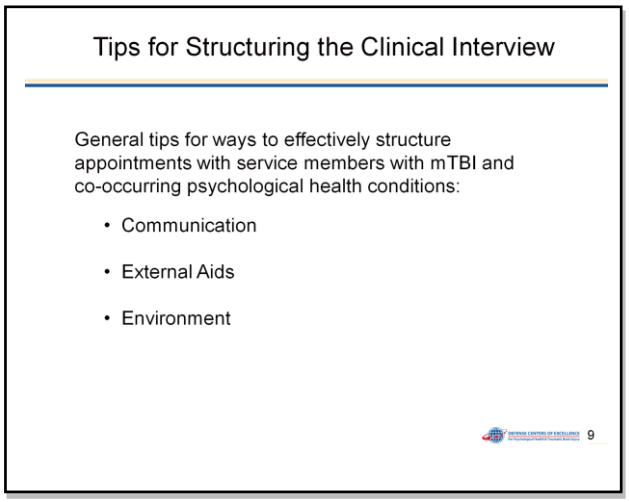
- **Communication** – use short, simple sentences, minimize the amount that is said at one time, speak slowly and clearly, use the same words when repeating information, summarize key points throughout the appointment, allow patient time to respond
- **External aids** – written notes, diagrams either by or for the patient, set session agendas
- **Environment** – more frequent yet shorter visits, set meeting time, structure, hold appointments on patient's best time of day, be open to contact between sessions, plan for longer duration of treatment, minimize distractions in visits and appointment environment

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Source of *Tips for Structuring the Clinical Interview* from the tool kit:

Kortte, KB, Briggs, F & Wegener, ST. (2005) Psychotherapy with Cognitively Impaired Adults. In GP Koocher, JC Norcross, & SS Hill, III (Eds.) The Psychologist's Desk Reference 2nd Edition (pp. 342-346), Oxford University Press.

Chronic Pain

Say:

SMART objective:

- The participant will review a clinical vignette and utilize the chronic pain tables of the tool kit to correctly differentiate between the common diagnoses for chronic pain symptoms in the individual who presents with a history of concussion and a co-occurring psychological health condition.
- The participant will verbally discuss the assessment tools used to evaluate chronic pain symptoms and the first and second step treatment interventions.

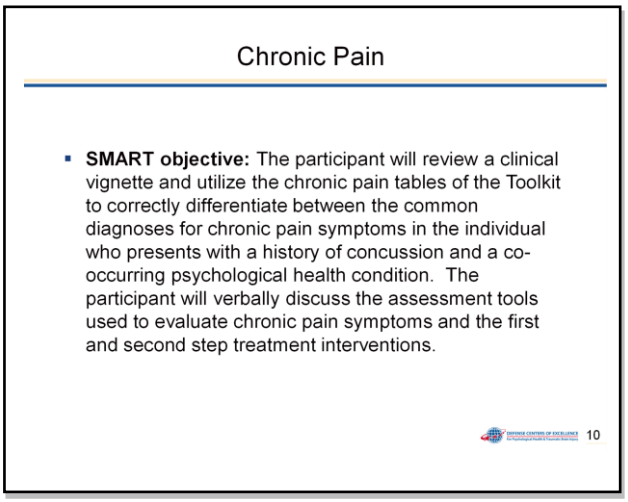
*SMART stands for specific, measurable, achievable, realistic and time-bound.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Chronic Pain

Say:

CPT Parker was injured in a motor vehicle rollover event in Afghanistan five months ago and sustained a brief loss of consciousness and period of confusion. He was subsequently diagnosed with a concussion. In addition to his head injury, he exacerbated an L5,S1 injury when he twisted in his seatbelt. He was treated in theater.

Parker's in-theater treatment plan included acetaminophen (Tylenol) and an NSAID (Motrin) for his headaches. In addition, he was treated with physical therapy and narcotic analgesia (Vicodin) for his acute back pain.

He left theater with continued headaches and intermittent low-grade back pain, which worsened with exertion.

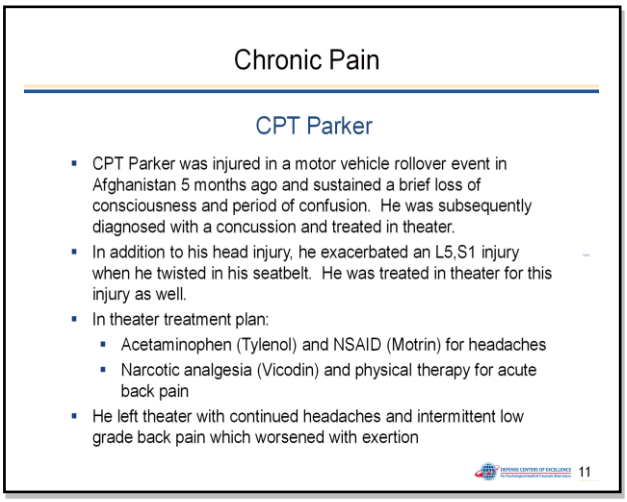
As the provider performs a history and physical, he inquires about over the counter medications. Parker has been alternating with Tylenol and Motrin at acceptable doses. He also reveals that he never stopped taking them after they were prescribed in theater because when he did, his headaches seemed to worsen.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Chronic Pain

Say:

CPT Parker's re-deployment treatment plan was to have him continue on Tylenol and Motrin, continue with physical therapy, and to gradually stop using the Vicodin. He presents to the family medicine clinic at his home station and states that he continues to have headaches that throb and interfere with his work. His back pain exists at a low level but when exacerbated is moderate/severe prompting him to take the Vicodin. He has noticed lately that when he is taking the Vicodin for his back, his headaches get much better. He is interested in having his prescription for Vicodin refilled to help with his headaches AND his back pain.

The provider educates Parker that by taking the Vicodin, he is taking extra acetaminophen (Tylenol) and that this should be avoided. The provider informs Parker that he should not continue to take the Vicodin that was prescribed for his back pain for his headaches.

Parker admits that he is concerned that the only thing working for his headaches at the present time is the Vicodin. He states to the provider that he has a buddy who was prescribed it after a surgery and got "hooked" on it. He doesn't want to be the guy hooked on Vicodin and emphasizes how important his career is to him.

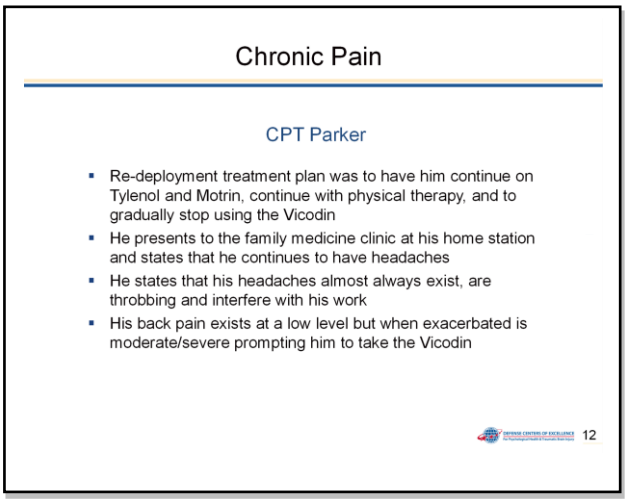
The provider decides to utilize the Co-occurring Conditions tool kit to further assist in differential diagnosis and treatment.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Summary of CPT Parker's vignette:

- Injured in motor vehicle rollover event in Afghanistan five months ago
- Brief LOC
- Period of confusion
- mTBI diagnosed in-theater
- Re-injured an L5, S1 injury when twisted in seatbelt
- Left theater with continued headaches and intermittent low-grade back pain (worse on exertion)
- Plan was to have him continue Tylenol and Motrin and follow up in CONUS
- Presents with:
    - Throbbing headaches, moderate/severe back pain, continued use of Vicodin
    - Desire for pain relief, insight that he should not continue to take the Vicodin that was prescribed for his back

