



Military TBI Case Management Quarterly Newsletter

TBI Case Management Community of Interest

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The ICE questionnaire allows you to tell us more about your awareness and satisfaction with the newsletter. Thank you for your participation.

Case Management

A Federal Inter/Intra-Agency Case Management Model for Transitions in Care

By Sheree Gordon and Elsie Moore, U.S. Department of Veterans Affairs Medical Center, Washington, DC; Lisa Perla, U.S. Department of Veterans Affairs Central Office, Washington, DC

A Community of Practice to facilitate a seamless transition among multiple systems of care for service members and veterans with significant injury or illness, including patients with traumatic brain injury (TBI) and other co-morbidities, has been established by the Departments of Defense (DoD) and Veterans Affairs (VA). Central to the practice is the identification of a Lead Coordinator who oversees coordination of care throughout a patient’s multiple transitions. The Lead Coordinator is present during each step along the path to recovery, ensuring a warm hand-off between case managers occurs. With over 48 case management programs across DoD and VA, this inter/intra-agency model provides a solution to many of the challenges of care coordination. The comprehensive DoD/VA Lead Coordinator checklist, a key component of this model, is accessible to providers and case managers and addresses domains of care relevant to the patient and their caregivers. Use of the checklist assures

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About the Quarterly Newsletter

The Military TBI Case Management Quarterly Newsletter is published by the Defense and Veterans Brain Injury Center, the traumatic brain injury (TBI) operational component of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. The newsletter is intended for providers who support warriors with traumatic brain injury (TBI) and their families. The newsletter is a forum to share ideas, best practices and resources among the TBI case management community. Comments and content suggestions for future editions of the newsletter and subscription updates may be sent to Mary Ellen Knuti, editor, at MaryEllen.Knuti.ctr@mail.mil.

Need to make a referral to DVVIC’s TBI Recovery Support Program (RSP) or request an onsite or video teleconferencing presentation about the RSP? Email: nrmc.dcoe.TBIrecoverysupport@mail.mil



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Quarterly Highlight

Art Therapy and Brain Wellness – When Words Aren’t Enough

By Jackie Biggs, Intrepid Spirit One, Fort Belvoir, VA



“My Hidden Secret” mask, created by a Marine to visually express aspects of his experience combating mTBI and PTSD. (Photo by Jackie Biggs)

The art therapy room is lined with masks, collages, paintings, boxes, and sculptures that express significant experiences in the lives of the service members who created them. Four service members hesitantly file into the room for their first session. They are being treated for mild traumatic brain injury (mTBI) and co-occurring psychological health (PH) conditions at Intrepid Spirit One, Fort Belvoir, Virginia.

As the art therapist at Intrepid Spirit One, I give the group a brief introduction to art therapy. Participants each receive a blank papier mache mask and are invited to use the materials of their choice to create a mask that is in some way a reflection of self.

“This is the complete opposite of how I’m used to operating,” one service member declares. Nonetheless, he engages in the task, immersing himself in the process of spontaneous art making, and then reluctantly sharing the concept and symbolism depicted in his mask. After the group session, members share, and a patient says, “This is really helpful because it shows me

that I am not alone.” Another adds, “I put this off for way too long. I thought ‘I’ve done a million different types of therapies, what’s art therapy possibly going to offer that’s different from anything else?’ But taking over an hour to create a reflection of myself, think carefully about what I added and why, has really made me look deeper into myself than I have before.”

According to the American Art Therapy Association website, “Art therapy is a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.” Art therapy works to improve a client’s physical and cognitive functioning as well as improve his or her emotional wellbeing. Additionally, art therapy provides an opportunity for non-verbal expression that allows clients to process emotions or events for which they may not have the words and can lead to discovery to benefit both the service member and other caregivers working to accelerate healing across the facility’s integrative, patient-centered care.

“Out of my various treatment modalities,” said a patient at Intrepid Spirit One, “art therapy is by far the best at helping me to release and understand my emotions regarding the overall effects of my brain injury and circumstances surrounding the injury.”

In Fall 2013, I was given the opportunity to pilot an art therapy program through a healing arts partnership established between Fort Belvoir and the National Endowment for the Arts. Although the pilot proposal was for a limited time, the patients and interdisciplinary team here quickly discovered the benefits of art therapy.

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Product Releases

Virtual Hope Box



The Virtual Hope Box mobile application (<http://t2health.dcoe.mil/apps/virtual-hope-box>), released by the Defense Department, helps service members and veterans focus on positive influences in their lives when they are upset or having a bad day. Using the app, they combine meaningful memories with relaxation coaching and distracting activities to help them cope when they are feeling down.

