

# Concussions and Returning to the Classroom

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WVU Center for Excellence in Disabilities

# A part of West Virginia University & WVU Health Sciences Center



# Part of a National Network

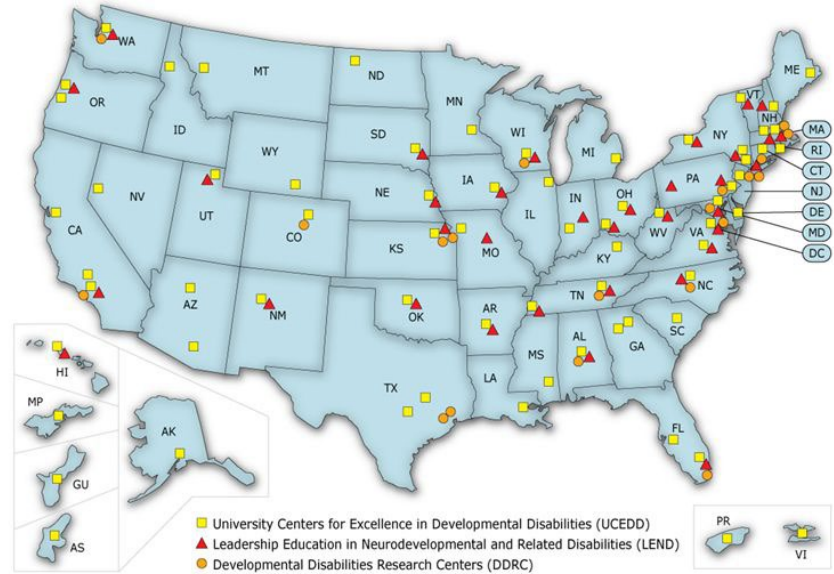


# AUCD

ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES

RESEARCH, EDUCATION, SERVICE

## UCEDDs, LENDs, and DDRCs



# WVU CED's Role:

- **Education and training** to University students in multiple disciplines to prepare a workforce that is able and willing to serve persons with disabilities
- **Technical assistance** to individuals with disabilities and direct care providers who serve them to enhance their skillset and improve service quality
- Gap filling **direct services** and supports in an effort to improve availability and acceptability of services for West Virginians
- **Dissemination** of information about the status of disabilities services in West Virginia and the nation
- **Research** activities conducted in collaboration with partners, to improve services and policies related to individuals with disabilities and their families.



# About WVU CED

- Serves individuals with disabilities across the life span in all 55 counties
- 7 Programs
- 4 Clinics
- Approx. 90 Staff
- Multiple state and federal partners



# Become an Affiliate

Looking for a way to be more connected to CED? Individuals can now sign up to be an Affiliate of the CED. Affiliates will:

- Receive updates on CED news and events
- Have opportunities to provide input regarding programs, services and research projects

<http://www.cedwvu.org/about-ced/become-an-affiliate/>

# Session Goal

Increase awareness of brain injuries and how it impacts students in the classroom, identify importance of Return to Learn, and how to implement Return to Learn protocol.

# Session Objectives

- Define TBI and prevalent statistics
- Review Consensus Statement for SRC – Amsterdam as it relates to RTP and RTL
- Recognize how Return To Learn (RTL) fits into education system
- Understand the roles and responsibilities of the concussion management team within school system
- Introduce REAP and TACT to help clinicians, athletic trainers, school nurses, guidance counselors, and teachers with appropriate academic adjustments during concussion recovery.



# Brain Facts

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Your brain is 73% water and only takes 2% dehydration to affect your attention, memory, and other cognitive skills.

Uses 20% of the body's blood and oxygen

The average brain generates 48.6 thoughts per minute; which is about 70,000 thoughts per day!

When awake, the brain produces enough energy to power a small lightbulb

Is not fully developed until our mid 20's.



## Frontal Lobe:

Primary motor cortex  
Attention  
Concentration  
Self monitoring  
Organization  
Expressive language  
Motor planning  
Awareness  
Personality  
Inhibition of behavior  
Emotional control  
Problem solving  
Planning  
Judgement/decision making

## Temporal Lobe:

Memory  
Receptive language  
Sequencing  
Hearing  
Organization  
Selective attention  
Emotional response  
Face recognition

## Brain Stem:

(Reticular activating system) Breathing, Arousal, Consciousness, Alertness, Concentration, Heart rate, Sleep wake cycle, (Cranial Nerves) hearing, touch, taste, balance

## Parietal Lobe:

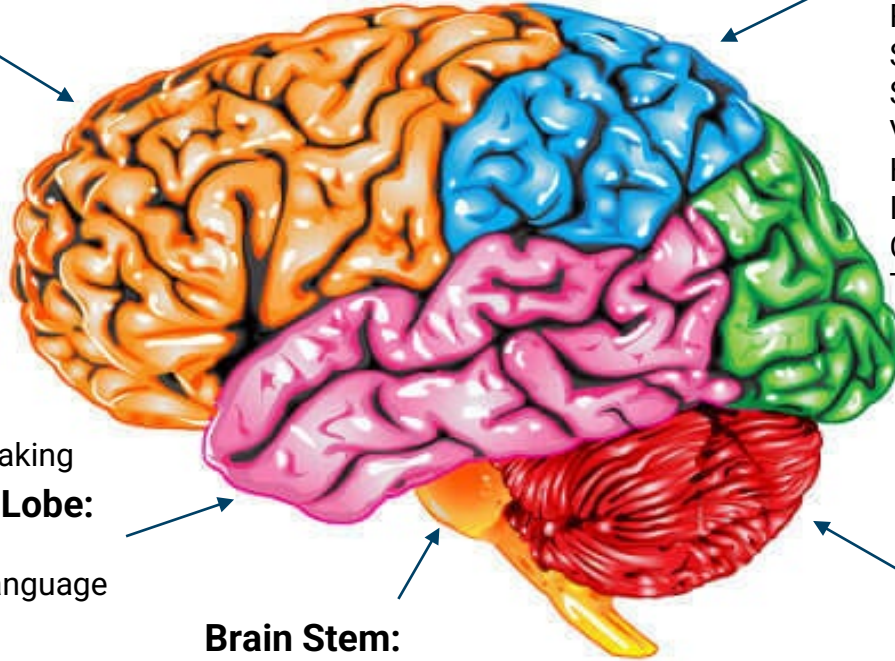
Primary sensory cortex  
Body awareness  
Respond to sensory information  
Sense of touch  
Spatial perception (depth perception)  
Visual perception  
Hand-eye coordination  
Identification size, shape, colors  
Object naming  
Tactile perception

## Occipital Lobe:

Vision  
Visual stimuli processing

## Cerebellum:

Balance and coordination  
Skilled motor activity  
Visual perception



# Traumatic Brain Injury Overview

- The Center for Disease Control and Prevention defines Traumatic Brain Injury (TBI) as a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury.
- In West Virginia, TBI also includes individuals who have anoxia due to near drowning.

## PHYSICAL

### How a Person Feels Physically

Headache/Pressure  
Blurred vision  
Dizziness  
Poor balance  
Ringing in ears  
Seeing "stars"  
Vacant stare/Glassy eyed

Nausea  
Vomiting  
Numbness/Tingling  
Sensitivity to light  
Sensitivity to noise  
Disorientation  
Neck Pain

## COGNITIVE

### How a Person Thinks

Feel in a "fog"  
Feel "slowed down"  
Difficulty remembering  
Difficulty concentrating/easily distracted  
Slowed speech  
Easily confused

## EMOTIONAL

### How a Person Feels Emotionally

Inappropriate emotions  
Personality change  
Nervousness/Anxiety  
Feeling more "emotional"

Irritability  
Sadness  
Lack of motivation

## SLEEP/ENERGY

### How a Person Experiences Their Energy Level and/or Sleep Patterns

Fatigue  
Excess sleep Trouble  
falling asleep

Drowsiness  
Sleeping less than usual



# Traumatic Brain Injury Severity

- **Mild (Concussion)**

- Symptoms may include: loss of memory, fatigue, confusion, disorientation, difficulty concentrating, headache, dizziness, blurry vision, nausea and vomiting

- **Moderate**

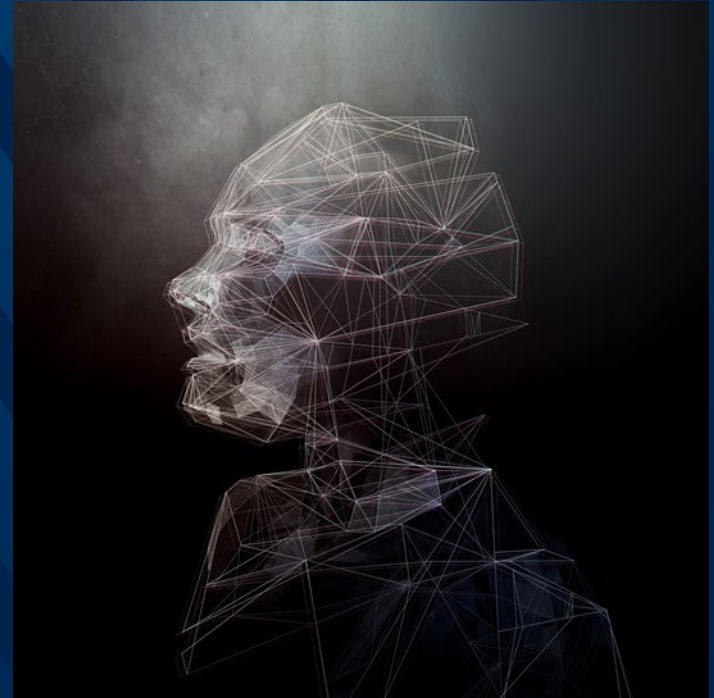
- Symptoms may include: slurred speech, fatigue, loss of consciousness, repeated nausea or vomiting, numbness or tingling in arms and/or legs, loss of coordination

- **Severe**

- Symptoms may include: loss of consciousness from several minutes to hours, clear liquid draining from ears or nose, inability to waken from sleep

# TBI Statistics

- TBI has often been referred to as the silent epidemic
- 80-90% are considered mild
  - Even mild injuries can be life altering and cause long term disability
- Remaining 10-20% are considered moderate to severe



# TBI Statistics

1.7-3.8 million new TBI's each year

5.3 million currently living with disabilities as a result of TBI

50,000+ die each year

275,000+ are hospitalized each year

# TBI in West Virginia



- 411 WV residents died due to traumatic brain injuries in 2015, representing 20% of all injury related deaths.
- 763 WV Residents were hospitalized for TBIs in 2015, 25% of injury related hospitalizations.



