



DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Update

Recovering Warrior Task Force (RWTF)

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Director

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Agenda

- DCoE Update
 - Background
 - 2012 Accomplishments
 - 2013 Way Ahead
- Responses to RWTF Questions
- Questions

Background

Mission, Vision, & Values

Mission

To improve the lives of our nation's Service members, families, and veterans by advancing excellence in psychological health and traumatic brain injury prevention and care

Vision

To be the Defense Department's trusted source and advocate for psychological health and traumatic brain injury knowledge and standards, and profoundly improve the system of care

Values

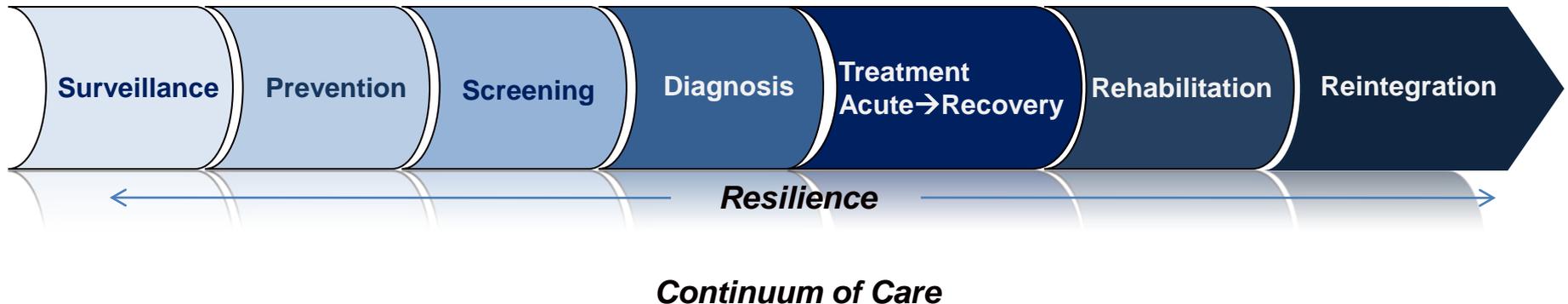
Excellence

Integrity

Teamwork

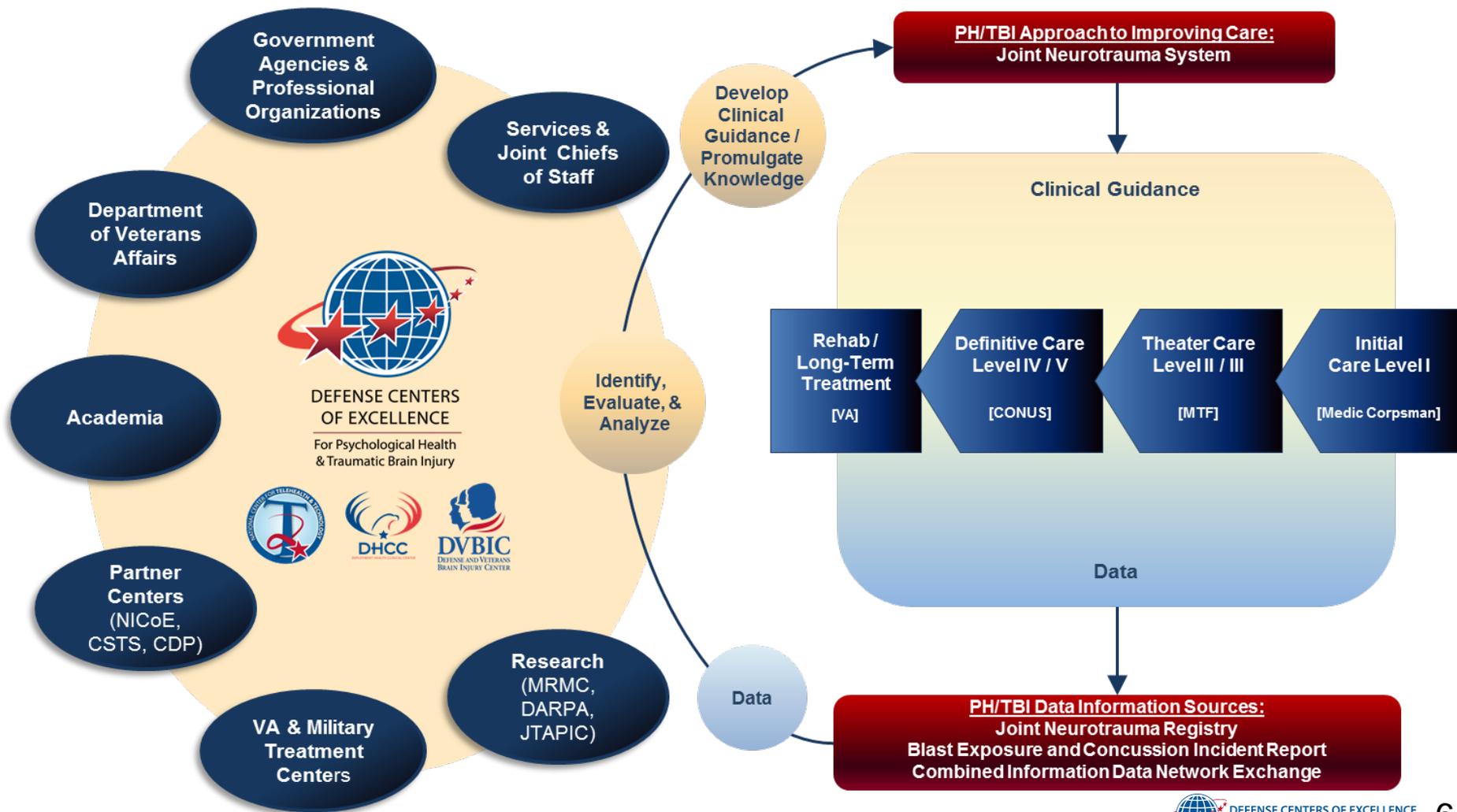
Value Proposition

The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) serves as the principal integrator and authority on psychological health (PH) / traumatic brain injury (TBI) knowledge and standards for the Department of Defense (DoD). We are uniquely positioned to accelerate improvements in PH/TBI outcomes and policy impacting the continuum of care and further reducing variability across the Services.



DCE: PH/TBI Integrator in the System of Care

“Effectively leveraging our knowledge and clinical expertise to improve the system of care”



2012: Year in Review

- Key Accomplishments
- Stakeholder Survey

2012 Key Accomplishments

- Revised Military Acute Concussion Evaluation (**MACE**) and **deployed guidelines**
- New **clinical recommendations**
 - *Indications and Conditions for Neuroendocrine Dysfunction Screening Post Mild TBI*
 - *Assessment and Management of Dizziness Associated with Mild TBI*
- New **toolkits**
 - *Substance Use Disorder*
 - *Training presentations to support the Major Depressive Disorders, Substance Use Disorder, Co-Occurring Conditions toolkits*
- DoD lead for 18 VA/DoD **Integrated Mental Health Strategy (IMHS)** strategic actions
- **Military Medicine** PH/TBI supplemental issue
- Key **conferences** and monthly **webinars**
- **IOM Phase I study on PTSD treatment**
- New **RAND studies**
- Directive Type Memorandum 09-033, “*Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting*” converted to **DoD Instruction**
