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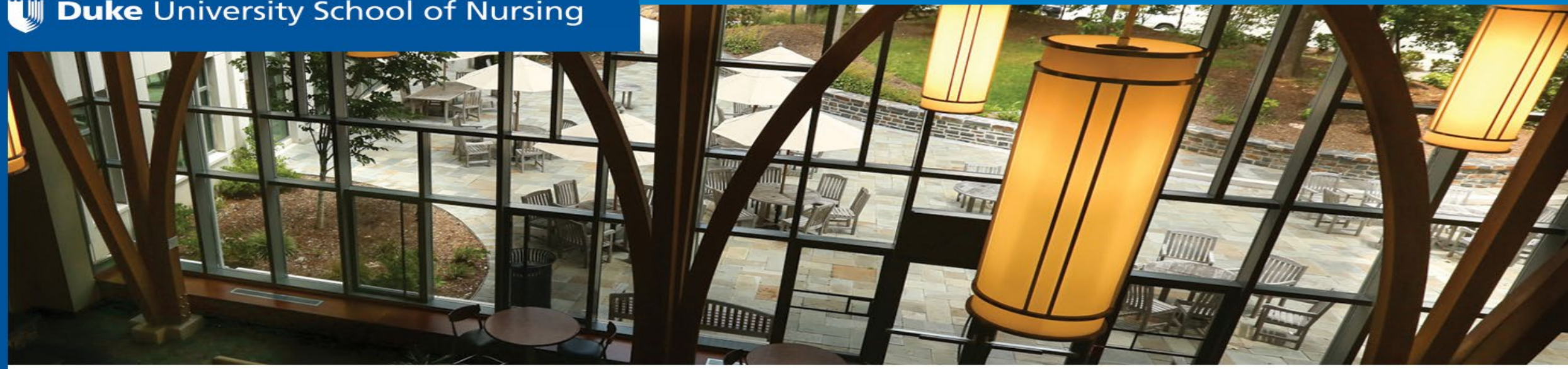

Challenges in TBI Transitional Care

Examining Traumatic Brain Injury as a Chronic Condition: A Workshop

Session 4: Gaps in The Current Landscape of Rehabilitation Care and Specialized Services for TBI as a Chronic Condition

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Challenges in TBI Transitional Care

- Poor post-hospital outcomes
- Numerous TBI-related issues negatively impacting self-management
  - **Navigating transitions in health and healthcare systems**
  - Coordinating care
  - Following provider guidance
- Lacking pre- and post-hospital support
  - Patient/family education
  - Providers with TBI expertise in outpatient setting
  - Care continuity
  - **Limited & fragmented access to post-hospital services and supports**
- Increased burden on family
- Desire for more support from providers

