Administration for Community Living
Traumatic Brain Injury State Partnership Grants
Performance Measurement Reporting Tool Cover Sheet

ACL Grant Award #: 90TBSG0036-03-01

Grantee

State: Nebraska

Agency Name: Nebraska Department of Education, Vocational Rehabilitation

Agency Address: 500 South 48th Street, 2nd Floor

Lincoln, NE 68510-2611

Project Director/Principal Investigator

Name: Keri Bennett

Phone Number: (308) 224-7571

Email: keri.bennett@nebraska.gov

Report Primary Contact

Name: Keri Bennett

Phone Number: (308) 224-7571

Email: keri.bennett@nebraska.gov

Total Project Period: June 1, 2018 - May 31, 2021

Reporting Period: December 1, 2020 - May 31, 2021

Date of Report Submission: 06/29/2021

ACL Project Officer: Ms. Dana Fink

ACL Grants Management Specialist: Mr. Sean Lewis

ACL Traumatic Brain Injury State Partnership Grants

Performance Measurement Reporting Tool

Updated June 9, 2020 for Grantee Completion

TABLE OF CONTENTS

OMB Control No. 0985-0066; Expiration Date: 03/31/2023

A. Grant Activities (all grantees respond)

1. Which activities did you carry out as part of your ACL project using program funding during this reporting period? (Check all that apply)

☒ **a. Partnership Development** - identifying and reaching out to new partners, coordinating and aligning activities, information exchange, collaboration on grant activities, collaboration on activities related to the grant

☒ **b. Planning and Infrastructure Development** - state planning, policy and procedures development, state councils, needs assessment, surveillance, registry, IT systems

☒ **c. Information and Referral/Assistance (I&R/A)** - bringing people and services together, answering questions from individuals and families about human service resources, helping people get connected to public benefits, sharing information about available services like home care and adaptive equipment. Note: I&R is about bringing people and services together. Individuals may reach out once or many times, but I&R typically does not involve ongoing engagement of individuals like Resource Facilitation. If the description provided here does not align with how your program defines this activity, please provide your definition here:

☒ **d. Screening** - using a standardized procedure, structured interview, or tool to elicit the lifetime history of TBI for an individual. Screening can be used for clinical, research, programmatic, eligibility determination, service delivery or treatment purposes. If the description provided here does not align with how your program defines this activity, please provide your definition here:

☐ **e. Resource Facilitation** – this category of activity could include development of resources such as databases, resource directories, and communications tools to improve service delivery. It could also mean providing assistance through an accessible, holistic, and person-centered process that engages individuals in decision making about their options, preferences, values, and financial resources and helps connect them with programming, services and supports they choose. In some states this may be called service coordination, service navigation, case management, options counseling, or person centered counseling. Resource facilitation could be of short term or long term duration. If the description provided here does not align with how your program defines this activity, please provide your definition here:

☒ **f. Training, Outreach and Awareness** - continuing education for professionals who may work with or provide services for people who have experienced a TBI, training for individuals who have experienced a TBI, public education and awareness, training for caregivers, on-the-job training for agency staff, cross-training with partnering agencies. If the description provided here does not align with how your program defines this activity, please provide your definition here:

☒ **Other 1** (Describe): Voice-driven Network Capacity Building

☐ **Other 2** (Describe):

☐ **Other 3** (Describe):

2. Did you target or limit some or all of your grant activities to support people in a particular setting or particular population during this reporting period? If yes, please select all that apply.
[NOTE: IF ALL OF THE ACTIVITIES ARE DESIGNED TO MORE GENERALLY SUPPORT ALL TBI SURVIVORS IN YOUR STATE, **DO NOT** CHECK 'YES, ALL' OR 'YES, SOME' FOR ANY SETTING/POPULATION. ONLY CHECK 'NO' BELOW AND DO NOT FILL OUT THE REST OF THE TABLE.]

☐ **NO, all of our activities are designed to more generally support all TBI survivors in our state**

Setting/Population	YES, ALL of our activities were primarily targeted to this group	YES, SOME of our activities were primarily targeted to this group
a. Athletes	☐	☐
b. Children and youth (younger than 22)	☐	☐
c. Adults (22-59)	☐	☐
d. Older adults (60 or over)	☐	☐
e. People who are homeless	☐	☐
f. People who are hospitalized	☐	☐
g. People who are incarcerated or formerly incarcerated	☐	☐
h. Medicaid home and community-based services participants	☐	☐
i. Native Americans	☐	☐
j. Other ethnic, racial or linguistic minorities	☐	☐
k. Residents of nursing facilities, rehab facilities or ICFs/MR	☐	☐