## Causes

- Motor Vehicle (33% in WV)
- ATV Accidents (10% in WV)
- Falls (27% in WV)
- Being struck by or against something
- Assaults and Fights
- Intimate Partner Violence/Domestic Violence
- Blast Injuries
- Gun Shot Wounds
- Sports Injuries

## Risk Factors

- Highest incidence:
  - Males all ages (1.5-2x more likely)
  - Children under 4
  - Age group 15-24
  - Adults over 60
- History of TBI
  - 3x more likely to have a 2<sup>nd</sup>
  - 8x more likely to have a 3<sup>rd</sup>

# Incidence of Concussion

- In 2019, about 15% of all U.S. high-school students self-reported one or more sports or recreation-related concussions within the preceding 12 months
- 40% + are concussions are from non-sports related activities (Eagan-Brown, BrainSTEPS)



# Consensus statement on concussion in sport: the 6th International Conference on Concussion in Sport—Amsterdam, October 2022

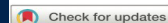
Jon S Patricios <sup>1</sup>, Kathryn J Schneider <sup>2</sup>, Jiri Dvorak <sup>3</sup>,  
Osman Hassan Ahmed <sup>4,5</sup>, Cheri Blauwet <sup>6,7</sup>, Robert C Cantu <sup>8,9</sup>,  
Gavin A Davis <sup>10,11</sup>, Ruben J Echemendia <sup>12,13</sup>, Michael Makdissi <sup>14,15</sup>,  
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## ABSTRACT

For over two decades, the Concussion in Sport Group has held meetings and developed five international statements on concussion in sport. This 6th statement in Amsterdam on 27–30 October 2022 and should be read in conjunction with the (1) methodology paper that outlines the consensus process in detail and (2) 10 systematic reviews that informed the conference outcomes. Over 3½ years, author groups conducted systematic reviews of predetermined priority topics relevant to concussion in sport. The format of the conference, expert panel meetings and workshops to revise or develop new clinical assessment tools, as described in the methodology paper, evolved from previous consensus meetings with several new components. Apart from this consensus statement, the conference process yielded revised tools including the Concussion Recognition Tool-6 (CRT6) and Sport Concussion Assessment Tool-6 (SCAT6, Child SCAT6), as well as a new tool, the Sport Concussion Office Assessment Tool-6 (SCOAT6, Child SCOAT6). This consensus process also integrated new features including a focus on the para athlete, the athlete's perspective, concussion-specific medical ethics and matters related to both athlete retirement and the potential long-term effects of SRC, including neurodegenerative disease. This statement summarises evidence-informed principles of concussion prevention, assessment and management, and emphasises those areas requiring more research.

## INTRODUCTION

This Amsterdam 2022 International Concussion Statement on Concussion in Sport (Statement) builds on previous Concussion in Sport Group (CISG) statements with the goal of updating current recommendations for sport-related concussion (SRC) through an evidence-informed consensus

methodology. The purpose of this Statement is to provide a summary of the evidence and practice recommendations based on science and expert panel consensus recommendations at the time of the conference. Additional outputs of the consensus process include freely available evidence-informed tools to assist in the detection and assessment of SRC, including the Concussion Recognition Tool-6 (CRT6), Sport Concussion Assessment Tool-6 (SCAT6), Child SCAT6, Sport Concussion Office Assessment Tool-6 (SCOAT6) and Child SCOAT6. Apart from this Statement, in the interest of knowledge translation, the tools are free to distribute in their original formats.

This Statement is developed for the healthcare professional (HCP) involved in the care of athletes at risk of SRC or who have sustained a suspected SRC at any level of sport (ie, recreational to professional). The authors recognise that differences in geography, healthcare structure and culture are important considerations when implementing the principles presented. Thus, this Statement provides recommendations that can be adapted for different sport, clinical and cultural environments and is not meant to be used as a prescriptive guideline. We also recognise that the science of concussion continues to evolve, and the Amsterdam Statement reflects the state of the evidence at the time of the Consensus Conference and will need to be updated as new scientific information emerges. Also included are recommendations for future research where notable gaps in the literature have been identified. Although this Statement provides recommendations and is a summary of the consensus process, it should be read in combination with the 10 systematic reviews and methodology papers that informed the consensus process and outcomes.

## MEDICOLEGAL CONSIDERATIONS

This Statement is not intended as a clinical practice directive or legal standard of care and should not

# Sport-Related Concussion SRC (for athletes)





# Return To Sport

**Table 2** Return-to-sport (RTS) strategy—each step typically takes a minimum of 24 hours

Step	Exercise strategy	Activity at each step	Goal
1	Symptom-limited activity	Daily activities that do not exacerbate symptoms (eg, walking).	Gradual reintroduction of work/school
2	Aerobic exercise <b>2A—Light</b> (up to approximately 55% maxHR) <b>then</b> <b>2B—Moderate</b> (up to approximately 70% maxHR)	Stationary cycling or walking at slow to medium pace. May start light resistance training that does not result in more than mild and brief exacerbation* of concussion symptoms.	Increase heart rate
3	Individual sport-specific exercise Note: If sport-specific training involves any risk of inadvertent head impact, medical clearance should occur prior to Step 3	Sport-specific training away from the team environment (eg, running, change of direction and/or individual training drills away from the team environment). No activities at risk of head impact.	Add movement, change of direction
Steps 4–6 should begin after the resolution of any symptoms, abnormalities in cognitive function and any other clinical findings related to the current concussion, including with and after physical exertion.			
4	Non-contact training drills	Exercise to high intensity including more challenging training drills (eg, passing drills, multiplayer training) can integrate into a team environment.	Resume usual intensity of exercise, coordination and increased thinking
5	Full contact practice	Participate in normal training activities.	Restore confidence and assess functional skills by coaching staff
6	Return to sport	Normal game play.	

\*Mild and brief exacerbation of symptoms (ie, an increase of no more than 2 points on a 0–10 point scale for less than an hour when compared with the baseline value reported prior to physical activity). Athletes may begin Step 1 (ie, symptom-limited activity) within 24 hours of injury, with progression through each subsequent step typically taking a minimum of 24 hours. If more than mild exacerbation of symptoms (ie, more than 2 points on a 0–10 scale) occurs during Steps 1–3, the athlete should stop and attempt to exercise the next day. Athletes experiencing concussion-related symptoms during Steps 4–6 should return to Step 3 to establish full resolution of symptoms with exertion before engaging in at-risk activities. Written determination of readiness to RTS should be provided by an HCP before unrestricted RTS as directed by local laws and/or sporting regulations.

HCP, healthcare professional; maxHR, predicted maximal heart rate according to age (ie, 220-age).

# National Return to Play RTP/Return to Sports RTS Legislation

Last updated: 2/19/2014

## Concussion Laws By State By Education Week

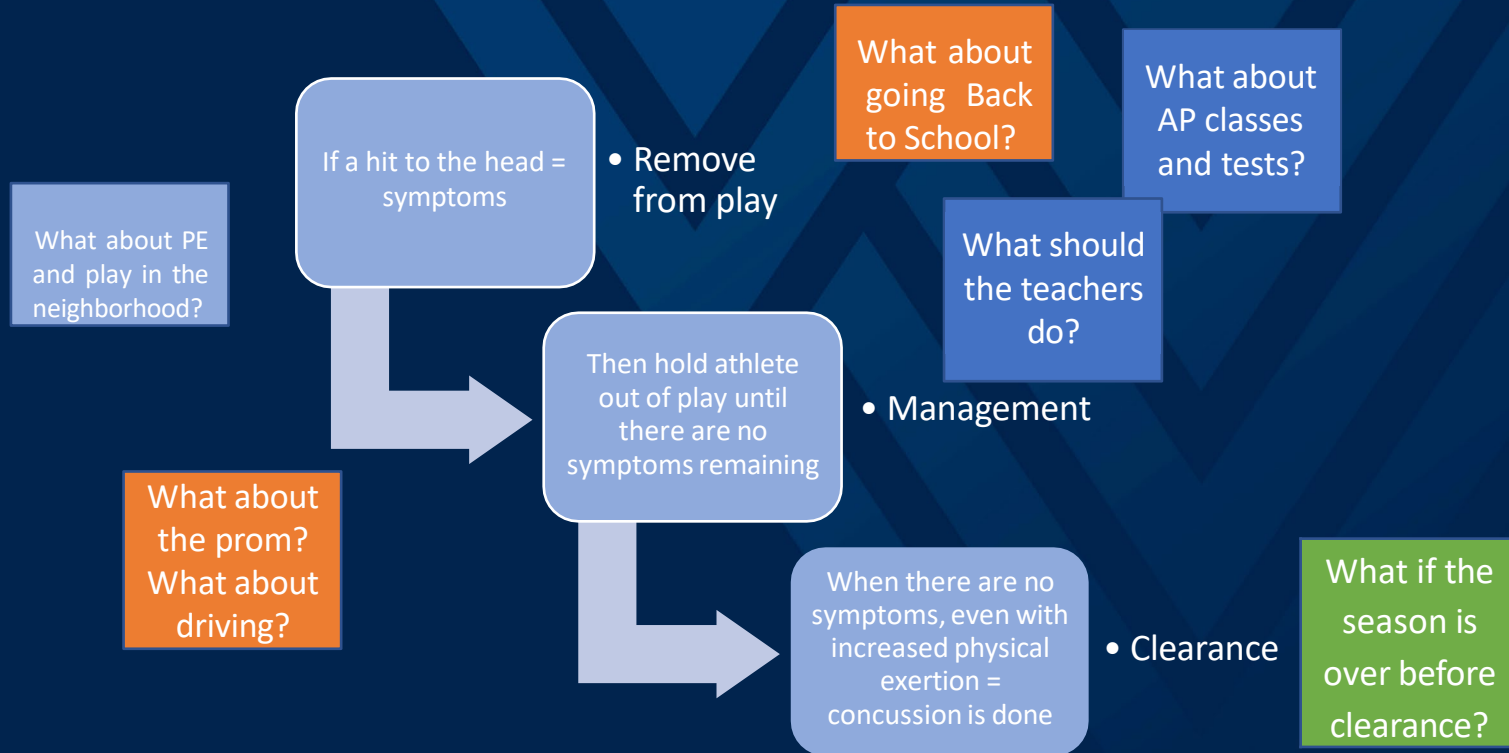
All States

Click on a state for  
detailed  
information.



Source: Education Week

# Kids and Concussion Management



# Return To Learn

**Table 1** Return-to-learn (RTL) strategy

Step	Mental activity	Activity at each step	Goal
1	Daily activities that do not result in more than a mild exacerbation* of symptoms related to the current concussion	Typical activities during the day (eg, reading) while minimising screen time. Start with 5–15 min at a time and increase gradually.	Gradual return to typical activities
2	School activities	Homework, reading or other cognitive activities outside of the classroom.	Increase tolerance to cognitive work
3	Return to school part time	Gradual introduction of schoolwork. May need to start with a partial school day or with greater access to rest breaks during the day.	Increase academic activities
4	Return to school full time	Gradually progress in school activities until a full day can be tolerated without more than mild* symptom exacerbation.	Return to full academic activities and catch up on missed work

Following an initial period of relative rest (24–48 hours following an injury at Step 1), athletes can begin a gradual and incremental increase in their cognitive load. Progression through the strategy for students should be slowed when there is more than a mild and brief symptom exacerbation.

\*Mild and brief exacerbation of symptoms is defined as an increase of no more than 2 points on a 0–10 point scale (with 0 representing no symptoms and 10 the worst symptoms imaginable) for less than an hour when compared with the baseline value reported prior to cognitive activity.

# Strict cognitive rest vs. no post-injury accommodations

Patients who were assigned an average of 40 hours of strict cognitive rest (being withheld from all activity)


vs.

Those who had no post-injury accommodations

Results: Children who were in the group not assigned to any post-injury accommodations became asymptomatic sooner than those who were assigned strict cognitive rest

# Strict Cognitive Rest vs. Gradual Return to Learning

Randomized study placed students from ED to either strict cognitive rest for 5 days vs. 1-2 days cognitive rest, then return to usual activity



Strict cognitive rest group had more post-concussive symptoms in 4 domains (ie, physical, cognitive, emotional, and sleep)


strict cognitive rest had less mental activity

strict cognitive rest approach had longer time to symptom resolution compared to other group




# Moderate vs. Cognitive rest and full exertion

The highest level of cognitive activity was associated with the most prolonged course of recovery.



Children with less cognitive activity had similar times to recovery, suggesting that complete restriction of activity is likely unnecessary and possibly unfavorable.



Those who participated in moderate levels of activity demonstrated the best outcomes in terms of neurocognitive and symptomatic recovery up to 33 days after concussion.