- **BECIR Service-specific reports**
- **METC** curriculum collaboration/review
- **Evaluation of National Guard PH programs**
- **RESPECT-Mil** Program screened 2.5M+ Soldiers
- New **mobile apps**
 - *PE Coach*
 - *Breathe2Relax*

Surveillance

Prevention

Screening &
Assessment

Diagnosis

Treatment
Acute → Recovery

Rehabilitation

Reintegration

Resilience

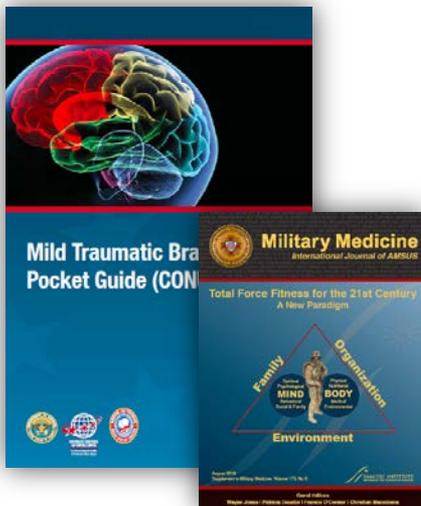
Stakeholder Survey Overview

- Survey administered to key senior stakeholders from JUL – AUG 2012 to:
 - Senior Military Medical Advisory Council (11 total); 36% response rate
 - Other key stakeholders in Office of the Assistant Secretary of Defense for Health Affairs, the Services, and VA (81 total); 46% response rate
- Survey developed to obtain key stakeholder feedback on DCoE's performance, and to better understand key stakeholder needs
- Survey consisted of 10 questions garnering feedback on:
 - Value of DCoE's PH/TBI clinical recommendations, tools, resources, and training products in improving PH/TBI care for stakeholder's organization
 - DCoE's effectiveness in communicating availability of products and promoting PH/TBI awareness
 - Emerging needs of stakeholder's organization

Key Survey Findings

Respondents indicated the following as the **most valuable** DCoE PH/TBI clinical recommendations, tools, resources, and training products¹:

Clinical Guidance & Tools	Resources & Training
Development of Clinical Toolkits	DCoE Website
mTBI Pocket Guide	Leadership/IMHS Strategic Initiatives
Resilience Strategy Implementation	DCoE Education/Training Events
Co-Occurring Conditions Toolkit	DoD Suicide Event Report
Joint Publication on Total Force Fitness	PH/TBI Mobile Applications



¹From list of selected DCoE products as of NOV 2011

Key Survey Findings (continued)

Areas for Improvement

- More prominent integrator role
- Communication to key stakeholders of product availability
- Stakeholder awareness of DCoE plans to disseminate products to customers/organizations

Sample Positive Comments

"DCoE and DVBIC's educational assets have contributed to the development of toolkits and fact sheets and has enabled clinicians and providers a format to reference such in easy, transferrable, mobile applications."