Setting/Population	YES, ALL of our activities were primarily targeted to this group	YES, SOME of our activities were primarily targeted to this group
l. Rural populations	☐	☒
m. People who experience unhealthy substance use or a substance use disorder	☐	☐
n. Students	☐	☐
o. Veterans or current service members	☐	☐
p. People who are victims of crime, domestic violence, or intimate partner violence	☐	☐
q. Other 1 (describe) Populations underserved by existing TBI	☐	☒
r. Other 2 (describe)	☐	☐
s. Other 3 (describe)	☐	☐

3. **Percent of your state's counties (parishes or boroughs) targeted and reached through your grant's activities during this reporting period:**

a. Total number of counties in state	# 93
b. Counties targeted for this project	# 93
c. Counties reached this reporting period	# 31

4. **For each of your grant activities, please provide how much of your total program funding you spent in the last completed grant year in support of each of the different activities listed below, rounded to closest $1,000.** *[NOTE: THIS QUESTION WILL BE ASKED ONCE A YEAR ABOUT THE LAST COMPLETED GRANT YEAR. THE AMOUNT IN ROW 'j' SHOULD TOTAL THE AMOUNTS IN ROWS 'a' THROUGH 'i'].*

a. Partnership Development	$ 69000
b. Planning and Infrastructure Development	$ 63000
c. Information and Referral/Assistance	$ 53000
d. Screening	$ 2000
e. Resource Facilitation	$ 0
f. Training, Outreach and Awareness	$ 59000
g. Other 1 (Describe):	$ 56000
h. Other 2 (Describe):	$ 0
i. Funds not yet spent including any carryover funds from last fiscal year	$ 148000
j. **Total Program Funding**	**$** 450000

OMB Control No. 0985-0066; Expiration Date: 03/31/2023

5. Did your project use any evidence-based practices, interventions, or programs as part of your grant activities during this reporting period?

■YES ☐NO

If yes, please describe:

Yes, to some extent. Peer Support is recognized as an evidence-based practice in the field of mental health recovery. The common lived experiences between people create a bond of trust and respect that forms the foundation for one person to guide, support and coach another person to recovery. The goal for Nebraska VR's TBI grant is to build an infrastructure that will foster this type of connectivity among people living with a brain injury. The Nebraska Injured Brain Network (NIBN) is the peer-run organization creating the network infrastructure through new chapters that are forming across the state. The technical assistance provided to NIBN with grant funding empowers them to become familiar with the concepts of peer support, and in turn, the NIBN members support each other as peers while this project evolves. Nebraska VR contracted with NIBN during this reporting period to plan and develop a pilot of Peer to Peer Supports for people with TBI.

B. Partnership Activities (all grantees respond)

6. Which organizations in your state received funding through the ACL State Partnership Program to carry out and/or support grant activities (primary awardee and sub-awarded partners) in this reporting period?

a. Lead Grantee Agency

i. **Name of organization**: Nebraska Vocational Rehabilitation (VR)

ii. **Type of organization (select all the designations below that apply to this organization):**

- ☐ State Medicaid Agency
- ☒ State Vocational Rehabilitation Agency,
- ☐ State Department of Education
- ☐ State Department of Criminal Justice/Corrections
- ☐ State Unit on Aging
- ☐ State Department for Developmental Disabilities
- ☐ State Behavioral and/or Mental Health Agency
- ☐ State Department of Public Health
- ☐ Tribal Council
- ☐ Other State Agency
- ☐ University Center on Excellence for Developmental Disabilities
- ☐ University
- ☐ Other (Specify):

b. Funded Partner 1 (If applicable complete; if not go to Question 7)

i. **Name of organization**: John M. Ferrone Management Consulting, Inc.

ii. **Type of organization (select all the designations below that apply to this organization):**

- ☐State Medicaid Agency
- ☐State Vocational Rehabilitation Agency,
- ☐State Department of Education
- ☐State Department of Criminal Justice/Corrections
- ☐State Unit on Aging
- ☐State Department for Developmental Disabilities
- ☐State Behavioral and/or Mental Health Agency
- ☐State Department of Public Health
- ☐Tribal Council/Organization
- ☐Other State Agency
- ☐University Center on Excellence for Developmental Disabilities.
- ☐University
- ☐State Independent Living Council
- ☐State I/DD Council
- ☐Affiliate of National Brain Injury Organization
- ☐County or Local Government Entity,
- ☐Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- ☐Public Health Department or Clinic
- ☐Recovery or Substance Abuse Treatment Center
- ☐VA Medical Center
- ☐Other Health Care Provider
- ☐University
- ☑Private Business/Employer
- ☐Other (Specify):

iii. **Is this partner new this reporting period?** ☐Yes ☑No

Funded Partner 2 (If applicable complete; if not go to Question 7)

i. **Name of organization**: Schmeeckle Research, Inc.

