



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.

Quarterly Highlight

Intrepid Spirits Summit

By Dr. Katharine Stout, DVBIC Clinical Affairs

TBI experts and leaders from across the Military Health System (MHS) convened in August for a four-day leadership summit, “Developing Consensus across the NICoE/Intrepid Spirit Centers Network.” They discussed the operations and functions of the National Intrepid Center of Excellence (NICoE) at Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Maryland, and the Intrepid Spirit Centers located at military treatment facilities throughout the country. For the first time, this meeting brought together leaders from the network sites, as well as DVBIC and TBI service leads from the Army, Navy, Marine Corps and Air Force to continue to move the field of TBI forward.



DVBIC was founded in 1992, largely in response to the first Persian Gulf War. Its goal was to integrate specialized TBI care, research and education across military treatment facilities and veterans medical centers. Since that time, the Department of Veterans Affairs (VA) and Defense Department have been on the forefront of developing an interdisciplinary approach to the rehabilitation of service members with TBI, particularly those injured from the recent conflicts in Afghanistan and Iraq.¹

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About the Newsletter

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

If you need TBI resource assistance or transition support for your patients, contact the DVBIC [TBI Recovery Support Program](#). You can also request an onsite or video teleconferencing presentation about the program.



DCoE



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DVBIC



DVBIC

Operation Family Caregiver

By Dr. Leisa Easom, Executive Director,
Rosalynn Carter Institute for Caregiving

Operation Family Caregiver (OFC) meets a need that for too long has simply gone unmet: providing support to the heroes behind our heroes. With nearly 2.6 million men and women serving in the military since 9/11, and millions more having served in previous wars, hundreds of thousands have returned with injuries—both visible and invisible—that leave them needing assistance from a family member or battle buddy. These circumstances have resulted in countless spouses, parents, children, or friends acting as caregivers, a role most of them never imagined. This “new normal” stretches families to their capacity, adding physical and emotional stress and strain.



Photo courtesy of Operation Family Caregiver

OFC, which launched in 2012, is the signature military caregiving program of the [Rosalynn Carter Institute for Caregiving](#) (RCI). RCI has offered support to caregivers of all stripes for 30 years. It was founded by former First Lady Rosalynn Carter, who saw that many of the challenges facing older people, the chronically ill, and those with dementia were being met by their loved ones, but that those loved ones—their caregivers—had been neglecting themselves. The Institute offers a number of programs that help caregivers find ways to take care of themselves.

OFC provides free and confidential support to the families of injured service members. Specially trained “coaches” help caregivers learn how to overcome the obstacles they face today and to manage any new challenges that might come along. These coaches work for or volunteer with local, community-based organizations, not the military, so requirements are minimal. To be eligible for OFC, a caregiver simply needs to be caring for a service member or veteran who suffers from posttraumatic stress, TBI, or a physical disability.

By early 2017, OFC will be [active in 14 locations in 10 states and the District of Columbia](#), and it can also deliver support nationwide via phone or Skype. A coach may visit the caregiver’s home or meet virtually, and together they customize a program tailored specifically to that family. As OFC has grown and expanded to new states, reaching many more caregivers, staff have seen firsthand the lasting impact the program is having on military families. Outcomes to date show that OFC has helped caregivers become more satisfied with their lives, have fewer health issues, and generally become more prepared to take care of their families. Caregivers who have completed the program report improved confidence in their ability to manage the day-to-day challenges of caregiving.

“Just having that cheering squad behind me saying, ‘You go girl, you got this – let’s strategize and problem solve – really made me feel like I was on the right track and I wasn’t alone,” said Gina Canaday, whose husband Jack was diagnosed with post-traumatic stress disorder and medically retired from the Army in 2015 after five deployments.

Reaching out is a sign of strength. To refer to the program, visit OFC Caregiver Support [page](#). Learn more about the program [here](#).