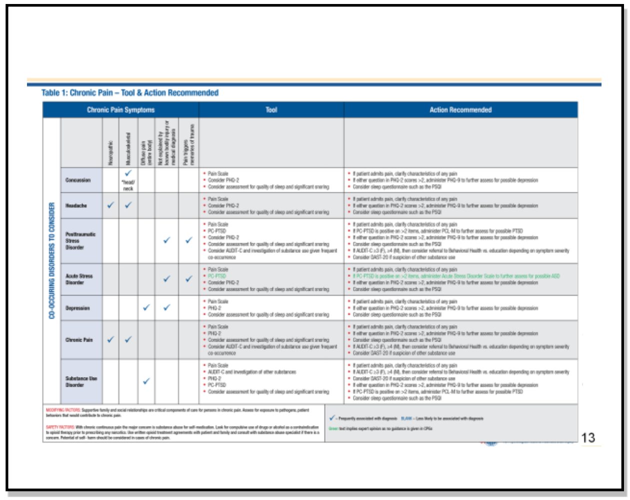


Table 1: Chronic Pain – Tool & Action Recommended

CO-OCCURING DISORDERS TO CONSIDER	Chronic Pain Symptoms: Neuropathic	Musculoskeletal	Diffuse pain (entire body)	Not explained by known bodily injury or medical diagnosis	Pain triggers memories of trauma	Tool	Action Recommended
Concussion		✓ *head/neck				• Pain Scale • Consider PHQ-2 • Consider assessment for quality of sleep and significant snoring	• If patient admits pain, clarify characteristics of any pain • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI
Headache	✓	✓				• Pain Scale • Consider PHQ-2 • Consider assessment for quality of sleep and significant snoring	• If patient admits pain, clarify characteristics of any pain • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI
Posttraumatic Stress Disorder				✓	✓	• Pain Scale • PC-PTSD • Consider PHQ-2 • Consider assessment for quality of sleep and significant snoring • Consider AUDIT-C and investigation of substance use given frequent co-occurrence	• If patient admits pain, clarify characteristics of any pain • If PC-PTSD is positive on >2 items, administer PCL-M to further assess for possible PTSD • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI • If AUDIT-C ≥3 (F), ≥4 (M), then consider referral to Behavioral Health vs. education depending on symptom severity • Consider DAST-20 if suspicion of other substance use
Acute Stress Disorder				✓	✓	• Pain Scale • PC-PTSD • Consider PHQ-2 • Consider assessment for quality of sleep and significant snoring	• If patient admits pain, clarify characteristics of any pain • If PC-PTSD is positive on >2 items, administer Acute Stress Disorder Scale to further assess for possible ASD • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI
Depression			✓	✓		• Pain Scale • PHQ-2 • Consider assessment for quality of sleep and significant snoring	• If patient admits pain, clarify characteristics of any pain • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI
Chronic Pain	✓	✓				• Pain Scale • PHQ-2 • Consider assessment for quality of sleep and significant snoring • Consider AUDIT-C and investigation of substance use given frequent co-occurrence	• If patient admits pain, clarify characteristics of any pain • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • Consider sleep questionnaire such as the PSQI • If AUDIT-C ≥3 (F), ≥4 (M), then consider referral to Behavioral Health vs. education depending on symptom severity • Consider DAST-20 if suspicion of other substance use
Substance Use Disorder			✓			• Pain Scale • AUDIT-C and investigation of other substances • PHQ-2 • PC-PTSD • Consider assessment for quality of sleep and significant snoring	• If patient admits pain, clarify characteristics of any pain • If AUDIT-C ≥3 (F), ≥4 (M), then consider referral to Behavioral Health vs. education depending on symptom severity • Consider DAST-20 if suspicion of other substance use • If either question in PHQ-2 scores >2, administer PHQ-9 to further assess for possible depression • If PC-PTSD is positive on >2 items, administer PCL-M to further assess for possible PTSD • Consider sleep questionnaire such as the PSQI

MODIFYING FACTORS: Supportive family and social relationships are critical components of care for persons in chronic pain. Assess for exposure to pathogens, patient behaviors that would contribute to chronic pain.

SAFETY FACTORS: With chronic continuous pain the major concern is substance abuse for self-medication. Look for compulsive use of drugs or alcohol as a contraindication to opioid therapy prior to prescribing any narcotics. Use written opioid treatment agreements with patient and family and consult with substance abuse specialist if there is a concern. Potential of self- harm should be considered in cases of chronic pain.

✓ = Frequently associated with diagnosis BLANK = Less likely to be associated with diagnosis

Green text implies expert opinion as no guidance is given in CPGs

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Table 1: Chronic Pain – Tool & Action Recommended

Say:

When a patient with mild TBI and co-occurring symptoms, such as CPT Parker, the provider should identify which symptom tab (sleep, mood, attention or chronic pain) of the tool kit should be used based on current symptoms. In this case, Parker's target symptom seems to be chronic pain. Therefore, the provider flips to Table 1 of the chronic pain tab, which is on page 30 of the tool kit.

Do:

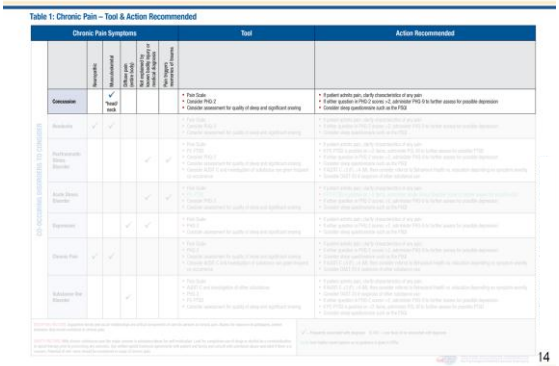
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

***Table 1: Chronic Pain – Tool & Action Recommended* Cont'd**



Say:

Next, the provider reviews the characteristics of chronic pain symptoms at the top of the table. The characteristics of complaints related to chronic pain include: neuropathic, musculoskeletal, diffuse pain (entire body), not explained by known bodily injury or medical diagnosis and pain triggers memories of trauma.

In our example, Parker complains of chronic low-grade back pain, which worsens with exertion and a fairly constant low-grade headache with bi-weekly exacerbations, throbbing in nature, and increased intensity severe enough to interfere with his work.

The characteristics of Parker's symptoms, when matched with those at the top of the mood tab, include: musculoskeletal.

Next, the provider determines the probable etiology of the specific symptoms. The "check-mark drawing" implies stronger association. Therefore, in our example, the provider looks to the concussion, headache and chronic pain rows as Parker's symptoms span these three diagnoses.

The concussion row is highlighted on this slide. This row includes the suggested assessment tools and the actions recommended for the management of concussion.

Do:

- Point out the columns in the table on the slide that refer to each of the characterists or chronic pain symptoms while naming them.

Additional Points (if any):

- None

Customizable Content (if any):

***Table 1: Chronic Pain – Tool & Action Recommended* Cont'd**

Say:

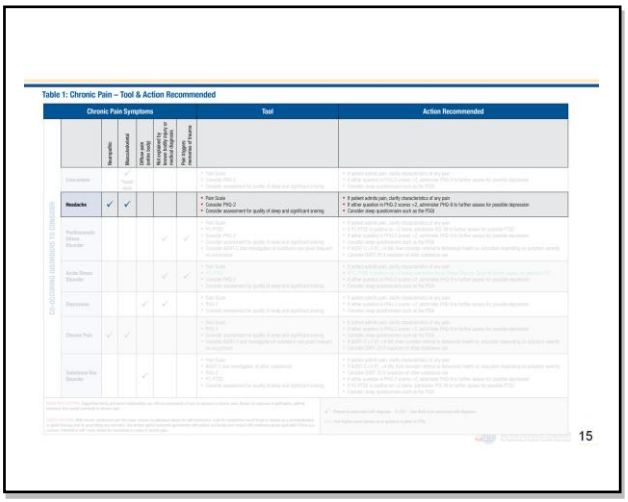
The headache row is highlighted on this slide. This row includes the suggested assessment tools, and the actions recommended for the management of headache.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Table 1: Chronic Pain – Tool & Action Recommended* Cont'd**

Say:

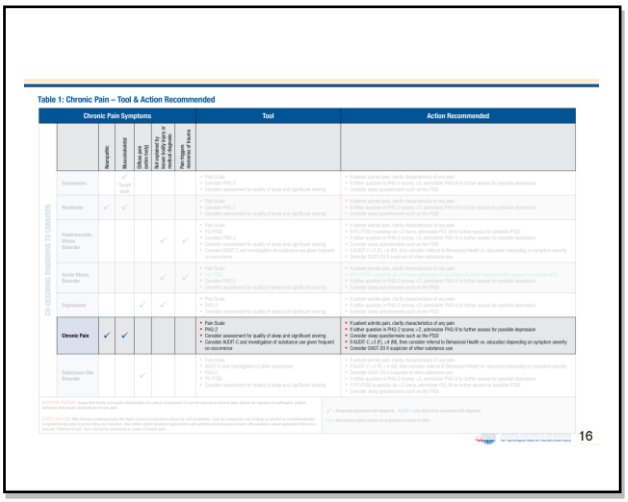
The chronic pain row is highlighted on this slide. This row includes the suggested assessment tools, and the actions recommended for the management of chronic pain.

Do:

- No activities

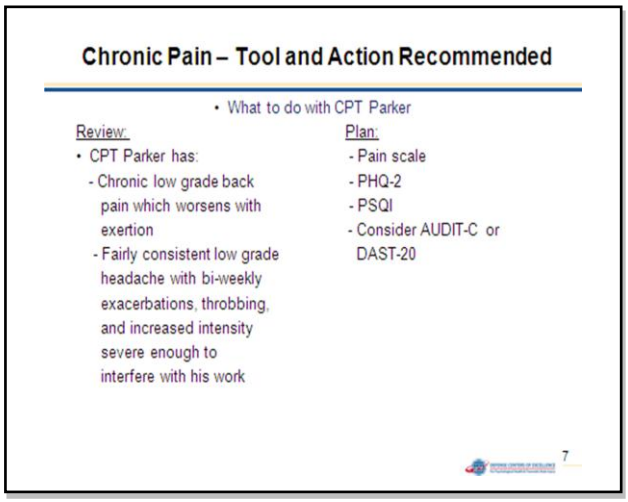
Additional Points (if any):

- None



Customizable Content (if any):

Chronic Pain - Tool and Action Recommended



Say:

The first thing the provider would do after recognizing that Parker's symptoms span these three diagnoses is to recognize the useful tools that will further help with the differential diagnosis.