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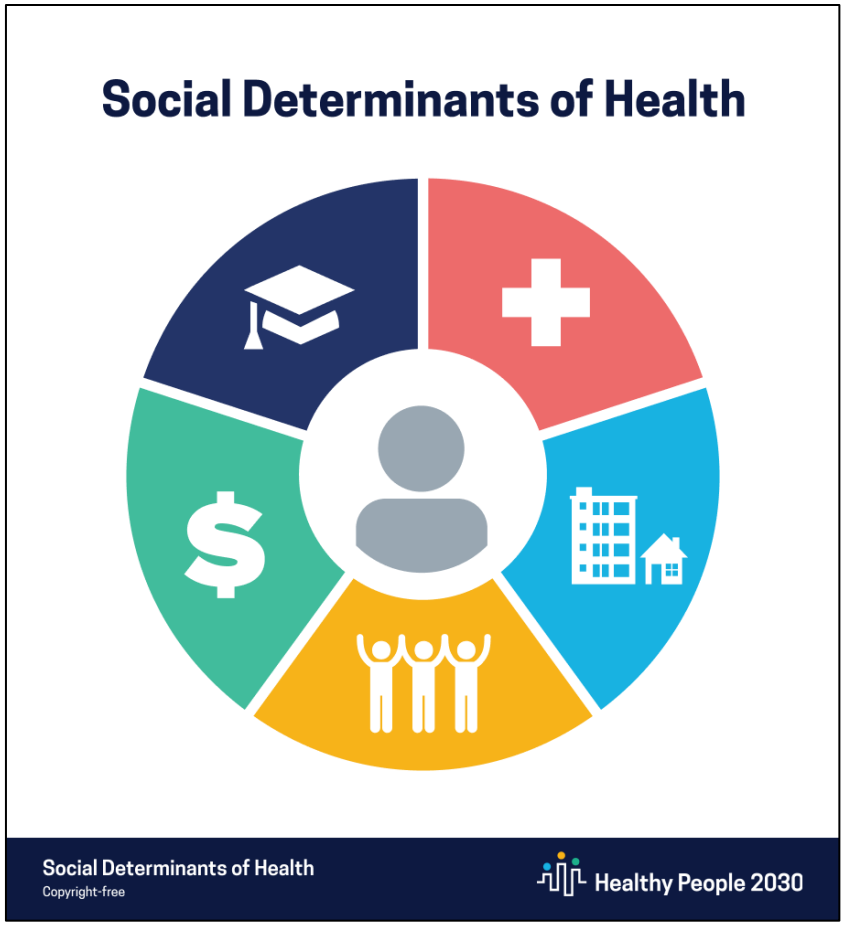
4. Ibemere, S. McReynolds, V., You, B., Anaya, B., Huang, M., Gonzalez-Guarda, R., Bettger, J.P., Oyesanya, T.O. (2024). Challenges in the transition from acute hospital care to home for Spanish-speaking Latino patients with TBI and families: Perspectives of healthcare providers and interpreters. Journal of Racial and Ethnic Health Disparities. doi: 10.1007/s40615-024-02088-9

Social Determinants of Health Influence Care Transitions

1. **Economic Stability**
   - Finances: health insurance status, money saved pre-injury
   - Home environment stability
   - Food insecurity
2. **Education Access and Quality**
   - Educational level and access to quality education
   - Personal health literacy
3. **Health Care Access and Quality**
   - Access to high quality providers in close proximity
   - Language barriers when communicating with health and service providers
   - Support from providers to manage wellbeing, health, healthcare
   - Resources from health system
4. **Neighborhood and Built Environment**
   - Safety of home environment
   - Presence of hazards in or near environment
5. **Social and Community Context**
   - Support from family, friends to manage wellbeing, health, and healthcare
   - Access to community-based resources



https://health.gov/healthypeople/priority-areas/social-determinants-health

Addressing TBI-Related Challenges with Transitional Care*

Transitional care is defined as actions in the clinical encounter designed to ensure the coordination and continuity of care for patients transferring between different locations or levels of care.

*High need for more TBI-specific transitional care programs

Sample Transitional Care Strategies
1. Identification of family caregiver(s) to support patient
2. Discharge planning/preparation
3. Patient/family needs assessment
4. Goal assessment, setting, and support for goal achievement
5. Referral to community-based services and resources based on needs and goals; services & resources may be TBI-specific
6. Patient/family education and training on self- and family-management of TBI and on Brain Injury Coping Skills (BICS)
7. Medication / complexity management
8. Care coordination / patient navigation
9. Interdisciplinary provider collaboration and accountability
10. Development of individualized urgent/emergent care plan(s)
11. Addressing patient/caregiver well-being
12. Hand-off to resource/service-providing entity (e.g., BIAA or state-affiliated Brain Injury Association) for further support
Note: Red font indicates TBI-specific components

BETTER: A TBI Transitional Care Intervention

BETTER TBI Transitional Care Program Activities

1. Assessment of patient / family needs and referral to community-based resources by phone
2. Patient goal setting and review of goals by phone
3. Health care coordination by phone (includes updating / establishing primary care physician)
4. Availability of transitional care manager to patient / family by phone
5. Training on self- and family-management and brain injury coping skills by phone or Zoom
6. Warm hand off / referral to state-affiliated Brain Injury Association

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Thank you!

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