"DCoE's role in the TBI Common Data Elements Project in 2008-2010 was enormously helpful. Without DCoE this project would not have been nearly as successful as it has turned out to be."

"I have worked with DCoE since March 2008. I consider them to be a valuable resource and partner."

"I think the tools are great and appreciate current information on training and research."

"TBI quad service has been highly effective."

2013 Way Ahead

- DCoE Governance / MRMC Alignment
- Internal Reorganization
- Key Emerging Projects

Re-alignment Background

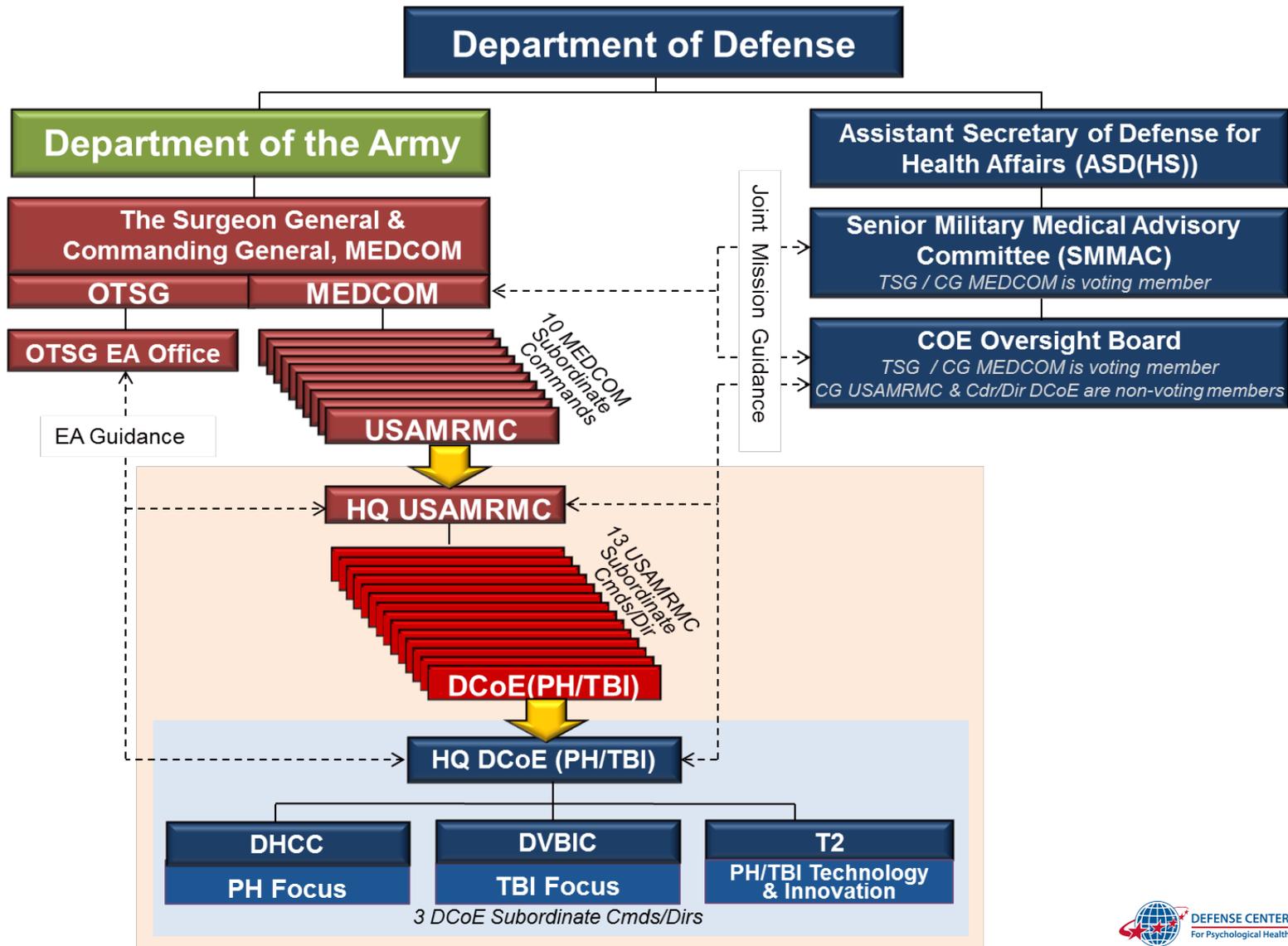
- Under Secretary of Defense for Personnel and Readiness directed¹:
 - The establishment of a Military Health System (MHS) Centers of Excellence (CoEs) Advisory Board that is responsible for providing policy guidance and oversight of all MHS CoEs, including DCoE
 - The transfer of support responsibility for DCoE from TRICARE Management Activity to the U.S. Army Medical Research and Materiel Command (MRMC)
- DCoE has aligned as an Executive Agent (EA) to Army with further alignment to MRMC, per DoD Directive (DoDD) 6000.17E
- DCoE will continue to carry out its mission defined by the Assistant Secretary of Defense for Health Affairs and approved by Congress
- Both DCoE and MRMC are currently meeting to ensure a timely transition, identifying and addressing potential barriers as they arise