From the "tool" column on the concussion, headache and chronic pain rows, here is the guidance for further assessing these symptoms:

- Administer the pain scale. CPT Parker has two sources of pain and so the provider asks him to complete a pain scale rating for both his headache and his back pain.
- Administer the PHQ-2
- Assess for quality of sleep and significant snoring using a tool such as the PSQI
- Consider use of the AUDIT-C and investigation of substance use given frequent co-occurrences
- Consider using the DAST-20 if suspicion of other substance use (other than alcohol)

To illustrate what these tools look like, they are shown on the next few slides.

Do:

- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Numeric Pain Rating Scale

Say:

The pain scale recommended in the tool kit is the Numeric Rating Pain Scale, located on page 126, and is often used in chronic opioid therapy.

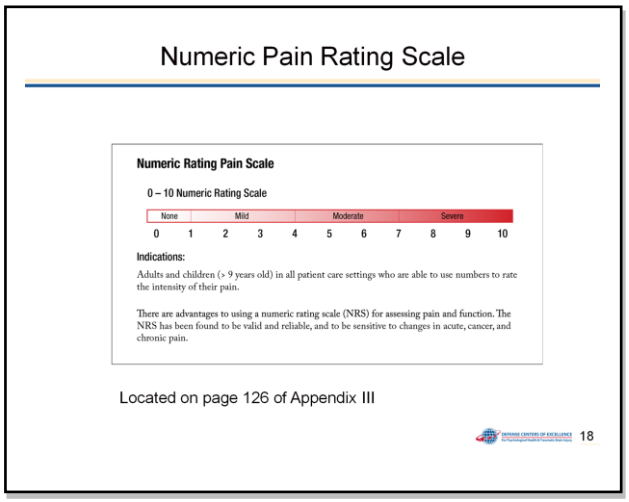
The indications for the pain scale are for adults and children, ten years or older, in all patient care settings who are able to use numbers to rate the intensity of their pain. The scale rates the intensity and quality of the pain.

Do:

- No activities

Additional Points (if any):

- These questions are also on page 126 of the tool kit in Appendix III



Customizable Content (if any):

***Numeric Pain Rating Scale* Cont'd**

Say:

These are the questions that assess the quality and intensity of the patient's pain.

Do:

- No activities

Additional Points (if any):

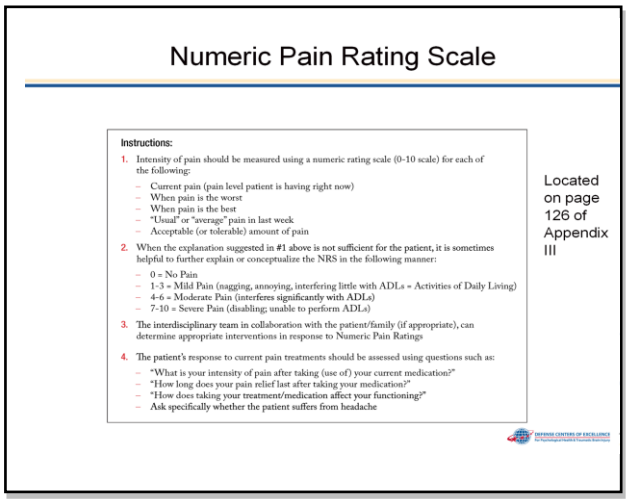
These questions and instructions are also on page 126 of the tool kit in Appendix III.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Patient Health Questionnaire 2 (PHQ-2)

Say:

Table 1 also recommends that the provider at least consider that Parker is having mood symptoms and recommends the use of the PHQ-2.

The Patient Health Questionnaire 2 is a tool for major depressive disorder that is effective for identifying patients with depression and can also be used to measure treatment outcomes. The authors state that patients with a PHQ-2 score of 3 or greater should be followed up with the PHQ-9 – as seen on this slide. For our purposes and for use in the tool kit, if the **PHQ-2 is greater than 2** it is recommended for the provider to consider using the PHQ-9 to further assess for possible depression.

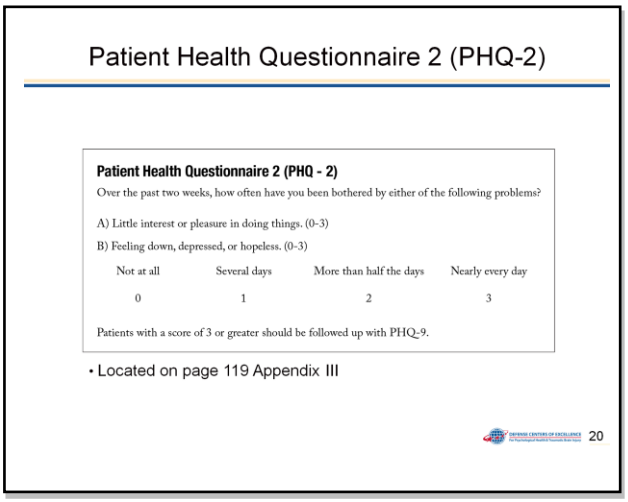
The PHQ-2 is located on page 119 of the tool kit.

Do:

- No activities

Additional Points (if any):

- It is very easy to incorporate the PHQ-2 questionnaire into a primary care assessment because it only has two screening items.



Customizable Content (if any):

Pittsburgh Sleep Quality Index (PSQI)

Say:

The Pittsburgh Sleep Quality Index (PSQI) is a 19 item self-rated questionnaire and has five questions rated by a bed partner or roommate that assesses sleep disturbances over a one-month time interval. However, only the self-rated items are used in scoring the scale. All scores are combined according to the scoring criteria included with the form to produce a global PSQI score.

Each component is scored from 0 to 3, yielding a global PSQI score between 0 and 21, with higher scores indicating lower quality of sleep. The PSQI is useful in identifying good and poor sleepers. A global PSQI score is greater than 5 indicates that a person is a “poor sleeper” having severe difficulties in at least two areas or moderate difficulties in more than three areas.

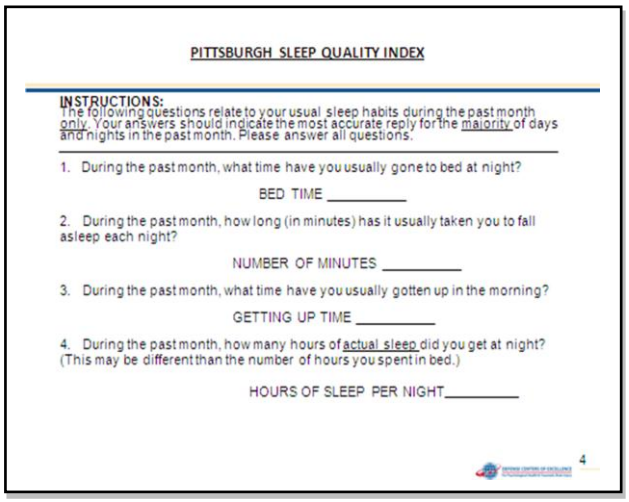
The link to the PSQI is on page 118 of the tool kit under the heading “Additional Provider Tools.”

Do:

- No activities

Additional Points (if any):

- None



PITTSBURGH SLEEP QUALITY INDEX

INSTRUCTIONS:
The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

BED TIME _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

3. During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME _____

4. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT_____

4

Customizable Content (if any):

Drug Abuse Screening Test (DAST-20)

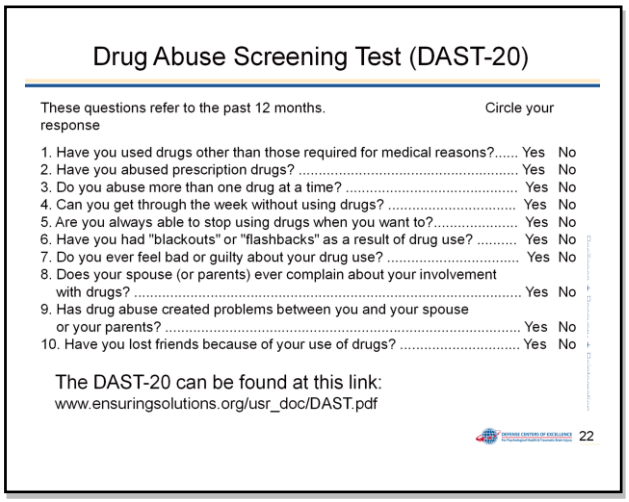
Say:

The provider is appropriately concerned with Parker's worry about misusing the Vicodin and decides to use a screening tool to rule out a problem of drug abuse BEFORE he begins to address Parker's chronic pain. Table 1 recommends considering the use of the Drug Abuse Screening Test (DAST-20). The first substance abuse screening tool to consider would be the AUDIT-C, but this is used to assess for hazardous drinking behavior. The provider in this example is concerned with Parker's Vicodin use.

