NEUROLOGY SECTION

CEREBRAL HAPPENINGS

Newsletter of the Brain Injury Special Interest Group

Issue 2, 2013

November 2013

Inside this issue:

Want to become involved?

Contact us about open positions this spring:

- **Chair**
- **Nominating member**
- **Newsletter Co-Editor**

FALL NEWSLETTER

NOVEMBER 2013

LETTER FROM THE CHAIR

Heidi Roth, PT, DHS, NCS
BI SIG Chair

Greetings Brain Injury SIG,

Welcome to the BI SIG's quarterly newsletter. First, I would like to thank the entire BI SIG and committee members for the hard work and dedication to promoting brain injury awareness, education and research. We would also like to thank Natalie Sibley, DPT, NCS and Carolyn Tassini, DPT, NCS for their service on the BI SIG Committee over the past three years. Their contributions were invaluable and they will be missed. I would like to welcome Jennifer Schinke, PT, DPT, NCS, PCS as the Vice Chair and Megan Richardson, DPT, MSPT to the Nominating Committee. Both of these women have transitioned into their leadership positions and are already significantly contributing to the SIG.

We are getting excited for CSM 2014 in Las Vegas! This year the BI SIG is honored to have Amy Berryman, OT and Karen Rasavage, OT from Denver presenting on Visual Rehabilitation and Functional Implications of Vision Deficits in the brain injury population. Not only has this topic area *not* been covered at CSM before, but also we are also excited to welcome occupational therapists to offer an interdisciplinary approach and discussion for this area. We are also excited to welcome Susy Halloran, PT, DPT, member of the BI SIG committee, to present *"Everyday Concussion and Physical Therapy: Who Knew?"*. We continue to strive to serve your interests, so please send us topic areas or speakers you feel would be beneficial for future presentations. The CSM programming guide is now available, so be sure to check it out through the following link: http://www.apta.org/CSM/Programming/.

Melissa Mendoza and the BIG SIG Committee have been working hard to update the website with a variety of resources for clinicians and community members. Information regarding concussion management, literature reviews, documentaries, and patient information are posted to the site. Please check out the website and send us relevant information that you think would benefit the BI community.

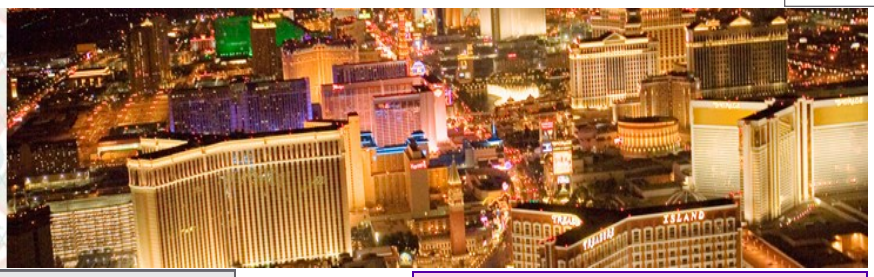
Another exciting advancement is the release of the Neurology Section's outcome measure recommendations developed by the TBI Evaluation Database to Guide Effectiveness (EDGE) Task Force. Outcome measures were selected and reviewed by the taskforce in collaboration with Rehabilitation Measures Database (RMD). EDGE documents provide TBI specific, rated recommendations for outcome measures specifying the use in different practice settings, recommendations for inclusion into entry-level PT education, as well as research. A thorough description, summary of psychometric and clinical properties of each outcome measure are all included in the RMD. These recommendations are designed to guide clinicians, educators and researchers to best serve the TBI population. Please take a moment and be aware of this amazing resource that is posted on the APTA Neurology Section's website!

As with all organizations, we are only as strong as our membership. We are continuing to work on projects to serve the brain injury community, as well as to generate innovative programming ideas. I want to thank everyone who has generously volunteered their expertise and time in the past months, which allows us to develop new ideas and foster ongoing projects. Remember, everyone can offer something! Please contact us with questions, feedback and recommendations. We would love to hear from you.

Warmest Regards,

Heidi Roth

Heidi Roth, PT, DHS, NCS



ANNUAL COMBINED SECTIONS MEETING

Las Vegas, NV

February 4-6, 2014

For hotel information please click on this link

Hotel Info

The Combined Sections Meeting (CSM) focuses on programming designed by all 18 of APTA's specialty sections. The spectacular event brings together more than 7,500 physical therapy professionals from around the nation for 5 stimulating days of exceptional programming, networking opportunities, and an exhibit hall filled with products and services to keep you and your practice on the cutting edge.

Main Conference Courses of Interest:

Tuesday, February 4

The Anne Shumway-Cook Lectureship—My Wonderful Neurorehabilitation Journey: Where I have been and where we could go.

Time: 8:00 am–10:00 am (See Program for Room)

Postdeployment Rehabilitation of Mild Traumatic Brain Injury: A Team Approach

Time: 3:00 pm–5:00 pm (See Program for Room)

Don't miss your Alumni Events this evening!