¹As documented in the APR 2011 Report to Congress on the Department of Defense Medical Centers of Excellence

Summary of Alignment Activities

- ✓ Established DCoE Transition Team (JUL 2011)
- ✓ MRMC-DCoE Offsite (OCT 2011)
- ✓ Quarterly IPRs with MRMC
- ✓ Weekly Internal & MRMC Transition Meetings
- ✓ EA DoD Directive Approval (JAN 2013)
- ❑ Funds/Personnel Transfers to Army (JAN 2013)
- ❑ Full Operating Capability (OCT 2013)

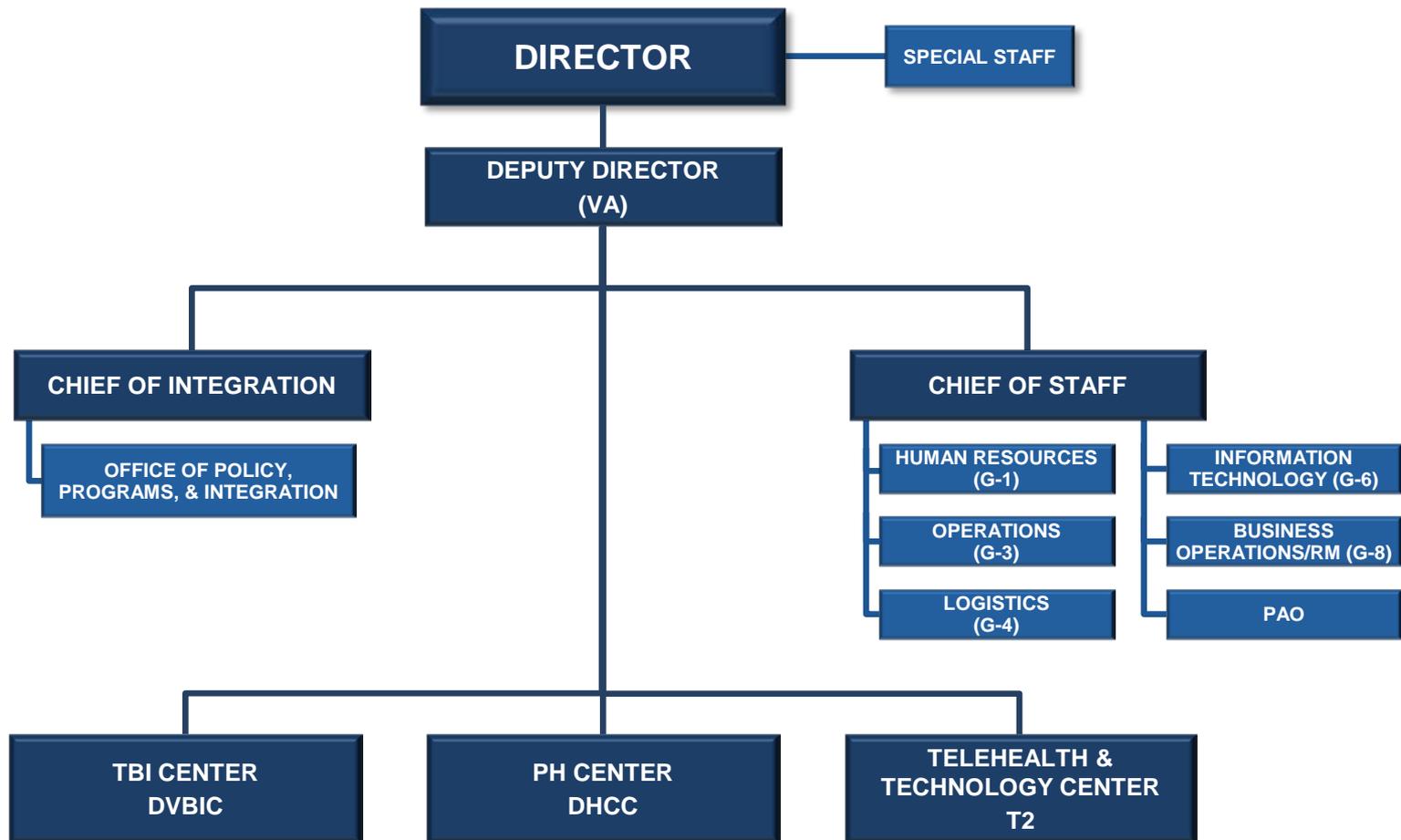
Proposed Governance Structure



Internal DCoE Reorganization

- ✓ Defined Purpose:
 - A unified DCoE, with effective, efficient, and streamlined functions
 - One integrated and collaborative CoE
 - An organization that effectively accomplishes the stated DCoE mission and vision
- ✓ DCoE Org & Structure Tiger Team (DEC 2011 – JUN 2012)
- ✓ DCoE Restructuring ‘Deep Dives’ (JUN – AUG 2012)
- ✓ CoA IPRs & Structure Decisions (SEP – OCT 2012)
- ✓ Transition Plan Development (OCT – NOV 2012)
- ❑ Transition Plan Implementation (Begin NOV 2012)

