Governor's Task Force on Traumatic Brain Injury

INFORMATION SURVEY
Private Service Provider and Case Workers Questionnaire

Governor John A. Kitzhaber, M.D., formed The Governor's Task Force on Traumatic Brain Injury with Executive Order NO. 01-02. One of the charges to the Task Force is to "… make recommendations regarding a coordinated state agency response to brain injury which focuses on the needs of persons with brain injury…" In carrying out this task, the Task Force is seeking your assistance and input so that our report reflects the perspective of persons with brain injury, their families and that of service providers. The following survey is targeted to private service providers and case workers. Your participation in this assessment will assist the Task Force in obtaining a clearer picture and understanding of the available services and areas for improvement or change.

The survey has four sections. Section I asks for general information about your organization and information on the current services it is providing for survivors of BI. Information from Section I will be used to supplement information in the Oregon Brain Injury Resouce Directory database (http://www.tr.wou.edu/tbi/tbires/Agencyse.htm) which is used by persons with brain injury , their family members, public and private service providers, and other organizations looking for information and assistance. Section IV asks for your opinion about the needs and gaps in the system of services for survivors. This section provides critical information that will aid the Governor's Task Force in developing recommendations to improve the State's response to meeting the needs of persons with brain injury and their families and improving service delivery.

In additional, we are asking for your help by forwarding a request to participate in survey to others who may be interested. In addition to being a provider, if you are a person with brain injury or family member, please fill out the survey for persons with brain injury, their families at **Survivor and Family Members Questionnaire.**

We thank you in advance for taking the time to complete this survey. Your responses will help the Task Force formulate recommendations that reflect the knowledge and experience of service providers; and by sending information on your organization to OBIRN, you will add to resource information that can be made available to brain injury survivors, family members and professionals serving them. We do appreciate all of your input.

Service Provider Survey

NOTE: Throughout this survey, we will use the abbreviations BI for Brain Injury as defined in ORS 411-065-0005 as "sudden onset of a neurological disorder secondary to disease or trauma." This includes but is not limited to Traumatic Brain Injury.

Name of person completing this questionnaire:____
Phone number:________________________________ Email: _________________________

SECTION I: General Information/Information for Oregon Brain Injury Resource Network (OBIRN) Resource Database

1. Organization Name:____
2. Address:____
3. Phone Number:____
4. Fax Number:____
5. Contact's Position:____
6. Contact's Phone Number:____

7. Contact's E-mail address:____

8. Internet URL address (Home page):____

9. Hours Open:____

10. Is your organization affiliated with a hospital? ___ YES (If yes, please give the name of the hospital.)___ NO
____

11. What criteria must a survivor of BI meet to receive services from your organization? (Please *circle?* all which apply.)
___ None
___ Residency in Oregon
___ U. S. Citizenship
___ Referral
___ Physical Condition
___ Minimum age of: _____
___ Maximum age of: _____
___ Other (Please describe.)_______________________________

12a. Is your organization: a. ___ Private, For profit ___b. Not-for-profit? ___c. Public Agency

12b. Does your organization have programs specifically developed for historically under-served populations (e.g., Children, Older Adults, Native Americans, Hispanics, African Americans, Asians)? ___ YES ___ NO

12c. Do you have bilingual staff? ___ YES ___ NO

13. Does your organization employ persons with special training and experience in serving persons with brain injury. Please explain. ___ YES ___ NO
____
____

14. What county or counties does your organization serve within Oregon?
___ Statewide or all ___ selected counties, please list below
____
____

15. Please check the setting where you most often provide services:
___ Acute Rehabilitation
___ Outpatient
___ Clinic
___ Home Health
___ Community
___ School
___ Employment Setting
___ Residential Setting (group home, institution, etc.)
___ Government Agency, please specify _______________________________
___ Other (please specify.) ____

16. What is the average age of consumers most typically served by your organization? ______________
What range of ages do you see?______________________

17. Have you used the Oregon Brain Injury Resource Network ?
___ YES (Please check all that apply) ___ NO (if No, please see http://www.tr.wou.edu/tbi/)
___ Phone ___ Online ___ Comments ____

Section II: Brain Injury (BI) Services

18. What is the BI program emphasis for your organization? (Please check all which apply.)

___ a. Acute rehabilitation
___ b. Coma management
___ c. Day treatment
___ d. Education
___ e. In-home service
___ f. Independent living
___ g. Long-term residential
___ h. Physical medicine and rehabilitation
___ i. Social/emotional/behavioral adjustment
___ j. Substance abuse
___ k. Transitional living
___ l. Vocational rehabilitation
___ m. Other (Please specify.)_________________
____
____
___ n. Not applicable

19. Indicate from which entities your organization receives referrals for services related to BI (check all that apply.)
___ a. County Health Department
___ b. Vocational Rehabilitation Services (Voc Rehab)
___ c. Other State Agency (not Vocational Rehabilitation)
___ d. Self-referrals by survivor or family member/care-giver
___ e. Hospitals
___ f. Schools
___ g. Professionals (e.g., physician, counselor, etc.)
___ h. Other (Specify source.)____
___ i. Not applicable

Section III: Service Matrix

20. Organizational Categories
Please place your organization into one of the following categories by circling the appropriate letter. If none of these categories is appropriate for your organization, please use the "Other" category to describe your organization.