The free mobile app is available for Android and iOS devices at the App Store, Google Play, and Amazon for Kindle Fire.

The Virtual Hope Box puts everything in one, easily accessible place. Users create a unique and personal app by customizing the various sections of the app with particularly pertinent items from their own lives. Users add their family photos, videos and recorded messages from loved ones, inspirational quotes, favorite songs, interactive relaxation exercises, affirmations, and reminders of successes and future aspirations. Also, with this app on a smartphone, the user can immediately contact support systems by calling, texting, or sending email. Providers will find this app a useful resource to recommend to their patients who are experiencing distress. In a clinical setting, a patient might set up his or her Virtual Hope Box with guidance from the provider and use the tool between therapy sessions. *(Courtesy of DCoE Public Affairs)*

Suicide Prevention Tools



(Photo by Steven Baker)

New tools to help providers assess and treat potentially suicidal patients are now available. Based on Departments of Veterans Affairs and Defense clinical practice guidelines (<http://www.healthquality.va.gov/guidelines/MH/srb/>), the tools integrate the latest evidence-based practices into recommendations on warning signs, protective factors, safety planning and effective treatments.

The first tool, the “Suicide Risk Provider Pocket Guide,” explains guidelines and decision aids for primary and specialty care providers to help them recognize symptoms of suicidal risk, then treat and manage them. The second tool, a “Safety Plan Worksheet,” is a provider-driven tool completed with the patient. The patient can use the completed worksheet as a quick reference guide to identify stressful triggers and warning signs, who to contact for support, and where to go with questions.

The suite of tools also includes brochures, one for patients and another for family members or battle buddies. “Suicide Prevention: Overcoming Suicidal Thoughts and Feelings” educates patients on risk management, strategies to build inner sources of strength, recognizing warning signs, effective coping strategies and the importance of engaging actively in treatment. “Suicide Prevention: A Guide for Military and Veteran Families” teaches about suicide warning signs, accessing care, appropriate treatments and ways to best support a loved one who is suicidal or in crisis.

The tools are available for download at the US Army Medical Department web site (under the Health Care Team menu on the left) and the Department of Veterans Affairs website. *(Courtesy of DCoE Public Affairs)*

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A Federal Inter/Intra-Agency Case Management Model

that redundancy is avoided and ongoing needs are identified. The list is available to case managers throughout the patient's recovery through a centralized web-based computer lab. This model is being implemented in stages to assure case managers have the tools and training needed for successful deployment of the initiative and that processes for improvement are recognized and addressed as next stages are implemented.

With this case management model, the flow of communication for patients transitioning between these large agencies typically begins in DoD. Military case management partners across the country reach out to their VA counterparts to discuss potential patient transfers and to review the Lead Coordinator checklist for each patient. Once the patient is transitioned into the VA health care system, a Care Management Review Team of both clinical and non-clinical providers convene. Team members may include representatives from the Transition Care Management, mental health, primary care, and polytrauma teams and others, such as military case managers, as needed. A decision is subsequently made regarding who will be assigned as the Lead Coordinator. This decision is made based primarily on the clinical and logistical needs of the patient and their family and can be revisited in ongoing review team meetings with adjustment to the Lead Coordinator role made according to the patient's recovery trajectory.

The role of the Lead Coordinator is a unique and key component to bridging communication and impacting patient outcomes. The case manager is the central point of contact working with the patient on their identified goals for recovery and integrating these goals with the Interdisciplinary Team. An important tool in team, patient and family communication and unique to polytrauma case management is the congressionally mandated use of an Individualized Rehabilitation Community Reintegration plan of care. Components of this care plan incorporate the patient and the family's goals as well as those identified with the patient by rehabilitation team members. The Mayo Portland Adaptability Inventory (MPAI) and the Mayo Portland Participation Index (M2PI) are standardized tools used to objectively measure patient progress and recovery.

Case Study: The following is a case study of a 23-year-old Army Reservist. He served two tours of duty, one in Iraq and one in Afghanistan, and reported exposure to significant blast events and endorsed symptoms consistent with mild TBI with probable overlap of other co-morbid conditions including post-traumatic stress disorder. The patient was seen by the military TBI Clinic provider with complaints of headaches, balance issues, tinnitus, blurred vision, photophobia, anxiety, irritability, sleep disturbance, and memory and concentration problems. The patient was prescribed medication for headaches, mood and sleep. He was referred for mental health, vestibular and cognitive evaluations. His wife was supportive but reported that she felt tired and depressed. Case management involvement included a DoD TBI case manager, a military liaison, and a recovery care coordinator. The decision regarding who should serve as the Lead Coordinator was dependent on the patient's primary complaints, as well as his military assignment. His care was assigned to the DoD TBI case manager. Case management was focused on supporting the patient throughout the evaluation and early treatment phases both medically and psychosocially.