New DCoE Organizational Structure



Key Emerging Projects

- PH Program Evaluation
 - Enterprise-wide initiative to determine the impact of clinical and non-clinical PH programs across the DoD over a five-year period
- PH Metrics/Pathways
 - Enterprise-level dashboard of PH measures to align (and evaluate the efficacy of) system of PH programs
 - Clinical pathways and patient level outcomes for PTSD based on Cleveland Clinic/Porter model
- Joint Neurotrauma Registry
 - Mechanism to promote real-time, data-driven clinical process improvements in concussion care via in-theater Concussion Care Centers based on Joint Theater Trauma Registry

Responses to RWTF Questions

RWTF Question #1a

You briefed the status of the customized evaluations of 20 PH & TBI programs being conducted as part of the 2011 RAND Study. What is the current status of these 20 program evaluations?

DCoE Response to Question #1a

What is the current status of these RAND program evaluations?

- DCoE/RAND originally determined that up to 20 programs would be evaluated for this project
 - DCoE/RAND determined that the project budget could support rigorous evaluations for 13 programs
 - A smaller number of larger-size, scientifically rigorous evaluations was preferred
- RAND initiated 13 program evaluations
 - Eleven of these program evaluations are ongoing and/or have been completed
 - Two program evaluations were initiated and terminated before completion
- Current Status:
 - Catalog of programs and database completed
 - Three program evaluations completed; one under security review
 - Eight remaining program evaluations are currently being conducted

RWTF Question #1b

You indicated that you were working to standardize TBI outcome measures in order to better analyze effectiveness of care. What is the status of DCoE's efforts to develop standardized outcome measures for TBI treatment?

DCoE Response to Question #1b

What is the status of DCoE's efforts to develop standardized outcome measures for TBI treatment?

- Outcome: Development of a dashboard of standardized outcome measures for TBI care that are reliable, ecologically valid, clinically useful and feasible to obtain
- Effort consists of three phases: development, design, and implementation
 - Phase I: Concept development and initial planning activities (JUL 2012 – MAY 2013)
 - RAND Study: Establish framework for quality assessment of DoD TBI care
 - Review of Measures: NINDS/NIDR Common Data Elements, HBO2 concussion clinical trial measures, Rehabilitation Measures Database, PH/TBI Registry, TBI Model Systems, NIH Toolbox for the Assessment of Neurological and Behavioral Function

DCoE Response to Question #1b (continued)

What is the status of DCoE's efforts to develop standardized outcome measures for TBI treatment?

- Phase II: Dashboard design (JUN – SEP 2013)
 - Select web-based platform
 - Customize data elements
 - Beta test
- Phase III: Outcomes dashboard implementation (OCT 2013)
 - Rollout to selected sites
 - Initial data collection

RWTF Question #1c

Regarding RWTF's Year 1 recommendation that DoD and VA ensure timely access to routine PTSD care across the continuum of Service to avoid exacerbation and crisis, you noted that DoD is "partnering with VA to ensure all deployed service members, veterans, and families can receive VA readjustment counseling/mental health services for three years from date of return." Please elaborate on this partnership, including which part of VA is providing these services and how these services relate to the five years of VA health care to which all combat veterans are entitled.

DCoE Response to Question #1c

Please elaborate on this partnership, including which part of VA is providing these services and how these services relate to the five years of VA health care to which all combat veterans are entitled.

- DoD and VA collaborate to shape policies and programs with a long term impact on RWs, during military service and after transition to civilian life
- Implementation of the DoD/VA Integrated Mental Health Strategy (IMHS) is underway. Comprising 28 strategic initiatives, this collaboration focuses on access to quality health care for Service members, veterans, and family members and will insure consistency of care across departments
 - IMHS #13: Enhance continuity of care for Service members who are relocating and receiving mental health care through *inTransition* program
 - IMHS #23: Include input, expertise from DoD Chaplains in defining role of VA Chaplain services and community clergy in mental health care at VA

DCoE Response to Question #1c (continued)

Please elaborate on this partnership, including which part of VA is providing these services and how these services relate to the five years of VA health care to which all combat veterans are entitled.

- All deployed Service members, veterans, and families can receive cost free VA readjustment counseling/mental health services for five years from date of return
 - Information regarding VA benefits is included in DoD events, briefings, and process (e.g., Transition Assistance Program (TAP), Yellow Ribbon, integration of Vocational Rehabilitation and Employment into IDES, etc.) to increase combat veteran awareness
 - Vet Centers provide (under Readjustment Counseling Services) social and psychological services including professional readjustment counseling to veterans and families and assistance in navigating community services

RWTF Question #1d

In FEB 11 you identified the challenge of lacking authority over how clinical services are delivered. As a strategy for mitigating this challenge, you described engaging with the SMMAC and its Integrated Councils and leveraging their influence. How effective has this strategy been?