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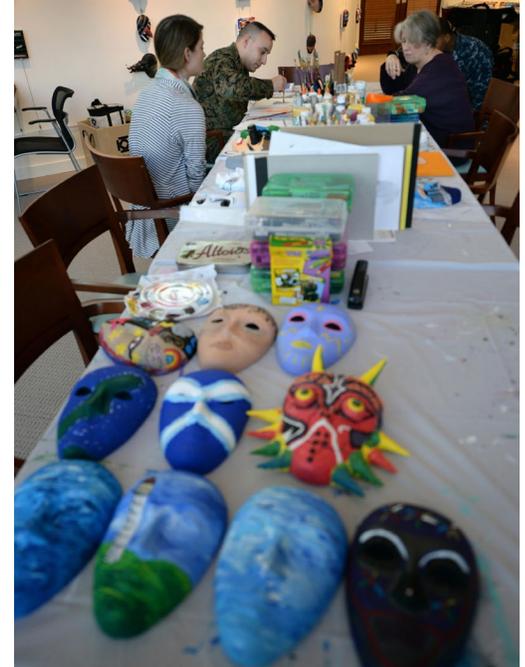
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In addition to the support from DVBIC for the treatment of TBI in the MHS, NICoE opened in 2010 to support the further assessment, treatment and research of TBI in service members and veterans. Since 2010, five TBI Intrepid Spirit Centers have opened across the MHS, including Fort Belvoir, Virginia, and Camp Lejeune, North Carolina, in 2013; Fort Campbell, Kentucky, in 2014; and Fort Hood, Texas, and Fort Bragg, North Carolina, in 2016. In addition, four centers are in various stages of planning and construction: Fort Bliss, Texas; Fort Carson, Colorado; Camp Pendleton, California; and Joint Base Lewis-McChord, Washington.²

NICoE and the Intrepid Spirit Centers focus on assessment, treatment and research for TBI in service members and veterans. The summit's purpose was to discuss and initiate consensus about the centers' clinical, research, and administrative approaches, as well as about how the network of Intrepid Spirit sites will work within the TBI Pathway of Care. The pathway is a data-driven system to provide an enterprise approach for coordinating clinical, research, education and training activities related to TBI care. This system integrates evidence-based clinical practices with consistent monitoring of patient outcomes to help the military services deliver quality TBI care.

The summit opened with remarks from Mr. Arnold Fisher and retired Army Gen. Richard Cody, representing Intrepid Fallen Heroes Fund (IFHF), which has provided funding for NICoE and the Intrepid Spirit Centers. During the first two days of the summit, leadership from the sites presented their program models. Discussion focused on standardization of measures and treatments and covered all aspects of the Intrepid Spirit assessments for both intensive outpatient programs and routine outpatient care. Administrative and management leaders also met to discuss staffing, budgets and coding related to the sites.

On the third day, the focus switched to TBI research, the Department of Defense TBI portfolio and the way ahead for the sites, including discussions on health outcomes and the data currently captured across the sites, to find points of commonality. On the final day, participants established work groups to continue the progress made in developing consensus across Intrepid Spirit Centers. These included groups on information technology data platforms, neuropsychology and clinical outcomes, as well as several administrative groups looking at staffing and coding. The summit marked the beginning of future collaboration between DVBIC, NICoE and the Intrepid Spirit sites to continue to refine the TBI care and research conducted in the DoD and with our VA partners.



Art therapy session at NICoE

(DoD photo by Marvin Lynchard)

References

1. <http://dvbic.dcoe.mil/history>
2. <https://www.fallenheroesfund.org/Intrepid-Spirit-Centers.aspx>



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Family Caregivers Sought for Study

DVBIC's 15-Year, Congressionally mandated, Longitudinal Family Caregiver Study, IRB Protocol Number 367721, will again be recruiting military caregivers in the next few months. Since 2012, DVBIC has been conducting this study that examines the effect of traumatic brain injury on post-9/11 family caregivers over a period of 15 years.

If you know of family members who would be interested in participating in the study, please contact Charline Simon, Research Coordinator, charline.e.simon.ctr@mail.mil for more detail and approved flyers and business cards.