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The need for caregiver support was identified. It was recognized his recent return to the home environment from combat resulted in minimal strategies or coping skills for issues related to living at home. Four weeks later at a follow-up appointment, the patient reported a decrease in headache frequency, his mood had improved and he was sleeping better. The patient was sent home for continued recovery with plans for follow-up with the primary care physician and post-deployment team at the patient's local VA Medical Center. At this time, the DoD TBI case manager and military treatment facility VA liaison communicated with the local VA Medical Center Transition Care Management Team regarding the relocation of the patient and his family to their catchment area. A warm handoff of care was provided including the Lead Coordinator checklist.

Warm Handoff = Detailed Communication

Both verbal and written, from one Lead Coordinator (LC) to the next to ensure the receiving medical and non-medical teams have the information needed to continue with the service member's/veteran's (SM/V) comprehensive plan

Every transfer **must** include a warm handoff:

- DoD  VA, VA  DoD, VA  VA **or** DoD  DoD
- Handoffs should be timely, well organized and seamless and may include use of the following methods: face-to-face, email, teleconference, video teleconference and secure transmission of documents

A good handoff sets up a LC and Care Management Team for success by:

- Providing documented and undocumented information
- Ensuring the SM/V's trust and health care partnership
- Ensuring care is provided during a critical transition point

A Care Management Team meeting was held at the VA medical center with the polytrauma case manager assigned as the Lead Coordinator. During his first appointment at the local VA, the patient reported problems at work, increased frequency and intensity of headaches, and sleeplessness due to nightmares. He reported abruptly stopping all medications. His wife reported he was drinking heavily and staying away from her and the children for most of the day. Discussions regarding post-deployment and medical issues since returning home and presenting symptoms were prioritized and an Individualized Rehabilitation Community Reintegration care plan was initiated with the patient and family's goals as the central focus. The patient was restarted on appropriate medications and both the wife and patient were educated regarding the importance of taking all medications as prescribed.

A vocational rehabilitation specialist engaged the patient regarding work status and the patient's long-term plan for continued employment or potential return to school. The Lead Coordinator continued to coordinate medical and psychosocial care, assuring all military connections remained intact by communicating with the military liaison as necessary. The Individualized Rehabilitation Community Reintegration plan of care was tracked by the polytrauma interdisciplinary team which included input from the patient and wife and a timeline for clinic visits was developed according to their work and home schedules.

A six-week follow-up clinic visit revealed the patient was beginning supported employment strategies at a local warehouse. He reported sleeping better and his headaches were improving. His wife reported he was compliant with his medications through the use of an electronic memory reminder application on his



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smartphone. The patient and his wife were being seen by a polytrauma family counselor and reported the home environment was much improved. At a twelve week follow-up appointment, the patient was successfully working full-time at the warehouse without vocational support. A team meeting with the Transition Care Management team and the polytrauma team determined the patient should begin follow-up and maintenance care through the primary care clinic which included successful transfer of the Lead Coordinator checklist to the primary care case manager.

The DoD and VA have made tremendous strides through development of the Community of Practice and Lead Coordinator Initiative. These efforts assure service members and veterans and their families receive the coordinated services needed for patient directed healthcare recovery and successful return to a stable family and community life.

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Art Therapy and Brain Wellness



Untitled montage painting, created by a Marine as a reflection of past, present and future as they relate to his combat experience in Afghanistan. (Photo by Jackie Biggs)

The program has become a fixed offering within the clinic. The art therapy program has evolved in many ways over the past year and currently offers an array of individual and group-based opportunities. Service members initially sign up for a series of three groups which entail mask making, expressive writing, and creating montage paintings. Afterwards, patients meet individually with me to evaluate whether they would benefit from continued one-on-one art therapy sessions with the intent of externalizing and processing particular emotions, issues, or traumatic events. Open studio art therapy groups are offered to patients who engage in more independent, longer-term art works as part of their healing. Outside of the clinic, a ceramics class for wounded warriors is offered once a week at a local art school to promote community integration, emotional regulation and mastery of a new skill within an open studio environment.

Patients who have engaged in art therapy treatment here describe feeling more relaxed and less irritable. It has helped to process their feelings about trauma, grief and loss. They report improvement in memory and motor and cognitive skills.