The DAST was designed to provide a brief instrument for clinical and non-clinical screening to detect drug abuse or dependence disorders. It is most useful in settings in which seeking treatment for drug use problems is not the patient's stated goal. It was adapted from the MAST to detect drug abuse or dependence pertaining to a range of psychoactive substances other than alcohol. The 28 self-report items cover a variety of consequences related to drug abuse without being specific about the drug, thus alleviating the necessity of using different instruments specific to each drug. A 20-item version of the DAST was found to have psychometric properties comparable with the 28-item version. Both versions are referred to as the DAST in the literature. In addition, the DAST provides a general measure of lifetime problem severity that can be used to guide further inquiry into drug-related problems and to help determine treatment intensity. It takes about five minutes to administer the DAST and two minutes to score.

Scoring the DAST-20: Score 1 point for each question answered "yes," except for questions four and five, for which a "no" receives 1 point.

[Continued on next page]



Drug Abuse Screening Test (DAST-20)

These questions refer to the past 12 months. Circle your response

1. Have you used drugs other than those required for medical reasons? ..... Yes No
2. Have you abused prescription drugs? ..... Yes No
3. Do you abuse more than one drug at a time? ..... Yes No
4. Can you get through the week without using drugs? ..... Yes No
5. Are you always able to stop using drugs when you want to? ..... Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? ..... Yes No
7. Do you ever feel bad or guilty about your drug use? ..... Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs? ..... Yes No
9. Has drug abuse created problems between you and your spouse or your parents? ..... Yes No
10. Have you lost friends because of your use of drugs? ..... Yes No

The DAST-20 can be found at this link:
www.ensuringsolutions.org/usr_doc/DAST.pdf

22

Customizable Content (if any):

[continued from previous page]

Scoring the DAST-20

Score	Severity	Intervention Recommended
0	N/A	N/A
1 – 5	Low	Brief Intervention
6 – 10	Intermediate (likely meets DSM criteria)	Outpatient (Intensive)
11 – 15	Substantial	Intensive
16 – 20	Severe	Intensive

The link to the DAST-20 assessment is found on page 118 of Appendix III and is on the bottom of this slide as well.

Do:

- No activities

Additional Points (if any):

- The scoring of the DAST-20 may also be found at the website link with the scale itself.
- The scoring quickly identifies which patients may benefit from intensive and even in-patient intervention.

Chronic Pain - Tool and Action Recommended

Say:

As previously mentioned, Parker completed the numeric rating pain scales for both his headaches and back pain.

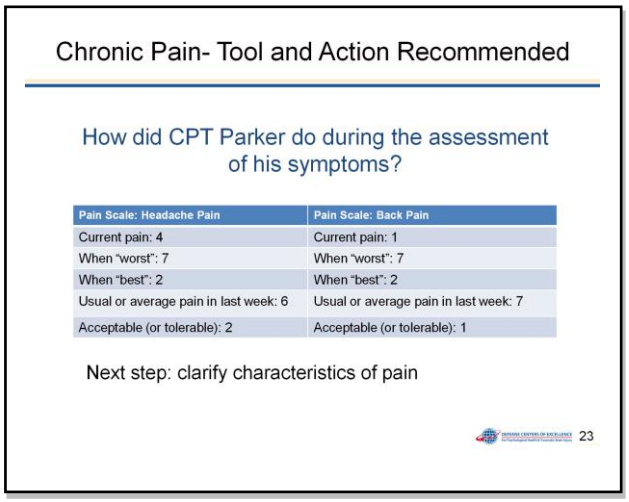
These pain scale scores listed on the slide prompted the provider to consider interventions to provide first steps of treatment options for Parker's chronic pain symptoms as outlined in Table 2 of the chronic pain tab. Before moving to treatment options for the headache and chronic back pain, the provider should clarify the characteristics of both areas of pain.

Do:

- No activities

Additional Points (if any):

- The questions on the slide clarify the characteristics of the pain and are found within the Numeric Rating Pain Scale on page 126 of the tool kit.



Customizable Content (if any):

Table 2: Treatment Tips for Chronic Pain Based on Potential Etiology

Say:

The provider next refers to Table 2 of the chronic pain tab and looks to the headache and chronic pain rows since that seems to be the etiology of Parker's symptoms based on the provider's assessments as noted in the previous slides.

Table 2 for chronic pain has two columns that discuss the first and second steps for treatment options.

Do:

- No activities

Additional Points (if any):

- Table 2 for chronic pain is found on page 33 of the tool kit

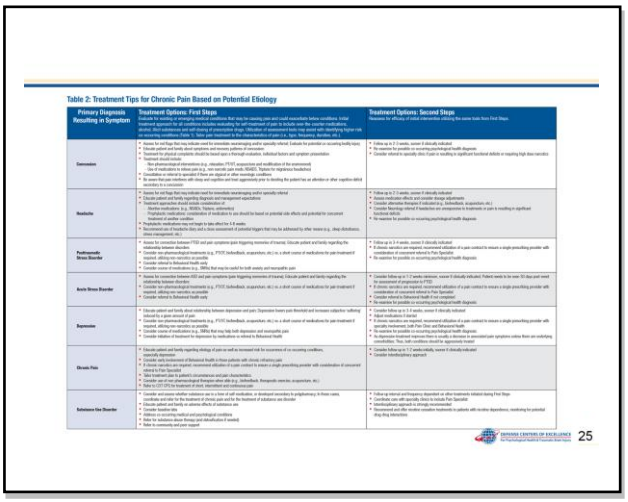


Table 2: Treatment Tips for Chronic Pain Based on Potential Etiology

Primary Diagnosis Resulting in Symptom	Treatment Options: First Steps	Treatment Options: Second Steps
Concussion		
Headache		
Posttraumatic Stress Disorder		
Acute Stress Disorder		
Depression		
Chronic Pain		
Substance Use Disorder		

25

Customizable Content (if any):

***Table 2: Treatment Tips for Chronic Pain Based on Potential Etiology* Cont'd**

Say:

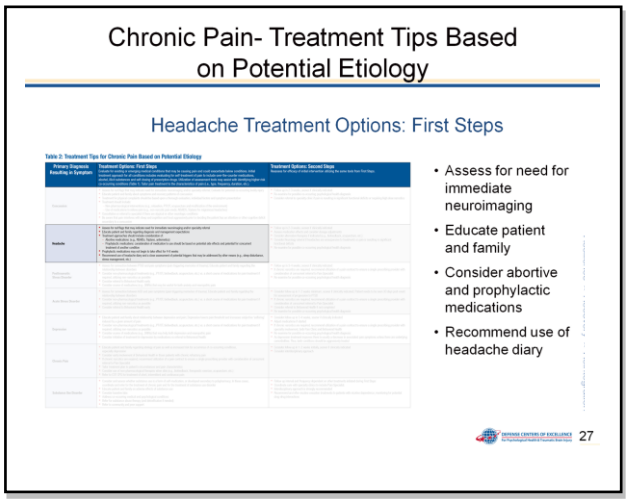
Here is the headache row. Let's look at the first step treatment options on the next slide.

Do:

- No activities

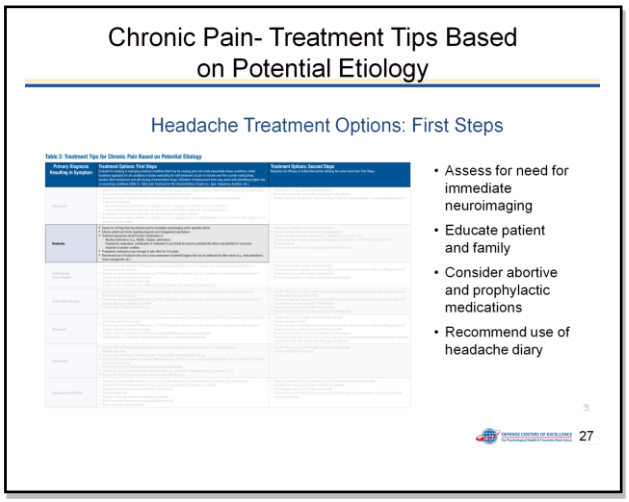
Additional Points (if any):

- None



Customizable Content (if any):

Chronic Pain - Treatment Tips Based on Potential Etiology



Say:

According to the treatment options: the first steps for headache, the provider would:

1) Assess for neurological red flags that may indicate the need for immediate neuroimaging and/or specialty referral such as findings on a neurological examination, new neurological complaints such as visual changes, weakness, sudden acute worsening of current symptoms, degree of headache never previously experienced.
2) Provide education to the patient and family on the diagnosis and recovery patterns and help to manage expectations.
3) Since Parker's headaches are ongoing and throbbing, the provider will continue abortive medications (NSAIDS: ibruprofen) and also consider prophylactic medications. The provider will refer to the tool kit for information on prophylactic medications for headache.
4) Understand that prophylactic medications may not begin to take effect for four to six weeks.
5) Recommend the use of a headache log in which Parker will basically keep a diary of what time of day the headaches occur most frequently and what seems to make them better or worse. Potential triggers may be identified by the use of a log.