# Guiding Principles of Recovery



Cognitive rest is usually recommended for the first 24-48 hours after injury when symptoms are most severe

Extended cognitive and physical rest may not improve recovery time



Avoid activities in all environments (e.g., home, work, leisure) that are known to exacerbate signs and symptoms which may prolong recovery



Adapt the environment and activity requirements:

Implement strategies and accommodations  
Facilitate a gradual, progressive plan to engage in functional activities while managing symptoms



# Barriers

Parents and adolescents lacked consistent guidelines for the adolescents' return to learn after a concussion.



# Barriers

- Category 1: Adolescents being misunderstood because concussions are invisible
- Category 2: Adolescents feeling pressure and being overwhelmed by their concussion
- Category 3: Academic accommodations lacking consistency, clarity and implementation



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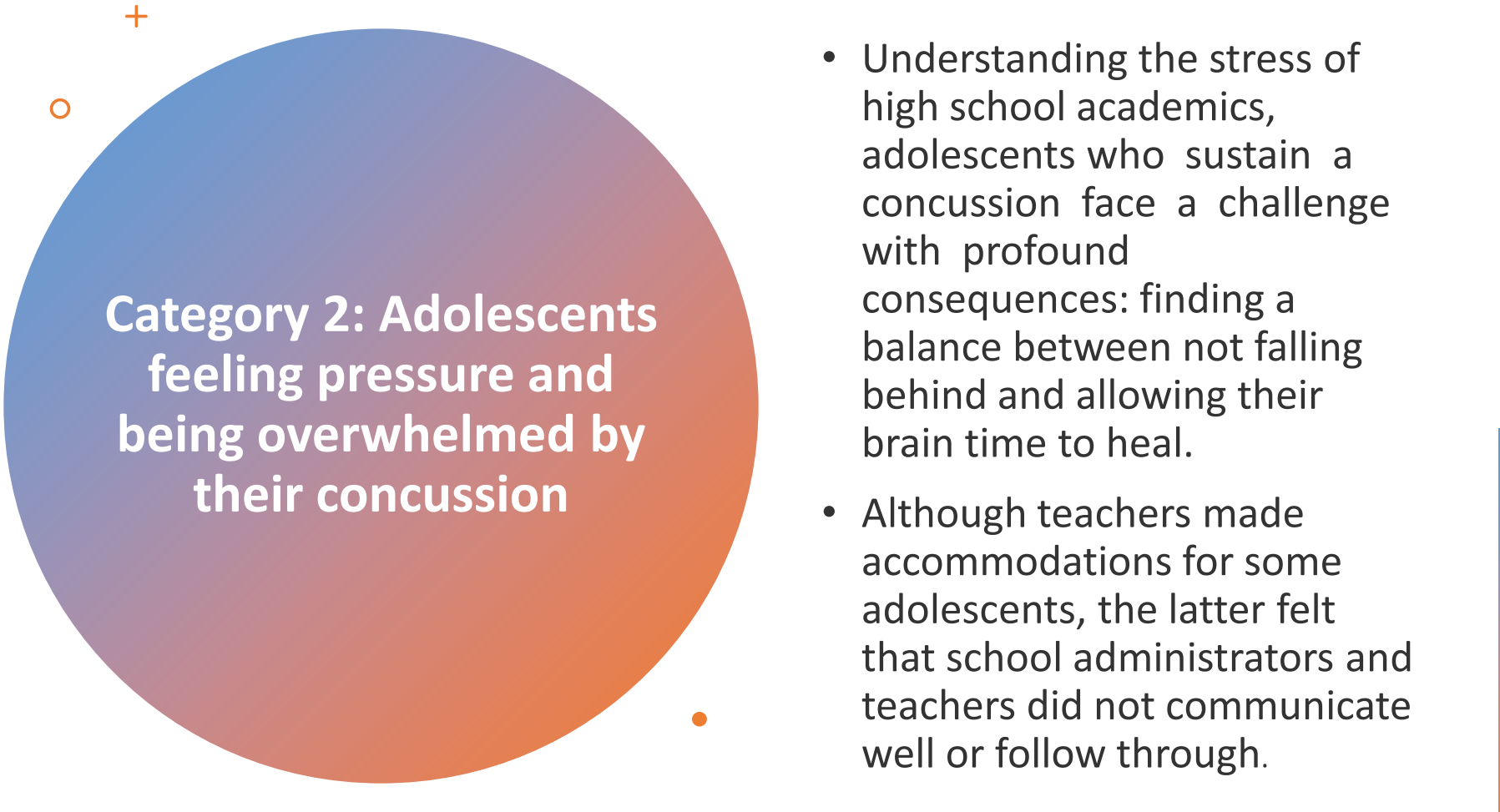
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## Category 1: Adolescents being misunderstood because concussions are invisible

- Adolescents in this study were consistently frustrated that their head injury was invisible when other injuries (e.g. broken arms or legs) were physically apparent. Because most concussion symptoms are subjective and based on report, it is difficult to quantify the extent of injury.

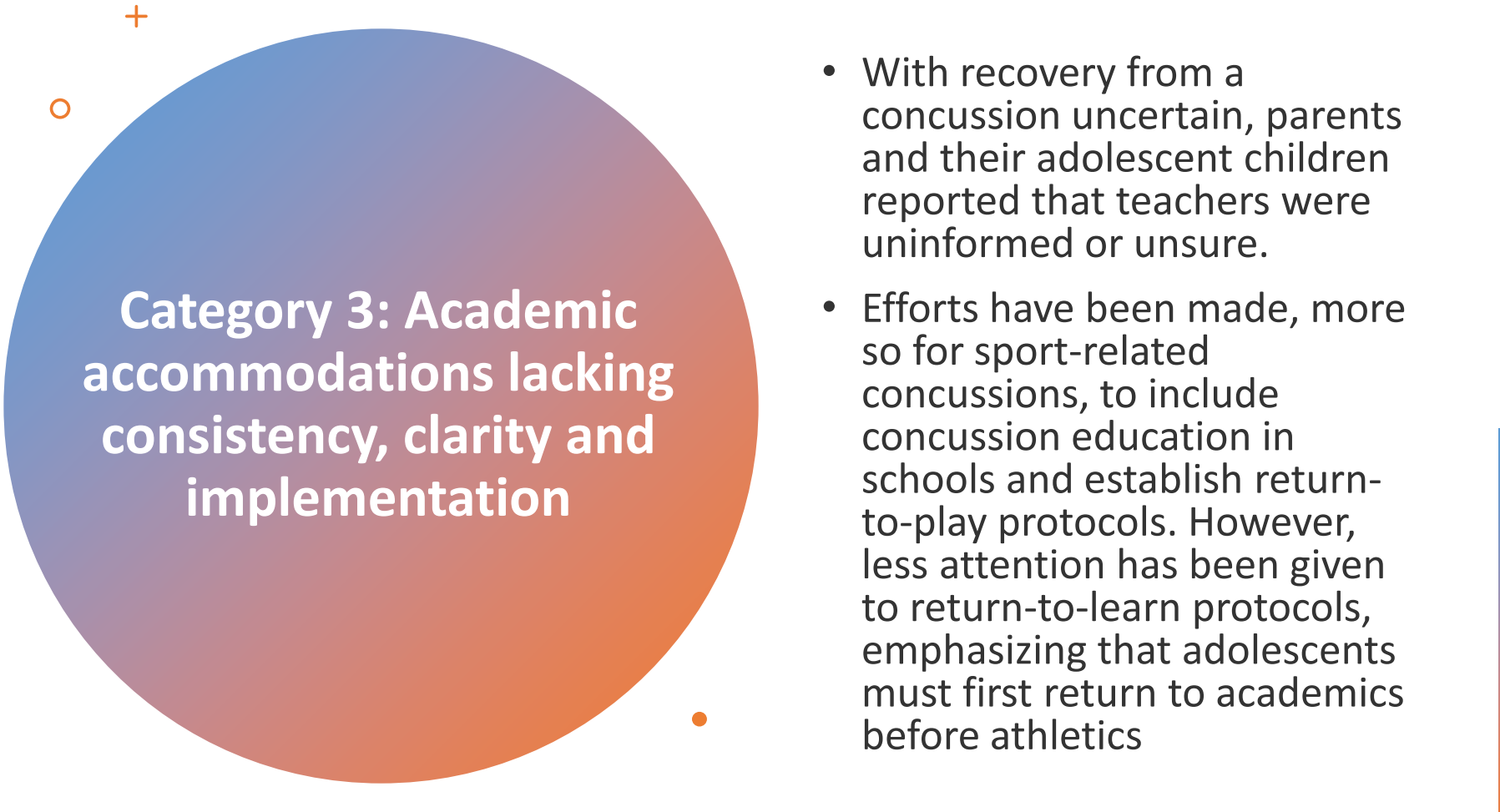




## Category 2: Adolescents feeling pressure and being overwhelmed by their concussion

- Understanding the stress of high school academics, adolescents who sustain a concussion face a challenge with profound consequences: finding a balance between not falling behind and allowing their brain time to heal.
- Although teachers made accommodations for some adolescents, the latter felt that school administrators and teachers did not communicate well or follow through.





### **Category 3: Academic accommodations lacking consistency, clarity and implementation**

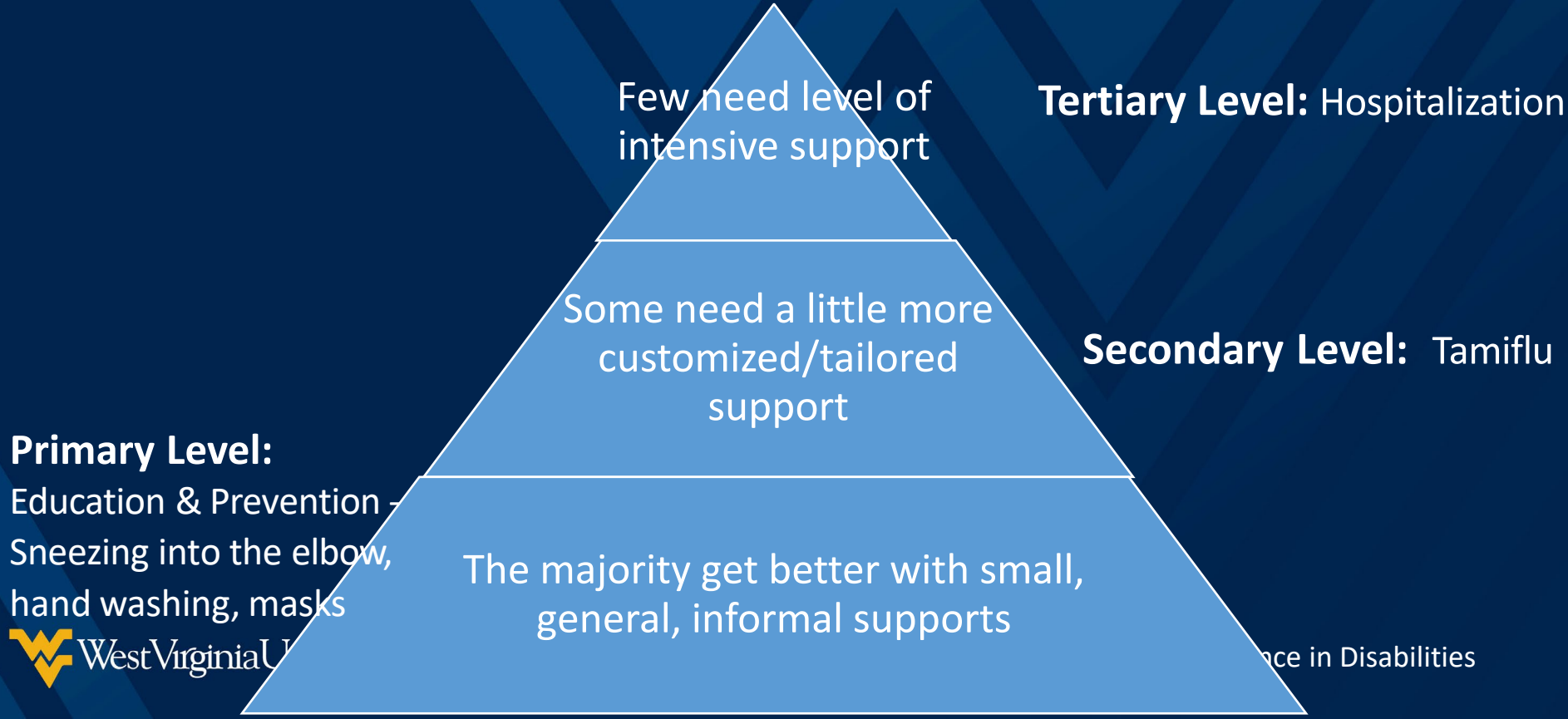
- With recovery from a concussion uncertain, parents and their adolescent children reported that teachers were uninformed or unsure.
- Efforts have been made, more so for sport-related concussions, to include concussion education in schools and establish return-to-play protocols. However, less attention has been given to return-to-learn protocols, emphasizing that adolescents must first return to academics before athletics