The study is recruiting any family member, friend, or significant other who helps a service member or veteran who had a traumatic brain injury after October 2001 while serving in the military. Help can include assistance with any day-to-day activity such as dressing, managing emotions, personality changes, anger/irritability, housework, remembering things, taking medications, managing money, providing financial assistance, running errands, shopping, transportation, or preparing meals. The TBI can be combat or non-combat related, deployment or non-deployment related.

The scientific directors of the Family Caregiver Study are actively analyzing the longitudinal data they have collected over the past four years and are starting to disseminate the findings at meetings and in journals, and will be incorporating the findings into the Year 7 Report to Congress due in 2017.

2016 DCoE Summit Wrap-up

By Myron J. Goodman, DCoE Public Affairs

The 2016 DCoE Summit concluded Sept. 15 after an intense three days that featured dozens of sessions on the latest developments in health care diagnostics and treatment of psychological health issues and TBI. At the summit, the clear message from defense leaders was the value clinicians provide service members.

Navy Vice Adm. Raquel Bono, a surgeon and director of the Defense Health Agency (DHA), drove home the message that the most important thing providers can do is maintain course by continuing to provide the level of care they already offer.

Bono highlighted three psychological health priorities for DHA: fortifying its relationship with the services, strengthening its role as a combat support agency and optimizing its operations. She also discussed a new TRICARE rule that decreases barriers to receiving mental health care in the MHS and took questions from the audience.

"We want to be more streamlined so we're serving the entire enterprise," Bono said to the 1,770 registered summit attendees. By doing so, DHA can help providers ensure care is even more accessible to patients, Bono said.



Defense Health Agency Director
Vice Adm. Raquel Bono
(DCoE photo by Terry Welch)



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Dr. Karen S. Guice, acting assistant secretary of defense for health affairs, offered high praise for all involved in treating patients coping with psychological health or TBI challenges. “Everything you do has meaning,” Guice said. “Everything you do has value.”

“For summit participants and providers in the MHS, the conference enabled the sharing of knowledge about the latest developments in psychological health and TBI”, said DCoE Director Navy Capt. Mike Colston. Colston made clear the importance of recognizing the number of advancements in psychological health and TBI care. These successes will continue to shape future progress.

“It’s an honor to host this year’s summit. The sessions and conversations highlighted so many areas of collaboration between health care professionals and academics, addressing all aspects of psychological health and TBI care, education and research,” said Colston. “Thank you to all the attendees and presenters who worked so diligently to share their knowledge and lessons learned as they translate research into better care for our military population.”

Army Col. Geoffrey G. Grammer, a psychiatrist and DVBIC national director, saluted the presenters as well as the clinicians who attended the summit, live and online, for their engagement with the presentations. “I was very impressed by the questions that were proposed by the online audience,” Grammer said. “It showed a level of attention to these presentations that was most welcome.”

Below are a few highlights from the final two days of the summit:

- Dr. Diane Castillo, a psychologist and treatment core chief for the VA Center of Excellence for Research on Returning War Veterans in Waco, Texas, discussed the effectiveness of cognitive and exposure-based therapies for female veterans with posttraumatic stress disorder (PTSD) who deployed in recent conflicts. Small-group prolonged-exposure therapy reduced the feelings of isolation for some veterans.
- Presenters from Landstuhl Regional Medical Center in Germany described a multidisciplinary six-week program for members of special operations forces that helped mid-career service members recover from injuries that included TBI, PTSD and back pain, even years after the injuries were sustained.
- Dr. Kate McGraw, a clinical psychologist and Deployment Health Clinical Center interim director, outlined some of the factors that affect female service members’ psychological health, including deployment and combat health issues, reproductive issues, musculoskeletal issues, suicide, sexual assault and harassment, as well as guidance to help them perform alongside male counterparts.
- Dr. Karen Besterman-Dahan, a research science specialist at the Center of Innovation in Disabilities and Rehabilitation Research, James A. Haley Veterans’ Hospital, reviewed a study on community reintegration in veterans with TBI. From the study, three things that benefited veterans were storytelling, increased communication and one-on-one social support.
- Adler University Professor Barton Buechner and Air Force Health Professions scholar Jeremy Jinkerson stressed that education is key to helping service members recover from moral injury.