NEUROLOGY SECTION
American Physical Therapy Association

Wednesday, February 5

NCS Breakfast and Presentation-- Lessons Learned by a Neurology Section Addict: Saying 'Yes' to Opportunities that are Right for You

6:45– 7:45 AM

TBI SIG: Clinical Evaluation and Management of Visual and Perceptual Impairments Following Brain Injury

8:00-10:00 (See programing for Room)

OPEN DOOR
APTA's Portal to Evidence-Based Practice

Thursday, February 6

TBI SIG: Everyday Concussion and Physical Therapy

Time: 8:00 am–10:00 am (See Program for Room)

In this Section:

A Closer Look at the Development of a Clinic Based Research !

Preliminary Evidence for the Use of Aggressive Mobilization Protocols in Disorders of Consciousness during Acute Rehabilitation

Jenny Schinke, PT, DPT, NCS, PCS
Brain Injury SIG Vice Chair
Brooks Rehabilitation
Jacksonville, FL

Investigative research into treatments for disorders of consciousness (DOC) has largely been focused on the effectiveness of medications on improving awareness and consciousness and eventual emergence from the minimally conscious state (MCS). Far less research has focused on the behavioral rehabilitation interventions that may contribute to effecting improvements in the clinical presentations of patients with DOC during acute rehabilitation.

Generalized weakness, debility, and learned disuse are conditions long identified in the literature as significant consequences resulting from extended critical care stays, especially following neurological disorders such as brain injuries, strokes, spinal cord injuries, and major multiple trauma injuries. The benefits of early activation through mobilization protocols are well documented as methods for attenuating or reversing the negative impact of immobility on recovery and for reducing secondary complications. The benefits of aggressive mobilization for patients with DOC, however, have yet to be investigated. Patients with prolonged DOC by their very nature have experienced extended lengths of stay in critical care units. Furthermore, all aspects of DOC diagnosis are dependent upon the observation of patient behaviors (i.e., motor output), particularly to accurately demarcate the transition from MCS to emergence from MCS. Enhancing motor output and reducing the negative impact of the consequences of long-term immobility would be advantageous for patients with DOC. Thus, we are sharing preliminary evidence for the potential benefit of implementing aggressive mobilization protocols (AMP) for patients with DOC.

A total of 30 records were retrospectively identified with patients diagnosed with a DOC following acute rehabilitation admission between September 2011 and August 2013. Variables collected during record review included: Admission Date, Discharge Date, Interrupted Stays and Re-admission date (s), DOB, Sex, DOC diagnosis following admission assessment, Emergence from DOC prior to discharge, Etiology of diagnosis, type of facilitated mobilization, duration and frequency of mobilization, and level of engagement. Calculated variables included: Admission Age, Total Length of Stay (LOS).

Of the 30 patients admitted, 11 received one of four types of facilitated mobilization. Of the 11 patients who received facilitated mobilization, 7 patients emerged either prior to discharge (N=4) or shortly after discharge to home (N=3) and were subsequently readmitted for acute rehabilitation. Of the 19 patients who did not receive any form of facilitated mobilization only 3 emerged prior to discharge.

This preliminary evidence suggests AMP should be formally investigated as a potential valuable addition to care plans for patients with DOC. AMP may assist patients with DOC to overcome severe weakness, debility, or learned disuse that may be negatively impacting their ability to respond to external stimuli. AMP may also facilitate recovery of arousal and awareness in low-level clinical profiles.

Snapshot of Traumatic Brain Injury Rehab in the UK

By **Megan Richardson, DPT, MSPT**

I recently worked four years on a community neurological rehabilitation team in the United Kingdom. The team consisted of physiotherapists and occupational therapists and linked closely with speech and language therapists. As it was all within the National Healthcare System (NHS), the community services are funded based on the locality of the patient or the general practitioner (GP). In this particular area of the Northwest, there is limited access to outpatient services and slowly improving access to community based/ home based therapy services. This means there can be a 'postcode lottery' where the services available to one patient may be different to another living just across the road.

Traumatic brain injury (TBI) rehabilitation was a proportion of the caseload of patients we saw in the community, ranging from mild to severe injury. We saw some patients in their own homes who had come from a specialist brain injury rehabilitation program with well established packages of care coordinated between healthcare and social services partnership working. Other patients were in NHS or private funded residential programs for longer term or slower stream rehabilitation or purely residential accommodation to meet the patient needs.

Often patients with TBI were accessing community services as a continuation of inpatient rehabilitation with ongoing goals to achieve or following a decline in functional ability years down the line. Most often this deterioration was down to lack of maintenance of a previous functional rehabilitation program, in which case focus on patient and carer education and re-instigation of a rehab regime was necessary, or due to a change in tone requiring spasticity management. Signposting to services such as electronic assistive technology, driving assessments and vocational rehabilitation were also part of this role.

How does this compare to the community BI rehabilitation available where you are?

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