Do:

- No activities

Additional Points (if any):

- The VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain also discusses treatment for short, intermittent and continuous pain.

Customizable Content (if any):

Table 2: Treatment Tips for Chronic Pain Based on Potential Etiology

Say:

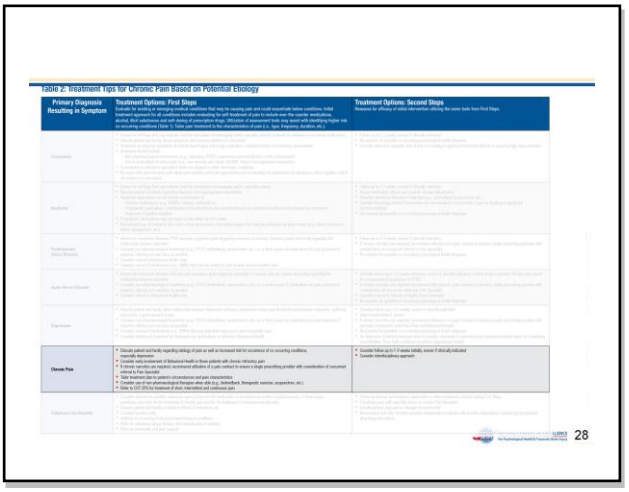
Here is the chronic pain row from Table 2. Let's look at the first step treatment options on the next slide.

Do:

- No activities

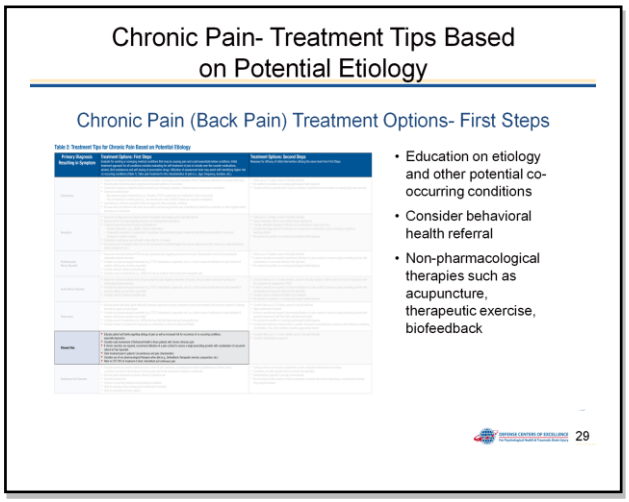
Additional Points (if any):

- None



Customizable Content (if any):

Chronic Pain - Treatment Tips for Chronic Pain Based on Potential Etiology



Say:

According to the treatment options, the first steps for chronic pain, the provider would:

1) Educate CPT Parker and his family on the etiology of his back pain and the risk for occurrence of other co-occurring conditions such as depression.
2) The provider will support Parker in using the narcotic analgesia during the infrequent occasion when his back pain has been exacerbated by exertion, until the pain is at the usual tolerable level. The DAST-20 was negative, but this will need to be re-assessed in the future to ensure that narcotic misuse is not occurring. If narcotic misuse is occurring, the provider would consider a pain contract and a single prescribing provider and a pain specialist consult. Since Vicodin will be used, the provider will discontinue use of Tylenol. Parker will also continue to work with his physical therapist.
3) Consider early involvement of behavioral health.
4) Consider the use of non-pharmacological therapies such as biofeedback, therapeutic exercise and acupuncture.

After considering the first steps in treatment options for both the headache diagnosis and chronic pain diagnosis, the provider refers to the medication recommendations in the tool kit.

Do:

- No activities

Additional Points (if any):

- The VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain also discusses treatment for short, intermittent and continuous pain.

Customizable Content (if any):

Medication Considerations

Say:

Page 36 of the tool kit includes the table of contents for the medications.

The provider knows from the Table 2 headache row recommendations that he or she should consider initiation (or maintenance of) abortive medications for headache and also consider medications for prophylaxis of headaches.

Do:

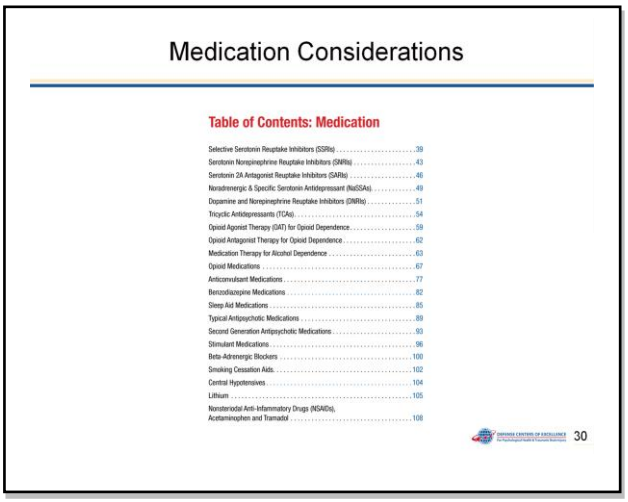
- No activities

Additional Points (if any):

Appendix I contains the medications that are potential pharmacological agents for use in co-occurring disordered patients.

It includes this information for each medication:

- Medication name (generic and brand name)
- Adult starting dose (max per day)
- Advantages/Disadvantages
- Pregnancy category
- Safety margin
- Efficacy
- Table of adverse drug effects
- Table of pros and cons for the use of a specific class of medication across the diagnoses of mild TBI, headache, acute stress, PTSD, depression, chronic pain and substance use disorders
- Black box warning if it exists for that class



Customizable Content (if any):

***Medication Considerations* Cont'd**

Say:

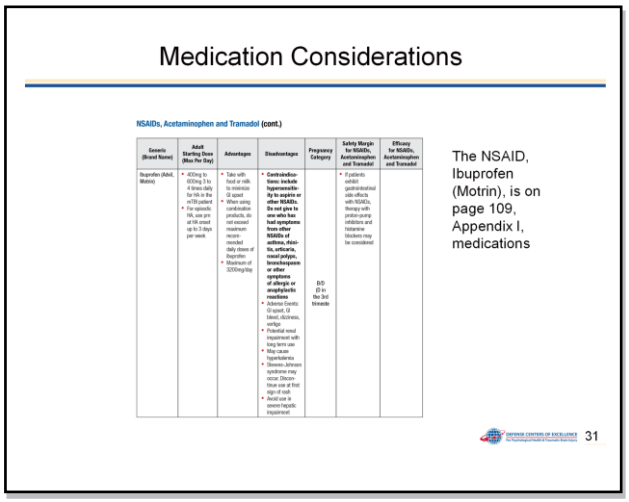
Here is a sample page of the nonsteroidal anti-inflammatory drugs (NSAIDs) which begin on page 108. Page 109 is highlighted here because CPT Parker is already taking ibuprofen (Motrin).

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Medication Considerations* Cont'd**

Say:

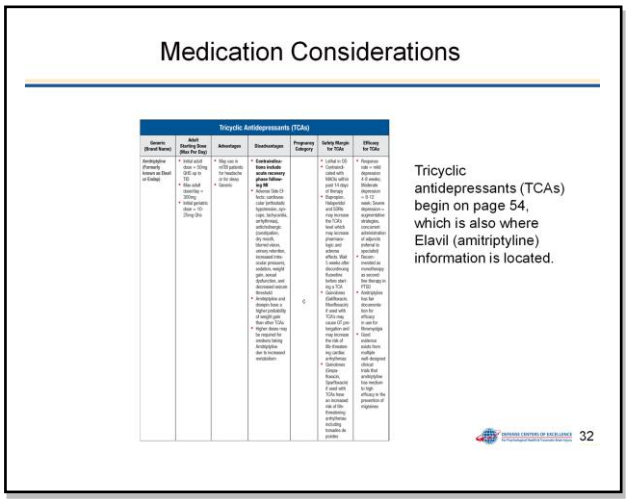
Here is a sample page of tricyclic antidepressants (TCAs) which begin on page 54. This is highlighted because Elavil (amitriptyline) can be used as headache prophylaxis.