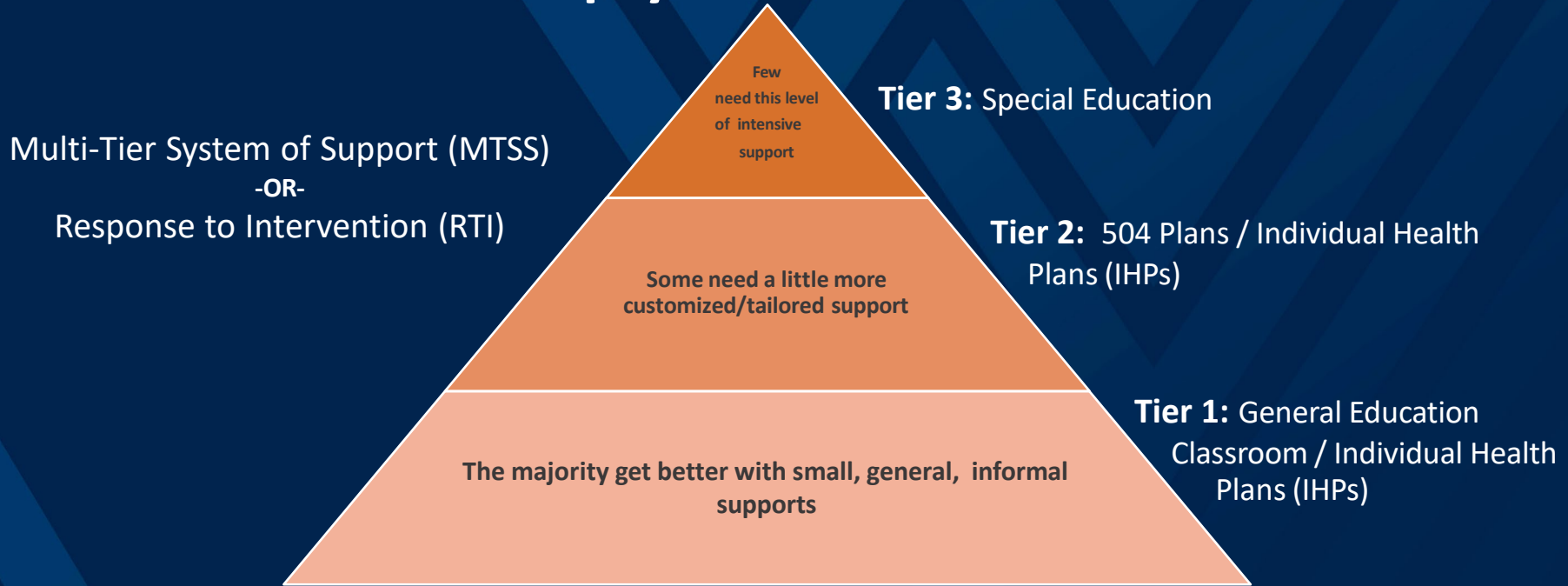
# Overarching Theme

- Guidelines are in-consistent for parents and their adolescent children
- Most schools were not equipped to help adolescents' transition back to school post-concussion.

# Public Health Model

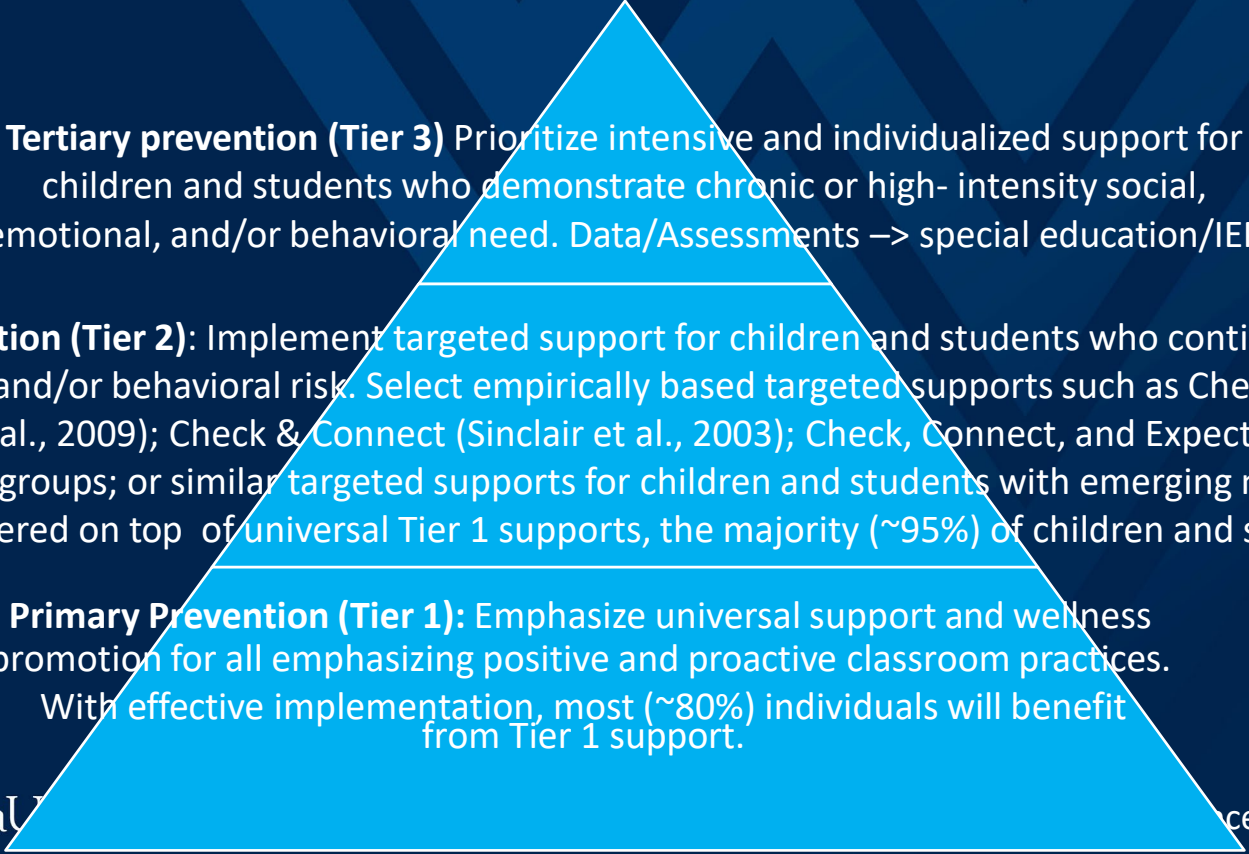


# Existing educational model for learning, behavior, medical & psych conditions



# Existing educational model for social/emotional concerns:

Source: Center for Pyramid Model Innovations, National Technical Assistance Center on Positive Behavioral Interventions and Supports).



**Tertiary prevention (Tier 3)** Prioritize intensive and individualized support for children and students who demonstrate chronic or high- intensity social, emotional, and/or behavioral need. Data/Assessments → special education/IEP

**Secondary Prevention (Tier 2):** Implement targeted support for children and students who continue to demonstrate social, emotional, and/or behavioral risk. Select empirically based targeted supports such as Check In Check Out (CICO; Hawken et al., 2009); Check & Connect (Sinclair et al., 2003); Check, Connect, and Expect (Cheney et al., 2009); social skills groups; or similar targeted supports for children and students with emerging needs. With targeted Tier 2 supports layered on top of universal Tier 1 supports, the majority (~95%) of children and students will benefit

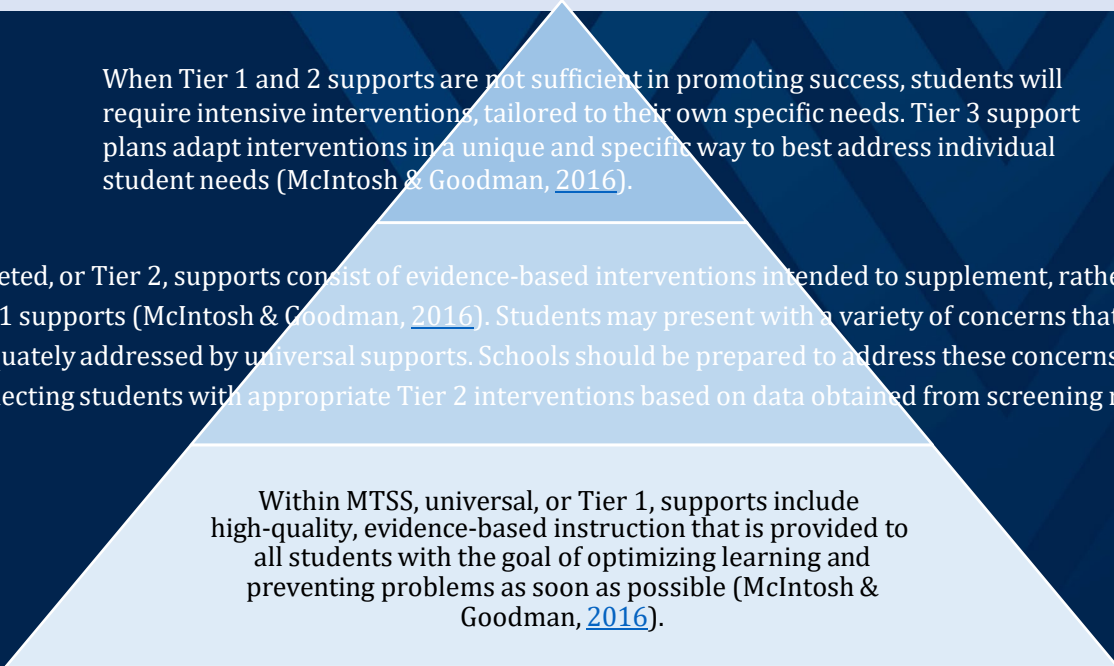
**Primary Prevention (Tier 1):** Emphasize universal support and wellness promotion for all emphasizing positive and proactive classroom practices.  
With effective implementation, most (~80%) individuals will benefit from Tier 1 support.



Most children experience symptoms recover within a week, although a small proportion are unwell for more than four weeks

The most reported symptoms were headache (62.2%) and fatigue (55.0%), and the median illness duration was six days. A total of 77 children (4.4%) experienced symptoms for at least 28 days, and this was more common in older children (5.1% in older v 3.1% in younger.)

Twenty five children had symptoms for at least 56 days



When Tier 1 and 2 supports are not sufficient in promoting success, students will require intensive interventions, tailored to their own specific needs. Tier 3 support plans adapt interventions in a unique and specific way to best address individual student needs (McIntosh & Goodman, [2016](#)).