DCoE Response to Question #1d

How effective has this strategy [engaging with SMMAC and integrating councils] been?

- Engaging the SMMAC and integrating councils has improved DCoE's ability to obtain clarity of stakeholder requirements/expectations and approved scope of efforts
- Recent examples of DCoE engagement with SMMAC/Integrating Councils:
 - Defining requirements and authorities for system level:
 - PH Measures/Dashboard
 - PTSD Clinical Pathways of Care
 - Program Evaluation
 - Telehealth Strategy
 - Obtaining guidance for supporting Services' program evaluation capability
 - Defining requirements and authorities for PH/TBI Registry as part of the MHS Federated Registry
 - Developing best solutions for DoD regarding PH/TBI centralized Institutional Review Board

RWTF Question #2

What changes are needed outside DCoE (e.g., legislation, policy) to enable DCoE to better fulfill its mission?

DCoE Response to Question #2

What changes are needed outside DCoE (e.g., legislation, policy) to enable DCoE to better fulfill its mission?

- DoDD 6000.17E was issued 2 JAN 2013 establishing the U.S. Army, with further alignment to MRMC, as the EA for DCoE; the follow on DOD Instruction to specify roles and responsibilities is in draft and will require DepSecDef signature when complete
- DoD leadership must clarify expectations, roles, and functions to allow MHS Centers of Excellence to be coordinating entities for their respective subject areas
- Mandate, through National Defense Authorization Act language, the formation of interagency DoD/VA PH and TBI registries (similar to vision registry language for the Vision Center of Excellence)

RWTF Question #3

What can DoD and the Services do to better meet the needs of:

- Recovering Warriors (RWs) with PTSD?
- Reserve Component (RC) RWs with PTSD?

DCoE Response to Question #3

What can DoD and the Services do to better meet the needs of RWs and RC RWs with PTSD?

- Increase direct clinical outreach — through screening, early identification and early referral — to Service members experiencing PTSD symptoms but who are not currently receiving treatment or care
 - Implement strategies to improve recognition of PTSD, overcome stigma regarding PH issues, facilitate health seeking behaviors in RWs, and increase efforts to ensure treatment continuity and completion
 - Leverage collaborative models of care in primary care settings and engage in health care system redesign efforts that support providers in addressing PTSD-related needs of RWs at the most common point of clinical care delivery
 - Ensure that case management systems are in place and clearly codify case management responsibilities and clinical expectations in order to monitor treatment adherence and outcomes and to alert providers of necessary treatment plan changes

DCoE Response to Question #3 (continued)

What can DoD and the Services do to better meet the needs of RWs and RC RWs with PTSD?

- Improve access to and quality of care for those Service members already engaged in treatment for PTSD
 - Employ implementation science and health services research strategies to develop, test, monitor, and improve reliable military health services systems that focus on PTSD care
 - Implement, monitor, and sustain provider adherence to the DoD/VA CPGs for PTSD
 - Deploy measurement-based care strategies for the treatment of PTSD throughout DoD and VA health systems to ensure appropriate and responsive treatment planning in all clinical settings
 - Monitor and benchmark clinical performance within and between care-delivery platforms and provide feedback so that system improvements may be implemented whenever appropriate

RWTF Question #4

How will the anticipated changes in the DSM-V, including the expansion to four PTSD symptom clusters and the addition of the new diagnosis, trauma- and stressor-related disorder, impact the availability of PTSD services?

DCoE Response to Question #4

How will the anticipated changes in the DSM-V, including the expansion to four PTSD symptom clusters and the addition of the new diagnosis, trauma- and stressor-related disorder, impact the availability of PTSD services?

- Concerns:
 - Majority of PTSD care is delivered in primary care settings
 - New criteria may add complexity without evidence of improved diagnostic accuracy or efficiency
 - Added complexity may be confusing to primary care providers and foster greater reliance on specialty care treatment with reduced primary care-based PTSD recognition
 - May experience increased demand in behavioral health specialty care resulting in increased referrals and delays in access to care
 - Anticipate need for widespread provider education and training regarding modified diagnostic criteria
- Ongoing monitoring of service utilization and diagnostic rates will be critical in determining scope of change and will inform appropriate and timely system-level changes to accommodate

RWTF Question #5

What are the new PTSD best practices in training providers, assessing the treatment provided, using clinical records to assess treatment provided, and addressing non-completion?

DCoE Response to Question #5

What are new PTSD best practices in training providers, assessing the treatment provided, using clinical records to assess treatment provided, and addressing non-completion?