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

Medication Pros and Cons of Tricyclics Adverse Drug Effects

Say:

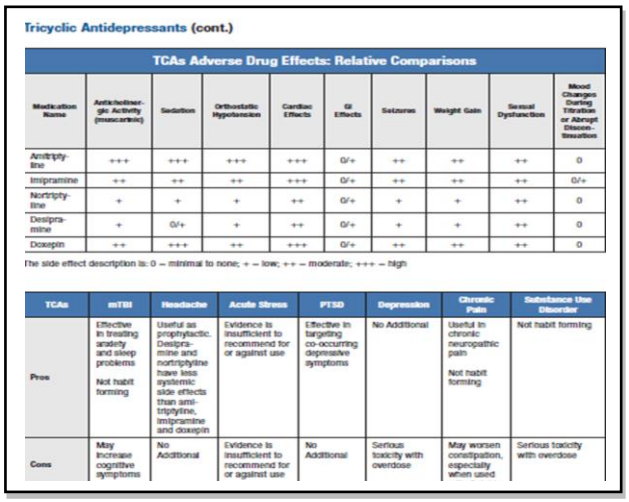
When considering the use of a TCA such as Elavil in patients with mTBI, it is important to appreciate the adverse drug effects and relative comparisons of the various medications in this class and also the pros and cons as seen in this table from Appendix 1, page 58.

Do:

- No activities

Additional Points (if any):

- None



Tricyclic Antidepressants (cont.)

TCAs Adverse Drug Effects: Relative Comparisons

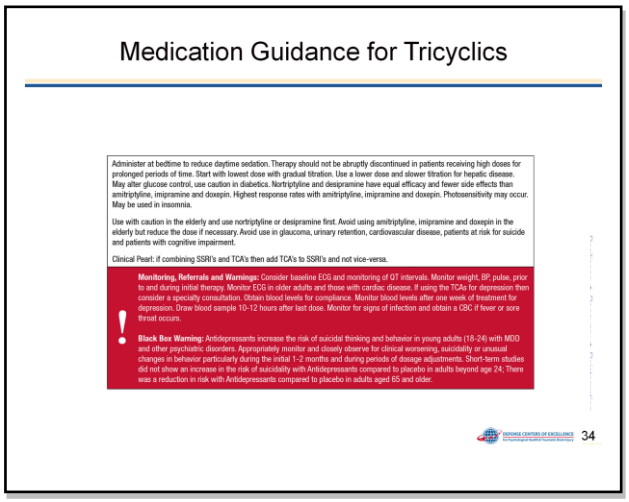
Medication Name	Anticholinergic Activity (muscarinic)	Sedation	Orthostatic Hypotension	Cardiac Effects	GI Effects	Seizures	Weight Gain	Sexual Dysfunction	Mood Changes During Titration or Abrupt Discontinuation
Amitriptyline	+++	+++	+++	+++	0/+	++	++	++	0
Imipramine	++	++	++	+++	0/+	++	++	++	0/+
Nortriptyline	+	+	+	++	0/+	+	+	++	0
Desipramine	+	0/+	+	++	0/+	+	+	++	0
Doxepin	++	+++	++	+++	0/+	++	++	++	0

The side effect description is: 0 – minimal to none; + – low; ++ – moderate; +++ – high

TCAs	mTBI	Headache	Acute Stress	PTSD	Depression	Chronic Pain	Substance Use Disorder
Pros	Effective in treating anxiety and sleep problems Not habit forming	Useful as prophylactic. Desipramine and nortriptyline have less systemic side effects than amitriptyline, imipramine and doxepin	Evidence is insufficient to recommend for or against use	Effective in targeting co-occurring depressive symptoms	No Additional	Useful in chronic neuropathic pain Not habit forming	Not habit forming
Cons	May increase cognitive symptoms	No Additional	Evidence is insufficient to recommend for or against use	No Additional	Serious toxicity with overdose	May worsen constipation, especially when used	Serious toxicity with overdose

Customizable Content (if any):

Medication Guidance for Tricyclics



Say:

Page 57 of Appendix 1 has specific guidance on the use of all TCAs:

- Take a thorough cardiac history and consider baseline EKG and monitoring of QT intervals as TCAs may widen the QT interval.
- Administer at bedtime to reduce daytime sedation.
- Use a low dose and titrate up slowly in the context of hepatic disease.
- Caution use in diabetics, as TCAs may alter glucose control.
- Use with caution in the elderly
- TCAs may be lethal in overdose, use cautiously in patients with a history of suicidality.

In addition, there is a black box warning about antidepressants increasing suicidal thinking in young adults ages 18-24. You may read the whole warning on the slide or in the tool kit itself.

Do:

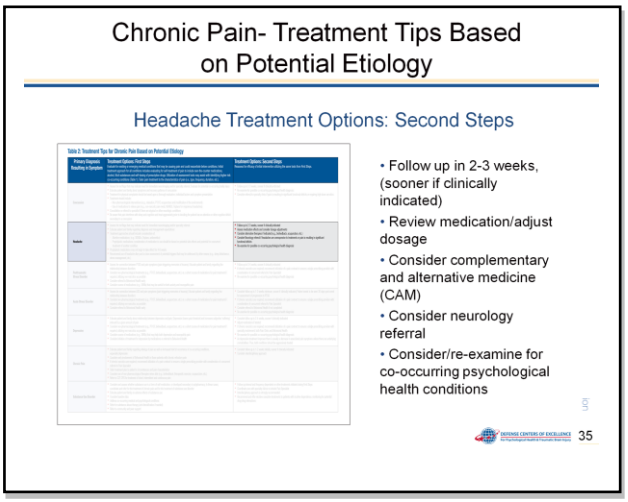
- No activities

Additional Points (if any):

- None

Customizable Content (if any):

Chronic Pain - Treatment Tips Based on Potential Etiology



Say:

According to Table 2, here are the second steps for treatment options:

1) This follow up is at two to three weeks or sooner.
2) Assess medication effects and consider dosage adjustments.
3) Consider alternate complementary and alternative medicine (CAM) therapies such as acupuncture, biofeedback and relaxation.
4) Consider neurology referral if headaches are unresponsive to treatments or pain is resulting in significant functional deficits.
5) Re-examine for possible co-occurring psychological health conditions.

Do:

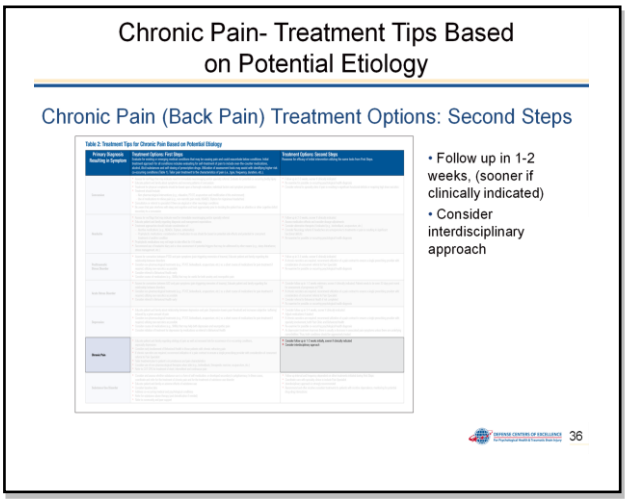
- No activities

Additional Points (if any):

- Chronic Pain Table 2 is on page 33 of the tool kit.

Customizable Content (if any):

Chronic Pain - Treatment Tips Based on Potential Etiology



Say:

According to Table 2, here are the second steps for chronic pain:

1) This follow up is at one to two weeks or sooner if clinically indicated.
2) Consider interdisciplinary approach.

Do:

- No activities

Additional Points (if any):

Chronic Pain Table 2 is on page 33 of the tool kit.

Customizable Content (if any):

Using the Tool Kit to Assist with Treatment Plan

Say:

This is a concise view of the treatment plan for CPT Parker that was recommended by following the tool kit guidance.

The provider used the tools recommended in Table 1 for headache to assess his headache symptoms and found that also endorsed symptoms of chronic back pain. The provider would:

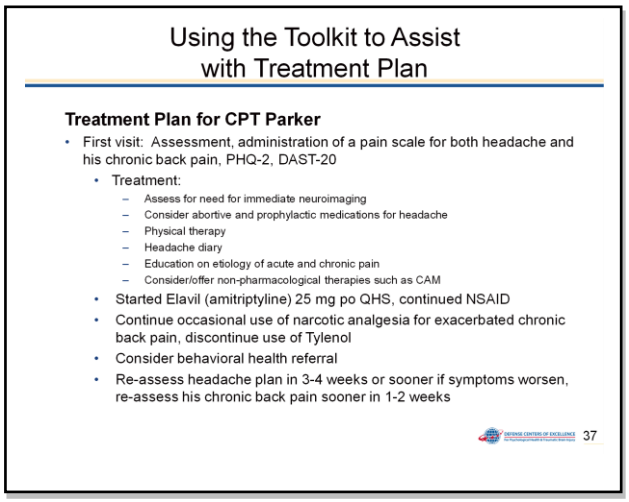
- Assess for the need for immediate neuroimaging
- Consider abortive and prophylactic medications for his headache
- Continue occasional use of narcotic analgesia for exacerbated chronic back pain
- Provide for physical therapy
- Recommend a headache diary
- Educate on etiology of acute and chronic pain
- Consider/offer non-pharmacological therapies such as CAM

Do:

- No activities

Additional Points (if any):

- None



Customizable Content (if any):

***Using the Tool kit to Assist with Treatment Plan* Cont'd**

Say:

At the second session, the provider re-evaluated CPT Parker's headache and chronic pain symptoms and re-administered the pain scales for both. Based on assessment, the provider declined to use further clinical tools (i.e., PHQ-2) for assessment in the follow up appointment. The provider evaluated Parker's response to Elavil. Parker revealed that the Elavil seemed to be starting to prevent the throbbing and intensive headaches that were interfering with his functioning at work. He had not taken any Vicodin since the last appointment and was working closely with his physical therapist to recover from his back injury and prevent further exacerbation of his pain. The provider decides to continue the medications (NSAIDs and Elavil) at their current dosage and follow up in three to four weeks.