Targeted, or Tier 2, supports consist of evidence-based interventions intended to supplement, rather than replace, Tier 1 supports (McIntosh & Goodman, [2016](#)). Students may present with a variety of concerns that may not be adequately addressed by universal supports. Schools should be prepared to address these concerns systematically by connecting students with appropriate Tier 2 interventions based on data obtained from screening measures.

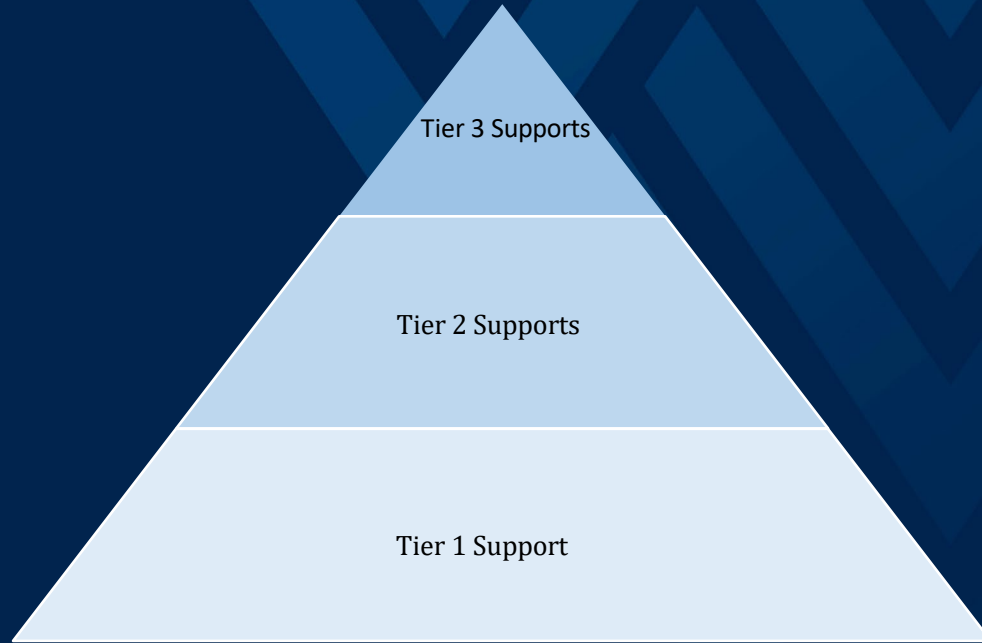
Within MTSS, universal, or Tier 1, supports include high-quality, evidence-based instruction that is provided to all students with the goal of optimizing learning and preventing problems as soon as possible (McIntosh & Goodman, [2016](#)).



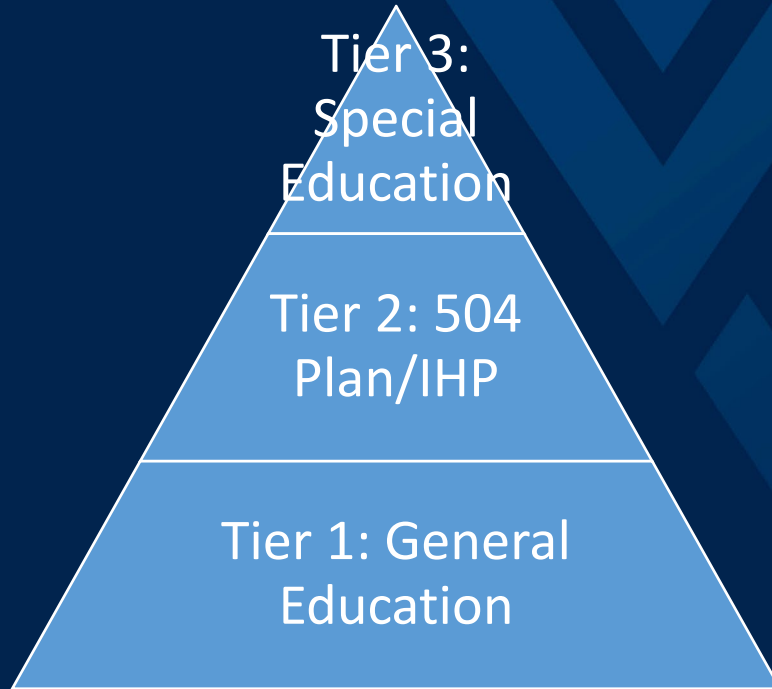
Most children who test positive for covid-19 and experience symptoms recover within a week, although a small proportion are unwell for more than four weeks

The most reported symptoms were headache (62.2%) and fatigue (55.0%), and the median illness duration was six days. A total of 77 children (4.4%) experienced symptoms for at least 28 days, and this was more common in older children (5.1% in older v 3.1% in younger.)

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# Concussion Management



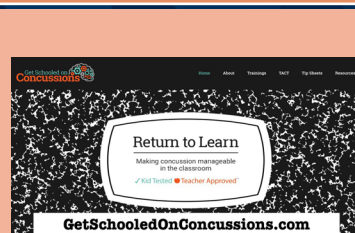
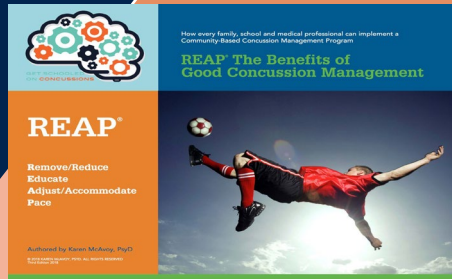
Majority of our RTL efforts for concussion are happening on a Tier 2 Level. We primarily train our School Nurses and Counselors

We are not building capacity with our Tier 1 First Responders (classroom teachers)

Majority of our systematic RTL interventions are at Tier 2 – when the student has struggled for 4+ weeks with “persisting symptoms” and may finally seek out rehabilitation at a concussion specialty clinic

# Training teachers at Tier 1 is Capacity Building. Capacity Building is essential for Sustainability in any large or small system

**Tier 1:** General Education  
Classroom &/or  
Individual Health  
Plans (IHPs)  
70% recovery rate **WITHIN**  
**28 days\***  
-Support needs to happen  
over days to weeks



How every family, school and medical professional can implement a  
Community-Based Concussion Management Program

# REAP® The Benefits of Good Concussion Management

# REAP®

**Remove/Reduce**  
**Educate**  
**Adjust/Accommodate**  
**Pace**



# Implementation Strategies

## Community Based Concussion Management

An “Interdisciplinary Team” = Adults who provide multiple perspectives of the student AND who provide multiple sources of data to gauge recovery status.

Family Team

School  
Team/Physical

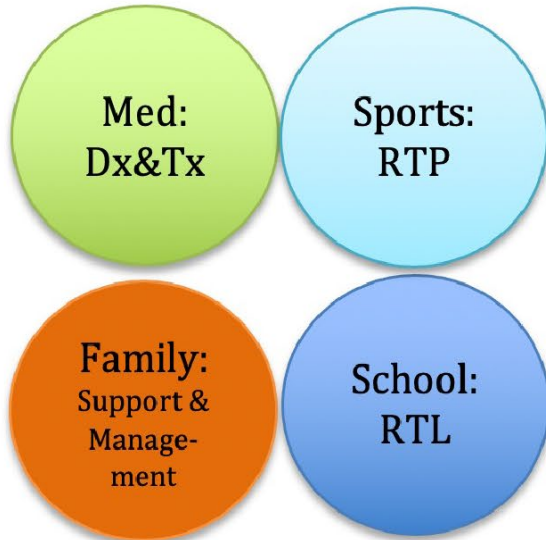
School  
Team/Academic

Medical Team

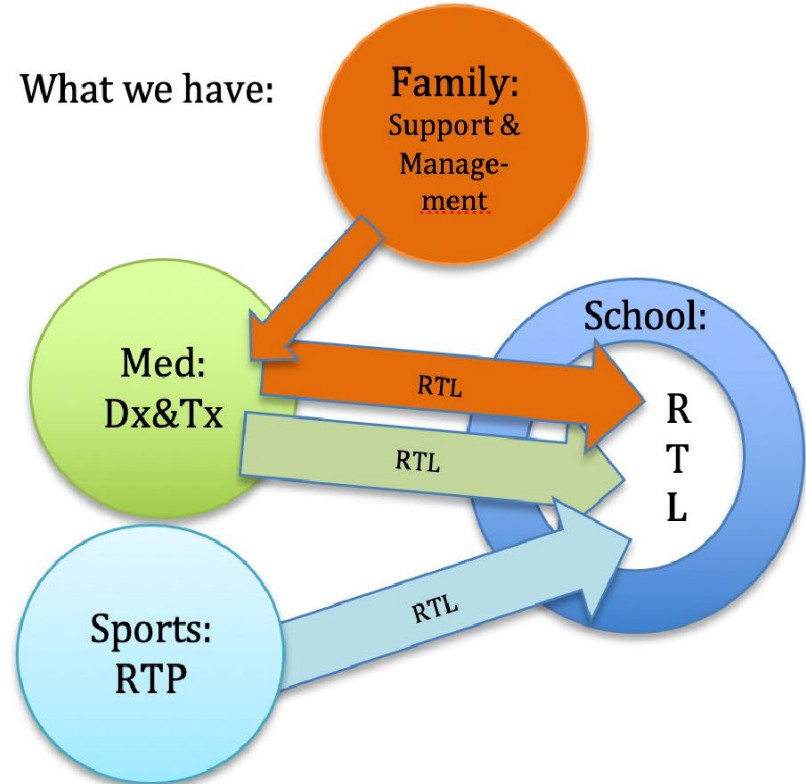


# Education has not yet “owned” RTL; Athletics and Medicine still direct RTL

What we want: Inter-disciplinary Teams  
Each team with equal & distinct roles  
Each team determines their own policy & procedures



What we have:



<p><b>Who will be on the family team?</b></p> <p>Students, Parents, Grandparents, Primary Caretakers, Siblings, Friends</p>	<p><b>Who will be on the School Team/Physical?</b></p> <p>Coaches, Athletic Trainers, PE Teachers, Playground Supervisors, School Nurses</p>	<p><b>Who will be on the School Team/Academic?</b></p> <p>Teachers, Counselors, School Psychologists, Social Workers, Administrators</p>	<p><b>Who will be on the Medical Team?</b></p> <p>Emergency Department, Primary Care Providers, Nurses, Concussions Specialists, Neurologists</p>
<p>Who from the family will watch, monitor and track the emotional and sleep/energy symptoms? And how will they communicate w/ school</p>	<p>Who at the school will watch, monitor and track the physical symptoms of the concussion?</p>	<p>Who at the school will watch, monitor and track the academic and emotional effects of the concussion?</p>	<p>How will the Medical Team get information from all of the other teams and who with medical team will be responsible for coordinating data and updates from the other teams?</p>

# Teacher Acute Concussion Tool (TACT)

- The Teacher Acute Concussion Tool (TACT) is the ONLY digital tool for Return to Learn Post-Concussion!
- The TACT is an electronic tool accessed easily by school nurses, ATC's, school counselor, administration, and PCP via the internet/QR code
- The TACT delivers 4 weeks of Return to Learn academic supports, via teacher email – in “real-time” => just when the student with a concussion is ready to re-enter the classroom
- No advanced training need; No time out of the classroom!



# Teacher Acute Concussion Tool (TACT)

## WV Landing Page

<https://www.getschooledonconcussions.com/west-virginia/>

*Password: TACTwvirginia2021*



## Welcome West Virginia Educators

We know that COVID-19 has created unique challenges for districts throughout the state leading to in-person vs. hybrid vs. remote learning. While the TACT was developed to provide guidance to teachers in the classroom, the contents of the TACT is equally helpful for students learning in a myriad of settings. We strongly suggest that teachers/schools coordinate a way to share the TACT information with parents/guardians supporting students with concussion who are learning (partially or fully) from home.