Interdisciplinary colleagues have also observed improved outcomes for patients as result of incorporating art therapy into their overall treatment plan. Dr. Jennie Samuel, Occupational Therapist, Intrepid Spirit One, said, “Prior to art therapy, there were no good options for patients for whom talking-based therapies were ineffective or too difficult to start right in on. Art therapy bridges the gap for patients who need to begin working through their traumatic experiences and build insight into their emotional status and functioning but are either unable or unwilling to participate in talking-based therapies.”

One patient in particular was having significant difficulty communicating with providers across disciplines before he engaged in art therapy. While engaging in group and individually based art therapy, he was able to become more aware of his physiological manifestations of stress.

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This has led to improved recognition of and management of triggers and insight into which types of memory loss are more related to mTBI versus PTSD. He also expressed he developed a deeper appreciation for what he has survived and the resulting effects of his experiences. Now this patient has reengaged in cognitive therapies where treatment is more effective now that he can better communicate and understand himself.

“I never thought or would have thought I would be able to express myself,” he said. “I hold a lot [in] that brings you down and [makes you] tired. But this [art] therapy is helping me to get through that. This allows you to speak in a different way.”

Art therapy continues to provide wounded warriors with a grounded, safe and effective means for externalization, insight, processing, and a voice when words aren't enough.

To learn more, please contact the author at Jacqueline.P.Biggs.Ctr@mail.mil.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Army, Air Force, Department of Defense, or U.S. Government.

Announcements

TBI Care: Our Mission in Action

Call for TBI care narratives – What are the challenges, successes, lessons learned that you, as a provider, have experienced when serving active-duty military, National Guard and reserves, and veterans with TBI, their family members and caregivers? How do case managers, care coordinators, OTs, PTs, social workers, nurses and intervene? What is the impact of collaborating with other care providers? Where is improvement in care needed? Share your experiences and resources here with your colleagues. For further information or to submit a care narrative, contact Mary Ellen Knuti, editor, MaryEllen.Knuti.ctr@mail.mil or 301.628.2932.

Recognizing Outstanding Military Health System and Dept. of Veterans Affairs Case Managers and Care Coordinators – Special edition due out in January 2015 will celebrate 20+ individuals for their support and services to wounded warriors with traumatic brain injury and their families.

DCoE/DVBIC 2015 Webinar Series

Jan. 8 – Performance Triad: Sleep, Nutrition, Exercise

Jan. 15 – Application of Behavioral Health Technology Tools in the Clinical Care of Mild TBI

Feb. 12 – Progressive Return to Activity Following Mild TBI: A Refresh

Feb. 19 – Clinical Benefits of Technology in Behavioral Health Care

Feb. 26 – Physical Symptoms and Mental Health

Continuing education credit is available from Duke Medicine. For more information about webinars and creating an account, go to <http://dcoe.mil/Webinars>.



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Dept. of Veterans Affairs Webinar

Jan. 14 – Service Utilization among Iraq and Afghanistan Veterans Screening Positive for Traumatic Brain Injury; for more information, go to <http://www.hsrd.research.va.gov/cyberseminars/catalog-upcoming.cfm>

Latest TBI Numbers

Prepared by DVBIC (<http://dvbic.dcoe.mil/dod-worldwide-numbers-tbi>)



DoD Numbers for Traumatic Brain Injury Worldwide – Totals

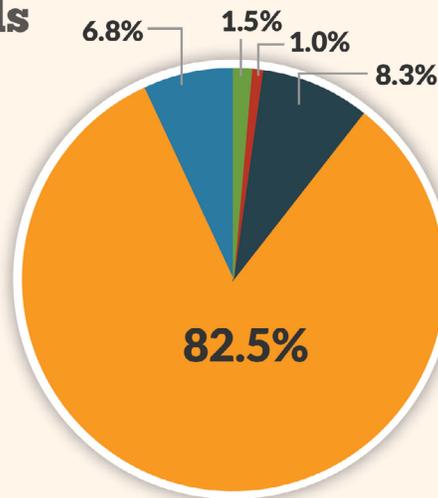
2000-2014 (Q1 - Q3)

■ Penetrating	4,577
■ Severe	3,126
■ Moderate	25,953
■ Mild	258,816
■ Not Classifiable	21,344

Total - All Severities 313,816

Source: Defense Medical Surveillance System (DMSS), Theater Medical Data Store (TMDS) provided by the Armed Forces Health Surveillance Center (AFHSC)

Prepared by the Defense and Veterans Brain Injury Center (DVBIC)
Percentages do not add up to 100% due to rounding



2000-2014 (Q1 - Q3), as of Dec 1, 2014