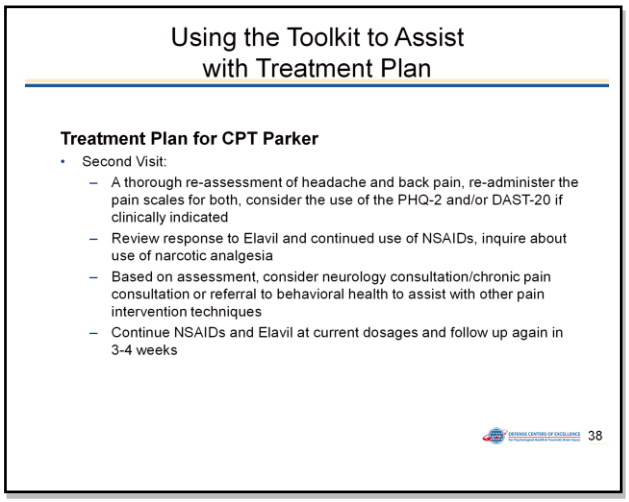
That concludes the review of the Co-occurring Conditions Toolkit chronic pain tab.

Do:

- No activities

Additional Points (if any):

- Summarize what was stated in the SMART objective:
  - The participants correctly assessed and differentiated between the most common diagnoses for chronic pain symptoms in the individual who presents with a history of concussion and a co-occurring psychological health condition.
  - The participants reviewed a clinical vignette of a patient with a chronic pain, concussion, and use of substances for pain. They verbally discussed the assessment tools used to evaluate chronic pain symptoms and the recommended first and second step interventions.



Customizable Content (if any):

End of slide presentation portion

Appendices

The following appendices are intended to provide the facilitator with:

APPENDIX A: EXPERIENTIAL EXERCISES

Below is the link to the Co-occurring Conditions Toolkit training video that was produced to accompany the tool kit and to demonstrate for providers how to utilize the tool kit. Instructors may choose to show any of the three parts of the training video to meet their specific needs. It is divided into three parts:

1) The first part of the training video highlights common definitions and illustrates the co-existing symptom domains.
2) The second part addresses how to use the tool kit and receive guidance for the management of mild traumatic brain injury and co-occurring physical and psychological health conditions.
3) The third part is clinical vignettes that further illustrate the complexity of this patient population.

If the instructor chooses to use the pre- and post-tests from Appendix B, all three videos must be shown in their entirety.

Tool kit Video: http://www.dcoe.health.mil/Training/TrainingTool kitsResources.aspx#vids.

If you are not able to access the above link, please follow the instructions below to access the tool kit manually on the DCoE website.

1) Go to: www.dcoe.health.mil
2) Click: Training & Events
3) Click: Provider Training Resources
4) Click: Clinical Tool Kits & Associated Training
5) Click: TBI Clinical Education tool kits
6) Click: Co-occurring Conditions Tool Kit Training Videos

APPENDIX B: EVALUATION MATERIALS

All evaluation materials and relevant guidance for instructors to evaluate the course are included in this appendix.

The pre- and post-tests included in this training manual are intended for audiences who have viewed the Co-occurring Conditions Tool kit Training Video *in its entirety*. Do not use the pre- and post-tests unless the entire video has been viewed.

Kirkpatrick Evaluation

In order to effectively measure the knowledge, skills and attitudes acquired through training or education, it may be appropriate to apply multiple evaluation techniques. Dr. Donald Kirkpatrick's training framework for evaluation is a straightforward means for measuring the impact of training-specific interventions on participant reaction, learning, behavior and outcomes. The table below highlights Kirkpatrick's Four Levels Evaluation Model™ and related data collection methods.

Kirkpatrick Level	Description	Data Collection Methods
Level 1 ***Reaction***	The degree to which participants react favorably to the training.	Course evaluation forms, verbal feedback, post-training surveys, increased participants through referrals.
Level 2 ***Learning***	To what degree participants acquire the intended knowledge, skills, attitudes, confidence and commitment based on their participation in a training event.	Pre- and post-training tests, performance-based skill evaluations, interviews or simulations.
Level 3 ***Behavior***	To what degree participants apply what they learned during training when they return to duty.	Observation and interviews of participants and their supervisors, chart reviews and self-assessments. Employing these methods over time will measure the degree of change and sustainability.
Level 4 ***Results***	To what degree targeted outcomes occur as a result of the training event and subsequent reinforcement.	Observation, interviews and focus groups; cultural assessment; financial information; statistics.

Further information about education and training evaluation can be found at http://www.dcoe.health.mil for the Training Effectiveness Tool Kit or under Training Effectiveness Toolkit.

Co-occurring Conditions Tool kit: Mild Traumatic Brain Injury and Psychological Health Evaluation Form

1. I clearly understood the course objectives. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable	5. I found this training guide easy to understand. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable
2. The course met all the stated objectives. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable	6. I would like to take more courses using training guides similar to this one. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable
3. The content was at the right level of detail. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable	7. The activities challenged my understanding of the content. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable
4. The content was presented in a logical sequence. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable	8. The content was relevant to the job. ○ Strongly Agree ○ Agree ○ Not Sure ○ Disagree ○ Strongly Disagree ○ Not Applicable

Co-occurring Conditions Tool kit: Mild Traumatic Brain Injury and Psychological Health
Pre-Test (Instructor Version)

1. The Department of Defense refers to the terms mild traumatic brain injury (mTBI) and concussion interchangeably.

a) True

b) False

Your Answer: _____

Correct Answer: A

2. Before a service member can be diagnosed with traumatic brain injury (TBI), an injury must have occurred and a person must experience an alteration in mental status as a result of the injury.

a) True

b) False

Your Answer: _____

Correct Answer: A

3. T or F: In order for a service member to have experienced a traumatic event, he or she must have experienced physical injury.

a) True

b) False

Your Answer: _____

Correct Answer: B

4. The Co-occurring Conditions Tool kit: Mild Traumatic Brain Injury and Psychological Health should be used as the standard of care or an exclusive course of management for co-occurring conditions involving TBI and psychological health?

a) True

b) False

Your Answer: _____

Correct Answer: B

5. Which of the following symptoms might an individual experience following an mTBI? Select all that apply.

a) Memory loss

b) Dizziness

c) Poor attention

d) Sleep disturbances

e) All of the above

f) None of the above

Your Answer: _____

Correct Answer: E

Co-occurring Conditions Tool kit: Mild Traumatic Brain Injury and Psychological Health
Pre-Test

1. The Department of Defense refers to the terms mild traumatic brain injury (mTBI) and concussion interchangeably.

a) True

b) False

Your Answer: _____

2. Before a service member can be diagnosed with traumatic brain injury (TBI), an injury must have occurred and a person must experience an alteration in mental status as a result of the injury.

a) True

b) False

Your Answer: _____

3. T or F: In order for a service member to have experienced a traumatic event, he or she must have experienced physical injury.

a) True

b) False

Your Answer: _____

4. The Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health should be used as the standard of care or an exclusive course of management for co-occurring conditions involving TBI and psychological health?

a) True

b) False

Your Answer: _____

5. Which of the following symptoms might an individual experience following an mTBI? Select all that apply.

a) Memory loss

b) Dizziness

c) Poor attention

d) Sleep disturbances

e) All of the above

f) None of the above

Your Answer: _____

Co-occurring Conditions Toolkit: Mild Traumatic Brain Injury and Psychological Health
Post-Test (Instructor Version)

NAME: _____ UNIT: _____

DATE: _____

In order for you to receive your certificate, you must select the best answer from the multiple choices listed below each question. Participants who receive a successful grade of 80% or higher will be issued certificates.