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury 2016 SUMMIT Enroll today at dcoe.cds.pesgce.com	<p style="color: #c00000; font-weight: bold; font-size: 1.2em;">Did you miss it?</p> <p>It’s OK. You can register for on-demand sessions and apply for continuing education credits now through April 2017.</p> <p>That’s right, you can access summit courses when and where you want.</p> <p style="color: #c00000; font-weight: bold;">Up to 28 hours of credits are available for health care professionals; credits vary by course.</p>
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Performance Triad

By Myron J. Goodman, DCoE Public Affairs

Most clinicians know that patients achieve optimum physical health by eating healthy, nutrient-based foods, staying active and consistently getting at least eight hours of quality sleep every night. But for patients with a TBI, these tasks may pose challenges.

“Regardless of the mechanism of injury, TBI can result in significant neurological impairment, acute clinical symptoms and functional disturbances,” said Gary McKinney, DVBIC clinical practice and clinical recommendations chief.

McKinney and experts from WRNMMC spoke about how primary care providers can apply the key focus areas of the [Army Performance Triad](#) (sleep, activity and nutrition) to boost patient recovery from TBI during a DCoE webinar July 14.

Army Medicine launched the Performance Triad plan in 2013 to help soldiers use educated lifestyle choices to maintain, restore and increase health. Patients with TBIs can follow the plan, which includes well-vetted clinical advice, to improve levels of [activity](#), [nutrition](#) and [sleep](#), and to take an active role in recovery.

Activity – “In the Performance Triad, physical activity is more than exercise: it is an active lifestyle. The Performance Triad breaks activity down by the level of active and sedentary exercise,” McKinney said. Physical activity does not solely mean going to the gym; it can be taking long walks, doing yard work or playing with children. The plan supports using a variety of activities, including anaerobic, aerobic and relaxation exercises to motivate patients to rebuild their physical health.

However, clinicians should alert TBI patients with certain limitations that they may need to modify some recommendations in the plan, McKinney said.

“If patients have recurring TBI symptoms, they should return to the previous stage of activity instead of continuing or moving to the next, as measured by physical exams, the NSI (Neurobehavioral Symptom Inventory), resting heart rate and blood pressure,” McKinney said.

To help providers as they modify activity levels, DVBIC offers a clinical suite of tools to guide patients in their return to activity following concussions: [Progressive Return to Activity \(PRA\) Following Acute Concussion/Mild TBI: Guidance](#)

[for the Primary Care Manager in Deployed and Non-Deployed Settings](#). The guidance outlines six stages of progression for a patient returning to activity.



Soldiers with 2nd Infantry Brigade Combat Team, 3rd Infantry Division, conduct physical readiness training at Camp Oliver, Fort Stewart, Georgia.

(U.S. Army Photo by Sgt. Robert Parrish)

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Nutrition – Patients with a TBI may initially have different nutritional needs from those highlighted in the Performance Triad, including the need for more calories and protein, said Army 1st Lt. Paul Rosbrook, assistant research director of the nutrition service department at WRNMMC.

“In the acute phase, calorie needs are increased by roughly 50 percent depending on the physiology of the wound, whether it was blunt trauma or penetrating,” Rosbrook said. The precise number of calories and protein recommended varies with each case.

Once TBI patients are in recovery, nutrition needs usually go back to their baseline requirement. At any stage, however, patients in recovery can follow the nutrition pillars of the Performance Triad. These pillars include:

- Remember proper fueling for performance and recovery.
- Consume eight daily servings of fruit and vegetables.
- Limit caffeine within six hours of sleep.
- Maintain proper body weight to reduce risk of injury.
- Be smart with supplementation.