- Provider training and consultation on empirically validated PTSD treatments (e.g., CBT, ET, CPT) through the Center for Deployment Psychology (CDP) and other VA/DoD resources
- Investments in IT systems that not only document care but that provide clinical decision support and assist providers and care managers to increase fidelity to proven intervention models (e.g., FIRST-STEPS)
- Establishment of systems that follow up provider training with monitoring, feedback, and performance benchmarking and that assist in the identification of needed system corrections or enhancements
- Non-completion of therapy is often due to the complexity of matching the right evidence-based treatment to the patient. Addressing continuity has to take into account the therapy method, duration, and dose

RWTF Question #6

What is DCoE's assessment of the availability of evidence-based treatment for TBI?

DCoE Response to Question #6

What is DCoE's assessment of the availability of evidence-based treatment for TBI?

- Evidence-based treatments for mTBI are available through the development and revisions of numerous CPGs and CRs:
 - Comprehensive dissemination plan developed with the TBI Service program managers
 - Hard and soft copy information available through DCoE, DVBIC and service specific websites (Army training network, Navy Knowledge Online, Air Force Knowledge Exchange)
 - Evidence-based treatments for severe and penetrating brain injuries are more evolved and robust than evidence-based treatments for mTBI
- Need to develop more evidence based treatments for the mTBI population
- To date, DoD has been the lead in advancing the science for TBI management (e.g., CPGs, Return to Duty guidelines, ISR, etc.)

RWTF Question #7

What can DoD and the Services do to better meet the needs of:

- RWs with TBI?
- RC RWs with TBI?

DCoE Response to Question #7

What can DoD and the Services do to better meet the needs of RWs and RC RWs with TBI?

- Severe and penetrating TBI's have a mature process available across the MHS and VA systems of care leveraging various points of support
- RWs with unresolved mTBI related symptoms after 4-6 weeks of treatment require case management interventions to include the development and implementation of a comprehensive recovery plan (CRP) by the DoD Lead Coordinator (LC). DVBIC's TBI Care Coordination program can augment the efforts of the LC by providing follow up services.
- DoD and the Services should ensure that the following steps are completed before RC RWs return home:
 - Complete the Post-Deployment Health Assessment (PDHA)
 - If RC RWs screen positive for TBI they should be required to complete an evaluation to determine a diagnosis
 - If they receive a diagnosis they should receive a CRP
 - RC RWs with a CRP for TBI should be assigned a DVBIC TBI Care Coordinator

RWTF Question #8

What are the new best practices in evidence-based treatment for TBI?

DCoE Response to Question #8

What are new best practices in evidence-based treatment for TBI?

- Since last JAN 2012, DCoE has released the following new TBI clinical tools that represent best practices in TBI treatment:
 - **Military Acute Concussion Evaluation (MACE)** (version 4.0)
 - **Concussion Management Algorithms in the Deployed Setting** (version 4.0) provides clinical management of the Service members with concussions at various points:
 - **Combat Medic/Corpsman Algorithm** guides the in-field assessment and management by combat medics
 - **Initial Provider Algorithm** guides the providers located at the forward operating bases, on how to further manage Service members with head injury, concussion
 - **Comprehensive Concussion Algorithm** guides in more definitive care that involves referral to and management at the MTF with neuroimaging capabilities
 - **Recurrent Concussion Algorithm** guides the providers through a more comprehensive evaluation, specialty assessments for: neurobehavioral symptom inventory; neuropsychological assessment; neuro-imaging; balance; and functional assessment

DCoE Response to Question #8 (continued)

What are new best practices in evidence-based treatment for TBI?

- **Assessment and Management of Dizziness Associated with mTBI** guides the providers through evaluation of dizziness after mTBI that is utilized for differential diagnosis for vertigo, disequilibrium and light headedness and appropriate referrals for management of each condition
- **Indications and Conditions for Neuroendocrine Dysfunction Screening Post mTBI** for persistent symptoms after concussion, per the CR screen for neuro endocrine dysfunction utilizing the following lab panel:
 - 0800 Cortisol levels (<12 mcg/dl, recommend follow up)
 - IGF — 1 Insulin-like Growth Factor
 - TSH — Thyroid Stimulating Hormone
 - FT4 — Free Thyroxine
 - LH — Luteinizing Hormone »» Testosterone (males only)
 - FSH — Follicle Stimulating Hormone »» Estradiol (females only)

RWTF Question #9

Regarding DoD Instruction 6490.11 – Management of Mild TBI/Concussion in the Deployed Setting, please provide the key differences between DTM 09-033 and DoDI 6490.11, and provide any additional information related to the issuance of this policy.

DCoE Response to Question #9

Please describe the key differences between DTM 09-033 and DoDI 6490.11 and additional information related to the policy issuance.

Section	DTM 09-033	DoDI 6490.11
Effective Date	21 JUN 2010	18 SEP2012
Entire Document	FOUO	Removed FOUO Designation
Purpose	Early detection leads to early treatment of concussion in the deployed setting	Same
Policy	<ul style="list-style-type: none"> Includes clinical algorithms for management of concussion. 	<ul style="list-style-type: none"> Provides for Civilian Expeditionary Workforce Requires documentation in the Electronic Health Record Medical evaluations to be completed as close to time of injury as possible Clinical algorithms for concussion care are not included in package but referred to on DCoE website.
Information Requirements	Same	Same

DCoE Response to Question #9 (continued)

Please describe the key differences between DTM 09-033 and DoDI 6490.11 and additional information related to the policy issuance.