1. The Department of Defense refers to the terms mild traumatic brain injury (mTBI) and concussion interchangeably?

a) True

b) False

Your Answer: _____

Correct Answer: A

2. Before a service member can be diagnosed with traumatic brain injury (TBI), an injury must have occurred and a person must experience an alteration in mental status as a result of the injury.

a) True

b) False

Your Answer: _____

Correct Answer: A

3. In order for a service member to have experienced a traumatic event, he or she must have experienced physical injury.

a) True

b) False

Your Answer: _____

Correct Answer: B

4. The Co-occurring Conditions Tool kit: Mild Traumatic Brain Injury and Psychological Health should be used as the standard of care or an exclusive course of management for co-occurring conditions involving TBI and psychological health.

a) True

b) False

Your Answer: _____

Correct Answer: B

5. Which of the following symptoms might an individual experience following an mTBI? Select all that apply.

a) Memory loss

b) Dizziness

c) Poor attention

d) Sleep disturbances

e) All of the above

f) None of the above

Your Answer: _____

Correct Answer: E

6. T or F: Chronic pain is defined as pain that persists longer than 3-6 months.

a) True

b) False

Your Answer: _____

Correct Answer: A

7. T or F: A traumatic event is defined by the DSM-IV as: A person experienced, witnessed or was confronted by an event that involved actual or threatened death or serious injury.

a) True

b) False

Your Answer: _____

Correct Answer: A

8. Why did SFC Taylor decide to go to the doctor?

a) Headaches
b) Trouble sleeping
c) Posttraumatic stress disorder
d) Concussion
e) A&B
f) None of the above

Your Answer: _____

Correct Answer: E

9. After the IED blast SFC Taylor was diagnosed with a _____?

a) Concussion
b) PTSD
c) Moderate TBI
d) None of the above

Your Answer: _____

Correct Answer: A

10. What were the symptoms SFC Taylor was experiencing when he first went to the doctor?

a) Trouble sleeping
b) Headaches
c) Nausea
d) More irritable and distracted
e) All of the above

Your Answer: _____

Correct Answer: E

Co-occurring Conditions Tool kit: Mild Traumatic Brain Injury and Psychological Health Post-Test

NAME: _____ UNIT: _____

DATE: _____

In order for you to receive your certificate, you must select the best answer from the multiple choices listed below each question. Participants who receive a successful grade of 80% or higher will be issued certificates.

1. The Department of Defense refers to the terms mild TBI and concussion interchangeably?

c) True

d) False

Your Answer: _____

2. Before a service member can be diagnosed with traumatic brain injury (TBI), an injury must have occurred and a person must experience an alteration in mental status as a result of the injury.

c) True

d) False

Your Answer: _____

3. In order for a service member to have experienced a traumatic event, he or she must have experienced physical injury.

c) True

d) False

Your Answer: _____

4. The Co-occurring Conditions Tool kit: Mild Traumatic Brain Injury and Psychological Health should be used as the standard of care or an exclusive course of management for co-occurring conditions involving TBI and psychological health.

c) True

d) False

Your Answer: _____

5. Which of the following symptoms might an individual experience following an mTBI? Select all that apply.

g) Memory loss

h) Dizziness

i) Poor attention

j) Sleep disturbances

k) All of the above

l) None of the above

Your Answer: _____

6. T or F: Chronic pain is defined as pain that persists longer than 3-6 months.

c) True

d) False

Your Answer: _____

7. T or F: A traumatic event is defined by the DSM-IV as: A person experienced, witnessed or was confronted by an event that involved actual or threatened death or serious injury.

c) True

d) False

Your Answer: _____

8. Why did SFC Taylor decide to go to the doctor?

g) Headaches

h) Trouble sleeping

i) Posttraumatic stress disorder

j) Concussion

k) A&B

l) None of the above

Your Answer: _____

9. After the IED blast SFC Taylor was diagnosed with a _____?

e) Concussion

f) PTSD

g) Moderate TBI

h) None of the above

Your Answer: _____

10. What were the symptoms SFC Taylor was experiencing when he first went to the doctor?

f) Trouble sleeping

g) Headaches

h) Nausea

i) More irritable and distracted

j) All of the above

Your Answer: _____

APPENDIX C: KEY TERMS

Definitions for key terms used in the course instructional materials are provided below.

Term	Definition
Acute Stress Disorder (ASD)	The individual has been exposed to a trauma, and experiences three or more of the following symptoms: • Numbing • Detachment • Absence of emotional responsiveness • Being in a daze • Derealization • Depersonalization • Dissociative amnesia (unable to recall an important aspect of the event) • Intrusive thoughts • Avoid stimuli that make them remember the event They will feel anxious or irritable and have trouble sleeping or concentrating. This disturbance will cause significant impairment in a specific area of their life such as their job or relationships. This disturbance will last for a minimum of two days and a maximum of four weeks and will have occurred within four weeks of the traumatic event. These time frames become important for our discussion of posttraumatic stress disorder, which is not diagnosed until 30 days after the event.
Chronic Pain	Chronic pain is pain that persists beyond expected healing time and generally persists longer than three to six months. It is typically not associated with reversible conditions. Chronic pain may be influenced by physical, psychological, social, cultural, and hereditary factors.
Depression	Depression is a mood disorder in which a person has at least five of these symptoms of depression for at least two weeks and one of the symptoms must be either: • a depressed mood or • loss of interest or pleasure in things that normally bring pleasure. The symptoms of depression are: • Sleep disturbances • Diminished interest in pleasurable things

	• Feelings of excessive guilt, hopelessness or worthlessness • Decreased energy level • Problems with concentration • Change in appetite or weight • Psychomotor agitation or retardation • Somatic complaints • Suicidal thoughts
Posttraumatic Stress Disorder (PTSD)	PTSD (Posttraumatic stress disorder) the individual has been exposed to a traumatic event and has symptoms that occur within three clusters**. • *Hyperarousal:* the individual is persistently activated or aroused in that they are irritable, angry, and hyper vigilant. They may have difficulty falling asleep and startle easily. • *Avoidance:* the individual will persistently avoid anything that reminds them of the event such as places or activities that remind them of it. They may also feel detached from their loved ones and avoid conversation about the trauma. • *Re-experiencing:* the individual has recurrent or intrusive distressing recollections of the event such as dreams or thoughts during the day. They also may act and feel as if the event is happening all over again. **These symptoms cause clinically significant distress or impairment for the person. These symptoms must have lasted for more than a month.
Substance Use Disorders (SUD)	It is not uncommon for individuals to self-medicate with over the counter or prescription medications, alcohol, or illicit substances when they are in physical or psychological distress. This self-medication can lead to abuse of substances such as alcohol, prescription and illicit drugs. This includes spectrums of substance abuse and dependence as defined by the diagnostic criteria of the Diagnostic and Statistical Manual 4th Edition.
Traumatic Brain Injury (TBI)	A TBI is a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. Not all blows or jolts to the head result in TBI. Brain injuries are either penetrating or closed. Some common causes of TBI in the military include: motor vehicle crashes, falls, assaults and blasts. Closed head injuries are classified as mild, moderate or severe. The terms concussion and mild TBI are used interchangeably in the Department of Defense.

Traumatic Event	Event in which a person experienced, witnessed, or was confronted by an event that involved actual or threatened death or serious injury.

APPENDIX D: ACRONYMS

Acronyms used in the course are provided below.

Term	Definition
ASD	Acute stress disorder
ASDS	Acute Stress Disorder Scale
AUDIT-C	Alcohol Use Disorders Identification Test – alcohol consumption
BLUF	Bottom line up front
CAM	complementary and alternative medicine
CDP	Center for Deployment Psychology
CSTS	Center for the Study of Traumatic Stress
CPG	clinical practice guideline
DVBIC	Defense and Veterans Brain Injury Center
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
DoD	Department of Defense
DHCC	Deployment Health Clinical Center
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DVD	digital versatile disk
DAST	Drug Abuse Screening Test
ED	Education directorate
IED	improvised explosive device
MDD	major depressive disorder

MAST	Michigan Alcoholism Screening Test
mTBI	mild traumatic brain injury
NICoE	National Intrepid Center of Excellence
NSAID	non-steroidal anti-inflammatory drug
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PHQ	Patient Health Questionnaire
PSQI	Pittsburgh Sleep Quality Index
PTSD	posttraumatic stress disorder
PCL-M	Posttraumatic Stress Disorder Checklist – Military Version
PC	primary care
PC-PTSD	Primary Care – Posttraumatic Stress Disorder
PH	psychological health
SSRI	selective serotonin reuptake inhibitors
SNRI	serotonin and norepinephrine reuptake inhibitors
SMART	specific, measurable, achievable, realistic, time-bound
SUD	substance use disorder
TBI	traumatic brain injury
T2	National Center for Telehealth and Technology
TCA	tricyclic anti-depressants
USUHS	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs

WRNMMC	Walter Reed National Military Medical Center

APPENDIX E: ICONS

This section includes icons and their descriptions that will be used throughout the instructor's module to highlight key learning points or linkage to additional learning materials (e.g., video vignette, role play scenario). Example icons and their corresponding actions are shown below.

Icon	Corresponding Action
	Activity
	Customizable Content
	Discussion
	eLearning Exercise
	Experiential Exercise
	Instructor Note
	Interactive Exercise
	Key Points
	Kit

	Materials
	Mneumonics
	Play Video
	Recommended Reading
	Simulation and Feedback
	Time
	Web
	Worksheets