Rosbrook recommended two to three servings of fruit, four to five servings of vegetables per day, and three servings of dairy or dairy alternates. Dairy contains calcium and vitamin D, which will help reduce the incidence of fractures and other stress-related bone injuries.

Rosbrook also detailed how poor sleep can affect nutritional outcomes. “Acute and chronic sleep deprivation, less than four to five hours, correlates with an increased hunger hormone called ghrelin, a reduced satiety hormone called Leptin, impaired glucose utilization, and reduced fruit and vegetable consumption,” he said.

Sleep – Four sleep disorders are common following concussion, according to Dr. David Panakkal, a TBI subject matter expert, formerly with DVBC: short-term insomnia, chronic insomnia, circadian rhythm sleep-wake disorder and obstructive sleep apnea syndrome. All four disorders can improve when patients follow the sleep recommendations of the Performance Triad:

- Keep a regular schedule.
- When possible, schedule seven to eight hours for sleep.
- Avoid LED screens two hours before bedtime.
- Stop caffeine at least six hours before bedtime.
- Do not drink alcohol before bed.
- Get your exercise in by early evening.
- Do not use over-the-counter medications without consulting a provider.
- Go to bed only when you are sleepy. Get out of bed if you can't sleep within 30 minutes.
- Nap wisely (preferably in the late morning or early afternoon for 30 - 60 minutes).
- Move the bedroom clock somewhere you cannot see it.



Visit the [DCoE webinar archive](#) to hear an audio recording of the webinar, get a webinar PDF transcript and download a copy of the PDF presentation and PDF resources.



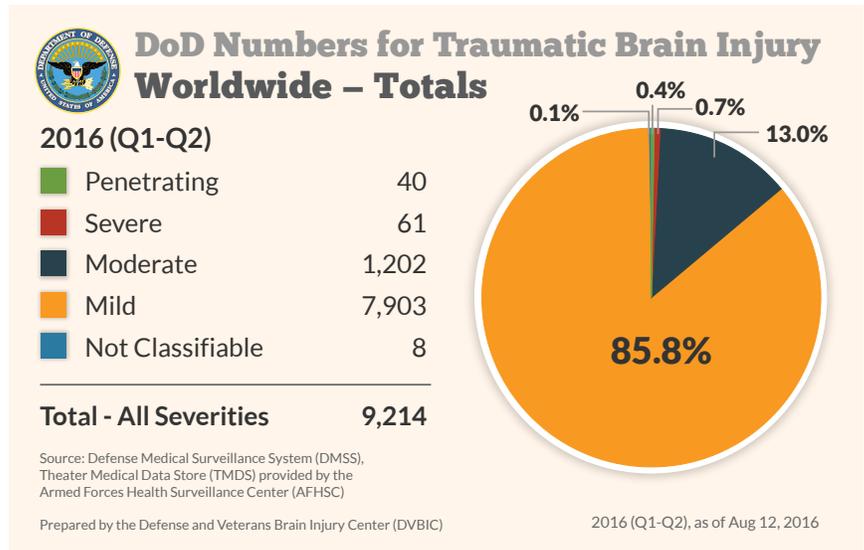
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Upcoming DCoE/DVBIC Webinars

- Dec 8 – Review of Advances in TBI Research
 - Dec 15 – Evidence-based Management of Suicide Risk Behavior: A Guideline Perspective
 - Dec 22 – Research Driving Development of the VA/DoD Clinical Practice Guidelines
 - Jan 12 – Substance Abuse and TBI
- Continuing education credit is available. For more information about webinars and creating an account, go to http://dcoe.mil/Training/Monthly_Webinars.aspx.

Latest TBI Numbers



In April 2015, the assistant secretary of defense clarified the TBI case definition. Effective October 2015, the International Classification of Diseases was updated. With the improved information, more moderate TBIs can be counted. Previously, some cases were categorized as “unclassifiable” severity due to more limited surveillance information. Worldwide numbers represent medical diagnoses of TBI that occurred anywhere U.S. forces are located, since 2000.