Section	DTM 09-033	DoDI 6490.11
Responsibilities	<ul style="list-style-type: none"> ▪ Under Secretary of Defense for Personnel and Readiness ▪ Assistant Secretary of Defense for Health Affairs ▪ Assistant Secretary of Defense for Reserve Affairs ▪ Secretaries of the Military Departments ▪ Chairman of the Joints Chiefs of Staff ▪ Commanders if the Combatant Commands 	<ul style="list-style-type: none"> ▪ Under Secretary of Defense for Personnel and Readiness ▪ Assistant Secretary of Defense for Health Affairs ▪ Deputy Assistant Secretary of Defense for Force Health Protection and Readiness ▪ Director, Tricare Management Activity ▪ Assistant Secretary of Defense for Reserve Affairs ▪ Secretaries of the Military Departments ▪ Chairman of the Joints Chiefs of Staff ▪ Commanders if the Combatant Commands
Procedures	Mandatory Events: events requiring mandatory command evaluations and reporting of exposure of all personnel	Potentially Concussive Events: events requiring mandatory rest periods and medical evaluations and reporting of exposure of all personnel

DCoE Response to Question #9 (continued)

Please describe the key differences between DTM 09-033 and DoDI 6490.11 and additional information related to the policy issuance.

Section	DTM 09-033	DoDI 6490.11
Procedures	<p>Mandatory Events:</p> <ul style="list-style-type: none"> ▪ Any Service member in a vehicle associated with a blast event, collision, or rollover. ▪ Any Service member within 50 meters of a blast (inside or outside) ▪ A direct blow to the head or witnessed loss of consciousness ▪ Command-directed, especially in a case with exposure to multiple blast events 	<p>Potentially Concussive Events:</p> <ul style="list-style-type: none"> ▪ Involvement in a vehicle blast event, collision, or rollover. ▪ Presence within 50 meters of a blast (inside or outside). ▪ A direct blow to the head or witnessed loss of consciousness. ▪ Exposure to more than one blast event (the Service member's commander shall direct a medical evaluation).
Procedures-Reports	<p>Minimum required data fields (8) for monthly reports to JTAPIC:</p> <ul style="list-style-type: none"> ▪ Date of Mandatory Event ▪ Type of Mandatory Event ▪ SIGACT number ▪ Personal identifier ▪ Unit ▪ Combatant Command ▪ Service member's distance from blast ▪ Disposition of any medical evaluation 	<p>Minimum required data field (9) are to be completed as operational conditions permit, preferably within 24 hours.</p> <ul style="list-style-type: none"> ▪ Date of Potentially Concussive Event ▪ Type of Potentially Concussive Event ▪ SIGACT number ▪ Personal identifier ▪ Service member's name ▪ Unit name, unit identification code, and home duty station ▪ Combatant Command ▪ Service member's distance from blast ▪ Disposition of any medical evaluation

DCoE Response to Question #9 (continued)

Please describe the key differences between DTM 09-033 and DoDI 6490.11 and additional information related to the policy issuance.

Section	DTM 09-33	DoDI 6490.11
Procedures-Medical Guidance	Neuropsychological Assessment: <ul style="list-style-type: none"> ▪ Attention ▪ Memory ▪ Processing Speed ▪ Executive Functioning ▪ Social Pragmatics ▪ DTM recommends that neuropsychological evaluation should be conducted over 4 hour period. 	Neuropsychological Assessment: (No one tool is recommended over another.) <ul style="list-style-type: none"> ▪ Attention ▪ Memory ▪ Processing Speed ▪ Executive Functioning ▪ 4 hr. recommendation taken out
Definitions	Same	Same

RWTF Question #10

What are best practices in the treatment of moderate and severe TBI? Will there be CPGs or other guidance for the field?

DCoE Response to Question #10

What are best practices in the treatment of moderate and severe TBI? Will there be CPGs or other guidance for the field?

- Joint Theater Trauma System (JTTS) Clinical Practice Guidelines (CPGs): Management of Patients with Severe Head Trauma, Neurosurgical Management Guidelines and Catastrophic Care Guidelines
 - Updated annually via review from experts in neurotrauma and neurosurgery from all the services, including DCoE
 - JTTS guidelines are utilized by all services as the standard for the treatment and management of moderate (12.2%) and severe (0.4%) TBI and provide very specific treatment protocols
 - These comprehensive guidelines were developed by expert trauma personnel and incorporate both military evidence and the civilian guidelines of the Brain Trauma Foundation (BTF) and the American Association of Neurological Surgeons (AANS)
 - DoD has directed \$4,399,752 for support of eight research programs for detecting increased intracranial pressure and for treating hydrocephalus

Question & Answer