BROUGHT TO YOU BY:



### ACCESS TACT

4-week specific classroom strategies delivered directly to your inbox tailored to your teaching style, content area, environmental and student factors.



### ACCESS TIP SHEETS

Access to over 30 individually crafted lessons on how to support students in the classroom and with protracted recovery.



### ACCESS VIDEOS

Video tutorials on the academic support of concussion management in elementary, middle and high schools.

If you are having trouble accessing this page, please contact Amanda Acord-Vira at [amanda.acordvira1@hsc.wvu.edu](mailto:amanda.acordvira1@hsc.wvu.edu).

## TACT (Teacher Acute Concussion Tool)

**I am completing the TACT right now: \***

- ☐ In “real-time” – a student in your school has been diagnosed with a concussion/COVID and is returning to the classroom soon and/or has already returned to the classroom.
- ☐ In a training on how to support students, in general, post-concussion/COVID

Your Information

Name \*

First

Last

School or Work Email \*

Must use school or work email. Personal email addresses and school/work emails that don't align with this state subscription will be blocked.

School Information

School/Clinic \*

District/Organization \*

Role at school/work \*

▼

Survey

Student ID Number

Optional

Role at School/Work:

*Nurse*

*Administrator*

*Support*

*Teacher*

*School Mental Health*

*Counselor*

*Athletic Trainer*

*Clinic Staff*

*NP/PA*

*Parent*

*Other*

or Excellence in Disabilities



### Additional email addresses

Enter all email addresses of teachers/related service providers/parents (up to 10 max). Who you enter is up to you, however, all of this student's teachers should be included. Others/parents are optional.

	⊕ ⊖
	⊕ ⊖
	⊕ ⊖
	⊕ ⊖

### Upload any additional information

No file chosen

Max. file size: 10 MB.

### Student attends \*

- ☐ Elementary level
- ☒ Middle, High School or College level

### Middle, High School or College level

Please mark the current timeframe in the current grading period (1 = very beginning of the grading period; 3 = middle of the grading period; 5 = end of the grading period): \*

1	2	3	4	5
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SUBMIT

TACT Team <info@getschooledonconcussions.com>  
To: Dixon, Jeremy

Tue 7/18/2023 11:27 AM

Lesson-1.7-Mental-Fatigue-Strate...  
227 KB

GSOC\_Cognitive\_Exertion\_Analog...  
289 KB

Lesson-1.9-Slowed-Processing-Sp...  
183 KB

Lesson-1.11-Avoid-the-Empty-Gra...  
187 KB

Lesson-1.12-Short-Term-Memory-...  
187 KB

Lesson-1.8-Symptom-Wheel.pdf  
200 KB

6 attachments (1 MB) Save all to OneDrive - WVUM & HSC Download all

Dear Teacher,

You are receiving this email from Jeremy Dixon - TEST from WVU CED on 07/18/2023 letting you know that student ID#:123456789 is returning to your classroom following a concussion/COVID.

The TACT will help you 1.) ease any student back into the classroom - after they have missed instruction due to injury like a concussion (or illness like COVID), 2.) ease any student back into a reasonable amount of work - after they have been physically ill or cognitively unavailable to learn, and 3.) help you and your student check for mastery and earn a fair grade.

Concussion research tells us that 70% of school-aged students resolve their concussion WITHIN 4 weeks. Therefore, quick, nimble and flexible "differentiated instruction" depends on you - the teachers - the FIRST RESPONDERS - in a seamless Return to Learn post-concussion (post-COVID, post-trauma). Based upon answers to the survey, here are some ideas to help you get started. We ask you to focus on these 3 things, in this order:

Mental Fatigue	Slowed Processing Speed	Short-Term Memory
Symptom (aka) Energy Management <ul style="list-style-type: none"> <li>Impacts attendance</li> <li>Impacts instruction</li> </ul>	Impacts work output <ul style="list-style-type: none"> <li>REMOVE non-essential work</li> <li>REDUCE semi-essential work</li> </ul>	Impacts demonstration of mastery, tests & grades <ul style="list-style-type: none"> <li>"Fair Testing"</li> <li>"Alternative Appraisals"</li> </ul>

# Notification of Concussion and Classroom Resources

- Dear Teacher,

You are receiving this email from Jeremy Dixon - TEST from WVU CED on 11/12/2023 letting you know that student ID#:123456789 is returning to your classroom following a concussion/COVID.

The TACT will help you:

- 1.) ease any student back into the classroom - after they have missed instruction due to injury like a concussion (or illness like COVID),
- 2.) ease any student back into a reasonable amount of work - after they have been physically ill or cognitively unavailable to learn, and
- 3.) help you and your student check for mastery and earn a fair grade.

## I have this student in both morning and afternoon classes

- Due to biochemical changes in the brain, a concussion (or COVID) can cause an **energy crisis** that leads to **mental fatigue** which leads to symptoms of headaches, dizziness, tiredness, "brain fog" => difficulty concentrating, remembering, thinking, mood and behavioral changes => irritability, sadness, anxiety, etc. Flaring of symptoms is one of the biggest contributors to truancy and getting behind academically because students with a concussion, COVID, the flu, mono and/or mental health trauma often just don't feel "well enough" to be AT school. Missed instruction from the classroom (with concussion = days to a week for rest and recovery; with COVID = 5+ days for isolation) is expected, and returning to the classroom with some symptoms of "brain fog" is expected for days to weeks to (sometimes, but hopefully not often) months. Your **1st goal** in supporting a student returning back into your classroom following concussion/COVID/trauma (or any medical/psychological condition that has kept them out of school for days/weeks) is to give them a "soft landing" and help them manage symptoms so they can be physically and cognitively present in class, all day, every day, so they can hear instruction.

### **Mental Fatigue** Strategies:

- "Pace" their energy - allow frequent 5 to 10 minute eye/brain/water/bathroom breaks **IN** the classroom after periods of mental exertion and/or
- "Strategic Rest Breaks" - a proactive 20 minute rest break in the school clinic 1X mid-morning and/or 1X mid-afternoon

If you teach this student in both morning and afternoon classes, encourage your student to pace energy so they can stay at school all day, if possible. **Being able to attend school and hear instruction is a necessary 1st step before adjustment of workload can happen.**

- Attachment(s):
  - [Lesson-1.7-Mental-Fatigue-Strategies](#)

## There are times in my classroom when there is minimal structure (center-based, hands on learning) and there are other times when my classroom is very structured (individual seat work, paper product output).

- We teach students and teachers to think of any injury or illness (be that from a concussion or COVID, the flu, mono, trauma) as an "energy crisis" causing cognitive inefficiency to use these 2 analogies:
  - "You are like an iPhone 3 updates behind; you are not broken, you are running on a low battery or inefficient software".
  - "Be like a car with a small gas tank; Do, then Fuel"

If you are teaching a lesson in a loud noise, highly visual environment, watch out for **mental fatigue** (and use **Mental Fatigue** Strategies from Question 1). On the other hand, experiential group work, discussion and oral presentations can sometimes also be less taxing for some students with cognitive inefficiency because it is traditionally less academic and they can more passively learn.

If you are teaching a lesson that demands concentrated attention and paperwork output, watch out for **mental fatigue** (and use **Mental Fatigue** Strategies from Question 1). Keep in mind that not ALL academic work is taxing to ALL students (depending upon their pre-illness/injury level of mastery), therefore, your student with "brain fog" may or may not flare symptoms in every topic area.

- Attachment(s):
  - [Cognitive Exertion Analogy-Garage](#)

# Mental Fatigue (Morning class vs. afternoon class)

- Flaring of symptoms is one of the biggest contributors to truancy and getting behind academically because students with a concussion often just don't feel "well enough" to be AT school.
- Missed instruction from the classroom is expected and returning to the classroom with some symptoms of "brain fog" is expected for days to weeks to (sometimes, but hopefully not often) months.

# Mental Fatigue (Morning class vs. afternoon class)

- **1st goal** in supporting a student returning back into your classroom following concussion is to give them a "soft landing" and help them manage symptoms so they can be physically and cognitively present in class, all day, every day, so they can hear instruction.

## **Mental Fatigue Strategies:**

- "Pace" their energy - allow frequent 5 to 10 minute eye/brain/water/bathroom breaks IN the classroom after periods of mental exertion and/or
- "Strategic Rest Breaks" - a proactive 20 minute rest break in the school clinic 1X mid-morning and/or 1X mid-afternoon
- Encourage your student to pace energy so they can stay at school all day, if possible. **Being able to attend school and hear instruction is a necessary 1st step before adjustment of workload can happen.**



**Some of the content I teach lends itself to in-class verbal participation/discussion and some of the content I teach lends itself to individual paperwork/project-based demonstration of mastery.**

- When you are teaching lessons that lend themselves to classroom discussion and participation, do everything you can to have your student with cognitive inefficiency be present in the classroom (see **Mental Fatigue** Strategies from Question 1) and allow for extra "wait time" when participating. When you are teaching a lesson that requires your students to show mastery of material by producing paper products/projects, your **2nd goal** will be to adjust the in-class and homework load for your student with cognitive inefficiency. Due to **slowed processing speed**, a student with "brain fog" cannot complete ALL in-class work and homework. You must decide what is absolutely essential for the student to know and learn over the course of recovery which might take up to 4 weeks:
  - REMOVE non-essential work (NICE to knows) and
  - REDUCE semi-essential work (NEED to knows) (i.e., every other problem) and
  - Make a plan for a reasonable amount of **essential** work (MUST knows)

REMOVE and REDUCE instead of EXTEND and POSTPONE! Keep your Grade Book populated throughout recovery. Grade on adjusted "essential" work instead of holding "0's" in the Grade Book for a later time. Empty Grade Books lead to heightened anxiety!

- Attachment(s):
  - [Lesson-1.9-Slowed-Processing-Speed-Strategies](#)
  - [Lesson-1.11-Avoid-the-Empty-Grade-Book](#)

**Some of my content builds on past learning from yesterday; some of my content builds on general concepts from weeks to months ago.**

- Once your student with any injury (concussion), illness (COVID, flu, mono) or trauma is managing symptoms well enough to be attending school and hearing instruction (**Mental Fatigue**) and once you have guided a reasonable amount of workload (**Slowed Processing Speed**), your **3rd goal** is to ask: how do you hold your student accountable for mastery of learned material (**Short-Term Memory STM**)?

Sometimes you teach content that layers over "general concepts" built over weeks or months and sometimes you teach content that layers over skills learned yesterday. If you are teaching new content that has already been learned solidly in the past, know that a student with "brain fog" is going to have more success in remembering new material ( aka **short-term memory** if it is already embedded in meaningful old learning (long-term memory). If you are teaching content that requires mastery of 1 concept before moving on (i.e., Math), check learning before moving on to the next concept. Check mastery of content by having student complete progressively harder problems but remove "practice" problems or consider having student only complete every other problem. For a short time, consider having your student only report out final answers instead of outlining the process of discovery.

- Attachment(s):
  - [Lesson-1.12-Short-Term-Memory-Strategies](#)

**Grading:**

- Research shows that we can hope that 70% of students with a concussion will resolve within 28 days. While there's not enough research yet on how long we can expect COVID-19 to impact learning, we are aware that some COVID "brain fog" can be minimal and some can last longer. That means that if a student sustains a concussion in the beginning 1/3 of a grading period, or gets ill with COVID-19 in the beginning 1/3 of a grading period AND has a good recovery, there is still a good chance the illness or injury will have minimal impact on grades as there is ample time for recovery before the end of a grading period. Teachers can help to promote as smooth a recovery as possible by: 1.) keeping students comfortable at school with a focus on good symptom management (using **Mental Fatigue** Strategies), 2.) keeping the student moving forward by REMOVING and REDUCING instead of EXTENDING and POSTPONING work (using **Slowed Processing Speed** Strategies) and 3.) finally by holding your student accountable for mastery of the material via "fair testing" or "alternative appraisals" (using **Short-Term Memory** Strategies). Consider exempting student from tests for the first 2 weeks of recovery. Focusing on these supports in the beginning of a grading period gives the student and teacher plenty of time to be on track for mid-grading period expectations, test/finals, projects and ultimately a successful end of grading period mark.