___ a. **Acute Hospital Programs and Services:** The primary identifier in this category is the availability of acute medical care.
___ b. **Specialty Hospital Programs and Services:** Included in this category are hospitals serving special populations. Areas of specialization include rehabilitation hospitals, pediatric intermediate care facilities, long-term acute care, and psychiatric care.
___ c. **Nursing Home/Extended Care Facilities Specialty Programs:** Nursing homes having specialty programs for head and/or spinal injured people.
___ d. **Individual Professional Services:** Included in this category are physicians, therapists, nurse case managers, counselors, psychologists, and many others.
___ e. **Home and Community-Based Service Delivery Programs:** Organizations providing a variety of services; the primary identifier in this category is that the programs are non-residential and not affiliated with hospitals.
___ f. **Community Residential Programs:** Organizations providing non-medical residential care.
___ g. **County Health Agencies**
___ h. **Other:** (Please describe.) ____

21. Service Categories
Please circle all services provided by your organization. If you provide a service not listed below, please use the "Other" category to describe that service.

___ a. **Day Treatment**: Social/recreational programming, support groups, cognitive rehabilitation, respite care (nonresidential), independent living training.
___ b. **Case Management**: Referral, school reintegration, social work, advocacy.
___ c. **Mental Health**: Neuropsychology, psychiatric, psychological, crisis intervention, counseling.
___ d. **Medical Rehabilitation**: Physical therapy, occupational therapy, speech therapy, respiratory, nursing, physiatrist, physician, ventilator.
___ e. **Substance Abuse**: Substance abuse detoxification.
___ f. **Vocational/Educational**: Academic, employment, driver education, vocational evaluation/training.
___ g. **County Health Agencies**
___ h. **Other** (Please describe.): ____

Section IV: Service Needs/Gaps

In this section, we would like you to provide your insights on needs and service gaps within your organization and the community. This section provides critical information that will aid the Governor's Task Force in developing its long-range plan recommendations to improve the system of services for persons with BI and their families. .

22. How well are services coordinated for people who need services from more than one agency? Select the number below that best describes the intra-service coordination for people with BI. "1" means "Services not coordinated well from one agency to another. " "5" means "Very good intra-agency coordination."

___ 1 ___2 ___ 3 ___ 4 ___ 5

23. What are the most critical areas where such coordination is needed? ____
____

24. What are the most important obstacles your organization faces in delivering services to persons with brain injury and/or their families? ____
____

25. What services to persons with BI and their families would you or your organization like to provide that you cannot provide? ____
____

26. Do you think that there are significant gaps in services for persons with BI and their families in Oregon?
___ YES ___ NO

26a. If yes, which do you consider to be the most significant? ______________________________________
____

27a. Is there an effective network of services for survivors of BI in your community? ___ YES ___ NO

27b. (If no, please describe why you feel it is ineffective.) ______________________________________
____

28a. Does your organization have any formal inter-agency agreements with another agency or organization that serves survivors of BI?

___ YES (If yes, please list the organization(s) and the purpose and/or nature of the agreement(s).)
___ NO (if no, please indicate if you think such a formal agreement would be helpful)

28b. Response to Yes or No above: ____
____

29. What is your most critical need or requirements at this time? _________________________________
____

30. Please add any other comments on matters not covered elsewhere in this questionnaire that you think would be helpful in improving services for persons with BI or their families? (Please provide below.)
____
____

Please *mail or fax* your completed survey by **September 15** (surveys after that date we cannot guarantee that they will be able to be included):

GTFTBI Provider Survey
Sherry Stock, Coordinator
1026 SE 209th Ave.
Gresham OR 97030

Fax to: (503) 373-7823
Attn: Jane-ellen Weidanz/Sherry Stock-GTFTBI

If you have any questions or comments regarding this survey, please call Sherry Stock at (503) 740-3155 or (503) 661-8894.

Thank you for taking the time to complete this survey. *Your responses will be helpful to the task force as it develops its recommendations.*