# In-class verbal participation/discussion vs. individual paperwork/project-based demonstration of mastery.

- When you are teaching lessons that lend themselves to classroom discussion and participation, do everything you can to have your student with cognitive inefficiency be present in the classroom and allow for extra “wait time” when participating
- When you are teaching a lesson that requires your students to show mastery of material by producing paper products/projects, your **2nd goal** will be to adjust the in-class and homework load for your student with cognitive inefficiency.

# In-class verbal participation/discussion vs. individual paperwork/project-based demonstration of mastery.

- Due to slowed processing speed, a student with "brain fog" cannot complete ALL in-class work and homework. You must decide what is absolutely essential for the student to know and learn over the course of recovery which might take up to 4 weeks:
  - REMOVE non-essential work (NICE to knows) and
  - REDUCE semi-essential work (NEED to knows) (i.e., every other problem) and
  - Make a plan for a reasonable amount of essential work (MUST knows)
- REMOVE and REDUCE instead of EXTEND and POSTPONE! Keep your Grade Book populated throughout recovery. Grade on adjusted "essential" work instead of holding "0's" in the Grade Book for a later time. Empty Grade Books lead to heightened anxiety!

# Some of my content builds on past learning from yesterday; some of my content builds on general concepts from weeks to months ago.

- **3rd goal** is to ask: how do you hold your student accountable for mastery of learned material
- If you are teaching content that requires mastery of 1 concept before moving on (i.e., Math), check learning before moving on to the next concept.
- Have student complete progressively harder problems but remove “practice” problems or consider having student only complete every other problem.
- For a short time, consider having your student only report out final answers instead of outlining the process of discovery.

# Grading

- Teachers can help to promote as smooth a recovery as possible by:
  - 1.) keeping students comfortable at school with a focus on good symptom management (using Mental Fatigue Strategies),
  - 2.) keeping the student moving forward by REMOVING and REDUCING instead of EXTENDING and POSTPONING work (using Slowed Processing Speed Strategies) and
  - 3.) finally by holding your student accountable for mastery of the material via "fair testing" or "alternative appraisals" (using Short-Term Memory Strategies).

**Some of the content I teach is by lecture (auditory) and some of the content I teach has numerous visual supplements.**

- If you are teaching in an auditory fashion, watch out for noise overstimulation contributing to **Mental Fatigue**. Allow:
  - use of ear buds or noise canceling headphones
  - allow student a "quiet place" to study at school (library, counseling office)
  - a "quiet lunch" arrangement (lunch in a classroom away from the busy cafeteria)

If you are teaching a topic with a lot of visual supplements, watch out for visual overstimulation contributing to **Mental Fatigue**. Headaches and nausea from a concussion, from concussion, COVID or from the flu can be exacerbated by rigorous eye strain/head movements. Allow:

- "listening and learning"
- buddy notes
- teacher outlines with highlights
- preferential seating: sitting closer to board if that provokes less symptoms or at the back of the room for videos if that provokes less symptoms
- paper handouts with minimal visual stimulation
- 1-sided copies
- Tinted overlays
- Colored (subtle colors) paper

Aid these academic supports with a lighter workload (**Slowed Processing Speed**) and creative grading (**Short-Term Memory** Strategies).

- *Attachment(s):*
  - [Lesson-1.8-Symptom-Wheel](#)

#### **Technology:**

- Electronic and visual technology can be taxing to students recovering from a concussion or COVID because focused eye demands can be exhausting. Therefore, when you are teaching a lesson where technology is needed, watch out for **Mental Fatigue** which may lead to flaring of symptoms. The common medical advice of NO computers, NO screens is not a reasonable or practical academic suggestion for any student who is returning to learn following an injury (such as a concussion) or an illness (such as COVID, mono or the flu). Instead, allow for measured/limited time on technology while keeping symptoms at bay with **Mental Fatigue** Strategies:
  - "Pacing"
  - "Strategic Rest Breaks"
  - Adjust font size, style and background lighting

Lighten work output expectations (**Slowed Processing Speed** Strategies) and be creative with assessing mastery and giving grades (**Short-Term Memory** Strategies).

#### **Reading:**

- Reading can be taxing to students with a concussion or COVID because focused eye demands can be exhausting. Therefore, when you are teaching a lesson where reading is needed, watch out for **Mental Fatigue** which may lead to flaring of symptoms. The common medical advice of NO reading during a concussion is not a reasonable or practical academic suggestion for any student who is returning to learn following an injury (such as a concussion) or illness (such as COVID, mono or the flu). Instead, allow for measured/limited time reading to keep symptoms at bay with **Mental Fatigue** Strategies. Allow for:
  - "Pacing"
  - "Strategic Rest Breaks"
  - Audio books
  - Larger font
  - Tinted overlays
  - Colored paper (subtle colors)
  - Tracking/Frame guide

Lighten work output expectations (**Slowed Processing Speed** Strategies) and be creative with assessing mastery and giving grades (**Short-Term Memory** Strategies).

# Lecture (auditory) vs. visual supplements.

- If you are teaching in an auditory fashion, watch out for noise overstimulation contributing to Mental Fatigue. Allow:
  - use of ear buds or noise canceling headphones
  - allow student a "quiet place" to study at school (library, counseling office)
  - a "quiet lunch" arrangement (lunch in a classroom away from the busy cafeteria)

# Lecture (auditory) vs. visual supplements.

- If you are teaching a topic with a lot of visual supplements, watch out for visual overstimulation contributing to Mental Fatigue. Headaches and nausea from a concussion can be exacerbated by rigorous eye strain/head movements. Allow:
  - "listening and learning"
  - buddy notes
  - teacher outlines with highlights
  - preferential seating: sitting closer to board if that provokes less symptoms or at the back of the room for videos if that provokes less symptoms
  - paper handouts with minimal visual stimulation



# Technology & Reading

- “Pacing”
- “Strategic Rest Breaks”
- Audio books
- Larger font
- Tinted overlays
- Colored paper (subtle colors)

# (Tier 1) Classroom Teachers



[1.1]

RTL for Tier 1/Classroom Teachers



[1.2]

Elementary vs. High School Language



[1.3]

How a Concussion Feels



[1.4]

Three Common Effects of Cognitive Inefficiency



[1.5]

Cognitive Inefficiency = Energy Crisis



[1.6]

What is Mental Fatigue?



[1.7]

Mental Fatigue Strategies



[1.8]

Symptom Wheel



[1.9]

Brain Fog Leads to Slowed Processing Speed Strategies



[1.10]

Biggest Mistake in RTL plans related to Slowed Processing Speed



[1.11]

Avoid the Empty Grade Book



[1.12]

Short-Term Memory Strategies



[1.13]

Biggest Mistake in RTL plans related to STM



[1.14]

Finals & Grades with Acute Cognitive Inefficiency



[1.15]

Fading Academic Adjustments



[1.16]

What to Do About Missed Instruction



[1.17]

What to Do About Work Output



[1.18]

What to Do About Tests



[1.19]

Teacher Feedback Form



[1.20]

Symptom Progress Monitoring



[1.21]

Extra-Curricular Activities



[1.22]

Making "School at Home" Successful After a Concussion



[1.23]

Keep a "School" Routine at Home: Elementary School Students



[1.24]

Keep a "School" Routine at Home: Middle & High School Students



[1.25]

A Hybrid Model: Some Days at School; Some Days at Home

## PHYSICAL:

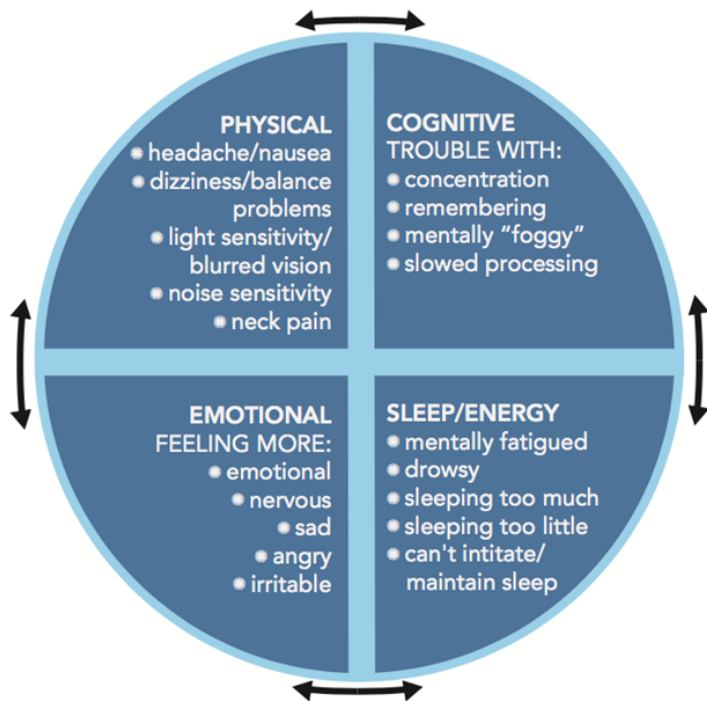
- "Strategic Rest" scheduled 15 to 20 minute breaks in clinic/quiet space (mid-morning; mid-afternoon, and/or as needed)
- Sunglasses (inside and outside)
- Quiet room/environment, quiet lunch, quiet recess
- More frequent breaks in classroom and/or in clinic
- Allow quiet passing in halls
- REMOVE from PE, physical recess, & dance classes without penalty
- Sit out of music, orchestra and computer classes if symptoms are provoked

## EMOTIONAL:

- Allow student to have "signal" to leave room
- Help staff understand that mental fatigue can manifest in "emotional meltdowns"
- Allow student to remove him/herself to de-escalate
- Allow student to visit with supportive adult (counselor, nurse, advisor)
- Watch for secondary symptoms of depression and anxiety usually due to social isolation and concern over "make-up work" and slipping grades. These extra emotional factors can delay recovery

# Symptom Wheel

## Suggested Academic Adjustments

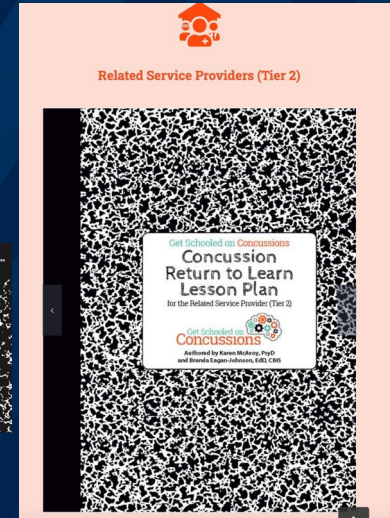


Read "Return to Learning: Going Back to School Following a Concussion" at [nasponline.org/publications/cq/40/6/return-to-learning.aspx](http://nasponline.org/publications/cq/40/6/return-to-learning.aspx) <sup>8</sup>

# Training Related Service Providers (school nurse, counselors, mental health) at Tier 2 for “persisting symptoms”

**Tier 3:** Special Education  
Individualized  
Education Plan (IEP)

**Tier 2:** 504 Plans &  
Individual Health  
Plans (IHPs)



**Tier 1:** Classroom Teachers



West Virginia University



& Aasha Brain Clinic

\* Zemek R, Barrowman N, Freedman SB, et al. Concussion in Children With Acute Concussion in the ED. JAMA. 2016;315(10):1014–1025. doi:10.1001/jama.2016.1203

Center for Excellence in Disabilities

# Tier 2 Supports

## Oculomotor/Convergence Insufficiency [Eyes]

- Limited computer screens/reading
- Large print
- Teacher/buddy notes
- Tinted overlays
- Preferential seating
- Audio books
- Corrective lenses

**Occupational or  
Physical Therapy**

## Vestibular Auditory Processing [Ears/Balance]

- Preferential seating
- Passing in halls early or late
- Extra time for locker
- Elevator key
- Headphones/ear buds

**Occupational or  
Physical Therapy**

## Mood/Behavior [Emotions & Behaviors]

- Extra TLC
- Clear expectations about work
- Check in/Check out
- Emotion Regulation
- Coping Mechanisms/Cog-Beh Tools

**Psych Support**

## Cervical Strain

[Increases headaches]

- Second set of books
- Extra time for locker
- Head on desk

**Physical Therapy (PT)**

## Postural Dizziness

- Increased water
- Frequent Water breaks
- Bathroom breaks
- Elevator key
- Slowly moving from sitting to standing

**PT**

## (Tier 2) Related Service Providers



[2.1]

RTL for Tier  
2/Related Service  
Providers



[2.2]

Return to School  
versus Return to  
Learn



[2.3]

Failure to Return to  
School Complicates  
Return to Learn



[2.4]

Ascending Levels of  
Support or  
MTSS/RTI Tiers



[2.5]

Concussion  
Rehabilitation



[2.6]

Phases of Recovery



[2.7]

Underlying Reasons  
Behind Protracted  
Recovery



WHEN • PT 1

[2.8]

When to Write a 504  
Plan (Part 1)



WHEN • PT 2

[2.9]

When to Write a 504  
Plan (Part 2)



HOW TO WRITE

[2.10]

How to Write a 504  
Plan



[2.11]

What a 504 Plan is  
NOT



[2.12]

Finals & Grades  
with Protracted  
Cognitive  
Inefficiency



[2.13]

When to Return Your  
Student to PE Class  
&/or Play at Recess?



[2.14]

School Notification of  
Suspected  
Concussion Incident  
Report



[2.15]

Sample School  
Notification of Head  
Injury



[2.16]

Return to Learn  
Training Pyramid

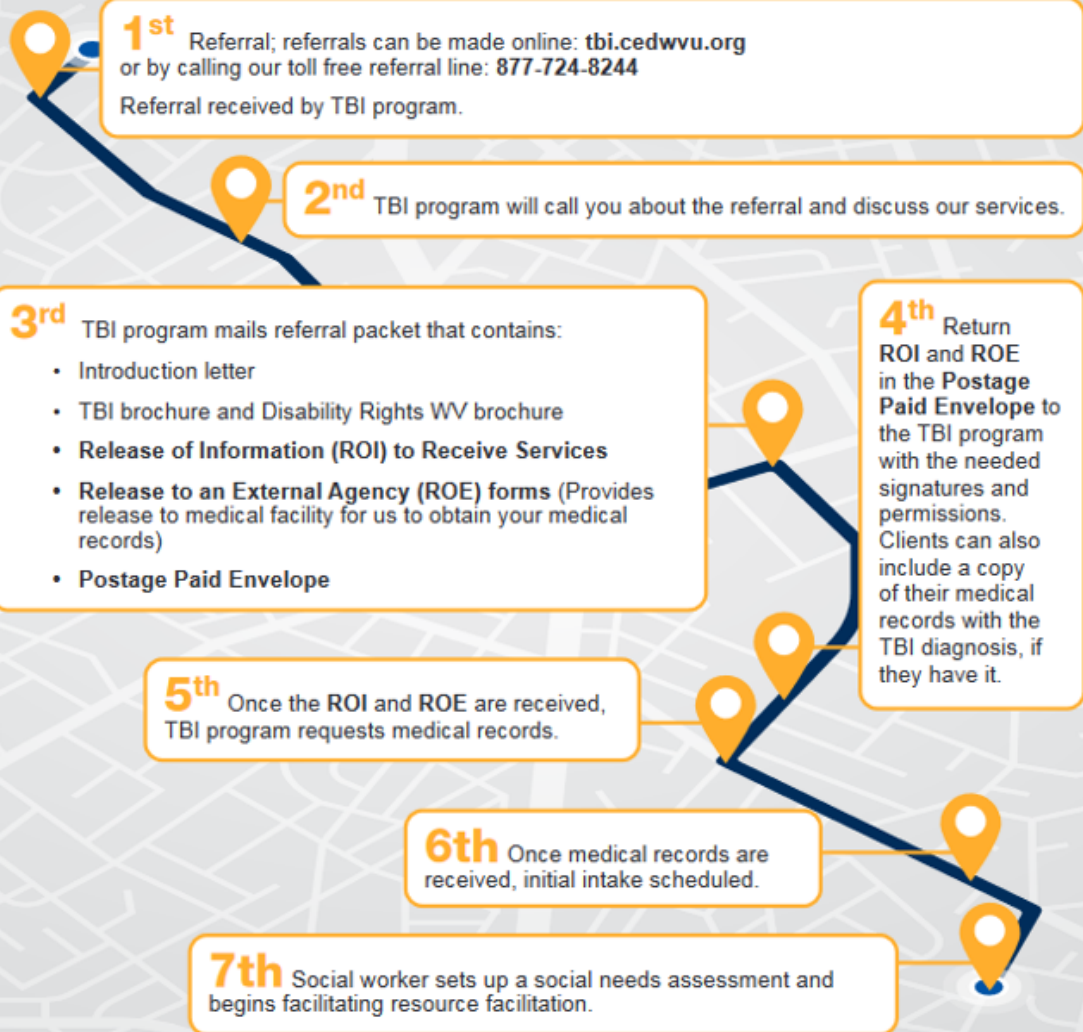


# Traumatic Brain Injury Services

- WVU CED is West Virginia's designated lead agency for coordination of services for West Virginians with TBI.
- Variety of services and resources offered who have experienced a TBI and their caregiver

# Eligibility of Services

- All services are free of charge to anyone who:
  - Is a current West Virginia resident
  - Provided medical documentation of a traumatic brain injury (TBI) to TBI Intake Coordinator



Program Manager  
Cortland Nesley

Intake Coordinator  
Carrie Cobun-Stark

Program Assistant  
Matthew Ryan

Outreach Coordinator  
Jeremy Dixon

Center for Excellence in Disabilities



## Resource Coordinators

Delena Arthur

Michelle Earl

Sharlene Liberto

Angela Morales

Courtney Pride

# Resource Coordination & Navigation

- Person centered planning
- Social Needs Assessment performed with regionally located Social Workers
- Create a plan to address any immediate needs, improve quality of life, and promote independence.



# Neuropsychological Evaluations

---



Evaluation that identifies strengths/weaknesses and create a comprehensive plan of strategies to improve quality of life



These evaluations may benefit a patient in the functional aspects of life and will be administered by Licensed WV Professionals.



Payment for this services is provided through TBI Services.

# Financial Assistance



**Funds For You** is a “payee of last resort” program set up to provide goods and services that will increase independence for our clients.



Funding provided by WV Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities funds the program fully.



# Financial Assistance

- Permitted Goods and Services
  - Medical/dental/vision services
  - Adaptive equipment or assistive technology
  - Home modifications
  - Therapy services (physical, speech, cognitive, and occupational)
  - Other items to promote independence

# Technical Assistance

- TBI Services can provide technical assistance to agencies that request information or supports relating to TBI.
- We also offer the educational Big Brain at multiple events across the state.





The Teacher Acute Concussion Tool

# TACT

is the **ONLY** digital tool for Return to Learn Post-Concussion!

## Instructions

- Scan QR Code or visit [www.getschooledonconcussions.com/west-virginia/](http://www.getschooledonconcussions.com/west-virginia/)



- Enter Password: TACTwv2021
- Click on "Access TACT"
- The TACT asks teachers to answer 7 questions (elementary school teachers) or 8 questions (middle/high school teachers) about WHAT, WHEN & HOW they teach
- The TACT sends immediate academic guidance to teachers, based on their answers to adjust their classroom to the Return to Learn (RTL) needs of the student post-concussion
- The TACT automatically sends 4 weeks of emails with continued academic guidance and support



Have you had a Traumatic Brain Injury?

Answer the questions below using Step 1 of The Ohio State University Traumatic Brain Injury Identification Method Screening Tool below:

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.
2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?
3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or on the playground?
4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone or from being shaken violently? Have you ever been shot in the head?
5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? If you served in the military, think about any combat or training-related incidents?

If you answered **YES** to any of these questions above, you may be eligible to receive services from our program.

# I am a person with a Brain Injury.

---

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

---



West Virginia University

CENTER FOR EXCELLENCE IN DISABILITIES  
TRAUMATIC BRAIN INJURY SERVICES

**Please turn  
card over**

I can best communicate in a calm, non-confrontational manner.  
If you observe any of the symptoms below, please help me by  
calling the emergency contact listed on this card. **THANK YOU.**

---

### **My Symptoms Include:**

- ☐ Poor coordination, balance or muscle control.
  - ☐ Slurred speech, impaired judgement.
  - ☐ Impaired attention, concentration, memory.
  - ☐ Delayed thought processing and response time.
  - ☐ Difficulty controlling anger or aggressive behavior.
  - ☐ Seizures, headaches or fatigue.
  - ☐ Sensitivity to light and sound.
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## **TBI Support Group Calendar**

<b>Group</b>	<b>Day of Month</b>	<b>Time</b>	<b>Contact</b>
Morgantown Brain Injury Support Group	First Thursday of each month	6:00 pm — 7:00 pm	Courtney Pride <a href="mailto:courtney.pride@hsc.wvu.edu">courtney.pride@hsc.wvu.edu</a> (304) 293-4692
Eastern Panhandle Brain Injury Support Group	Second Monday of each month	6:30 pm— 8:00 pm	Sarah Hitchings <a href="mailto:wvepbig@gmail.com">wvepbig@gmail.com</a> (304) 596-3550
Brain Injury Group of Southern WV	Third Tuesday of each month	12:00 pm — 2:00 pm	Shannon Hughart <a href="mailto:shannon@pnbwv.com">shannon@pnbwv.com</a> (304) 222-1132
Monthly Mindfulness Sessions	Third Friday of each month	12:00 pm— 1:00 pm	Cortland Nesley <a href="mailto:tbi@hsc.wvu.edu">tbi@hsc.wvu.edu</a> 877-724-8244
Mid-Ohio Valley Brain Injury Support and Informational Group	Fourth Tuesday of each month	5:30 pm— 6:30 pm	Sara Rose <a href="mailto:srose@jcdworks.com">srose@jcdworks.com</a> (304) 273-9311 x307
Brain Injury Group at Marshall	Last Wednesday of each month	6:00 pm— 7:30 pm	Kelly Rutherford <a href="mailto:davis139@marshall.edu">davis139@marshall.edu</a> (304) 696-2982
Caregiver Support Group	Last Friday of each month	12:00 pm— 2:00 pm	Carrie Cobun-Stark <a href="mailto:ccobun@hsc.wvu.edu">ccobun@hsc.wvu.edu</a>

# 2024 TBI Conference

March 2024

Conference Agenda TBA

Professionals, Individuals  
with TBI, & Caregivers



# How to make a referral?

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Call Toll Free: 877-724-8244.

<https://tbi.cedwvu.org/>

Then click:

**REFER SOMEONE TO THE PROGRAM**





Thank you!



# Evaluation



[https://wvu.qualtrics.com/jfe/form/SV\\_0D84uHR5SCCoSLc](https://wvu.qualtrics.com/jfe/form/SV_0D84uHR5SCCoSLc)