ii. **Type of organization (select all the designations below that apply to this organization):**

- ☐State Medicaid Agency
- ☐State Vocational Rehabilitation Agency,
- ☐State Department of Education
- ☐State Department of Criminal Justice/Corrections
- ☐State Unit on Aging
- ☐State Department for Developmental Disabilities
- ☐State Behavioral and/or Mental Health Agency
- ☐State Department of Public Health
- ☐Tribal Council/Organization
- ☐Other State Agency
- ☐University Center on Excellence for Developmental Disabilities.
- ☐University
- ☐State Independent Living Council
- ☐State I/DD Council
- ☐Affiliate of National Brain Injury Organization
- ☐County or Local Government Entity,
- ☐Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- ☐Public Health Department or Clinic
- ☐Recovery or Substance Abuse Treatment Center
- ☐VA Medical Center
- ☐Other Health Care Provider
- ☐University
- ☑Private Business/Employer
- ☐Other (Specify):

iii. **Is this partner new this reporting period?** ☐Yes ☑No

Funded Partner 3 (If applicable complete, if not go to Question 7)

i. **Name of organization:** Nebraska DHHS, Division of Public Health

ii. **Type of organization (select all the designations below that apply to this organization):**

- ☐State Medicaid Agency
- ☐State Vocational Rehabilitation Agency,
- ☐State Department of Education
- ☐State Department of Criminal Justice/Corrections
- ☐State Unit on Aging
- ☐State Department for Developmental Disabilities
- ☐State Behavioral and/or Mental Health Agency
- ☒State Department of Public Health
- ☐Tribal Council/Organization
- ☐Other State Agency
- ☐University Center on Excellence for Developmental Disabilities.
- ☐University
- ☐State Independent Living Council
- ☐State I/DD Council
- ☐Affiliate of National Brain Injury Organization
- ☐County or Local Government Entity,
- ☐Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- ☐Public Health Department or Clinic
- ☐Recovery or Substance Abuse Treatment Center
- ☐VA Medical Center
- ☐Other Health Care Provider
- ☐University
- ☐Private Business/Employer
- ☐Other (Specify):

iii. **Is this partner new this reporting period?** ☐Yes ☒No

LIST ADDITIONAL FUNDED PARTNERS, AND ORGANIZATION TYPE, AS NEEDED IN THE FIELD BELOW:

Nebraska Injured Brain Network (NIBN), Peer-run Brain Injury Organization
National Association of State Head Injury Administrators (NASHIA), national organization for state employees who support brain injury programs
Brain Injury Alliance of Nebraska (BIA-NE), Affiliate of National Brain Injury Organization

7. **Which types of organizations are program partners and support program activities but *did not receive* program funds during this reporting period?**

a. Types of Unfunded Partners

Select all the types of organizations that are unfunded partners and indicate if this type of organization is new (as of this reporting period) or a continuing partner.

- ☐ State Medicaid Agency
- ☐ State Vocational Rehabilitation Agency,
- ☐ State Department of Education
- ☐ State Department of Criminal Justice/Corrections
- ☐ State Unit on Aging
- ☐ State Department for Developmental Disabilities
- ☐ State Behavioral and/or Mental Health Agency
- ☐ State Department of Public Health
- ☑ Protection and Advocacy Programs
- ☐ Tribal Council/Organization
- ☐ Other State Agency
- ☐ University Center on Excellence for Developmental Disabilities.
- ☐ University
- ☑ State Independent Living Council
- ☑ State I/DD Council
- ☐ Affiliate of National Brain Injury Organization
- ☐ County or Local Government Entity
- ☑ Community-Based Services Organization (e.g. CAA, ADRC, AAA, CIL),
- ☐ Public Health Department or Clinic
- ☐ Recovery or Substance Abuse Treatment Center
- ☐ VA Medical Center
- ☐ Other Health Care Provider
- ☐ University
- ☐ Private Business/Employer
- ☐ Other (Specify):

8. **Is there anything else you would like to let ACL know about your Partnership activities during this reporting period?** *This question is not mandatory.*

No, thank you.

C. Planning and Infrastructure Development (all grantees respond)

9. Please list your advisory council members for this project period and place a check by their affiliations. You may check all that apply if a person represents two or more affiliated entities.

GRANTEES CAN ADD THE NAMES BELOW OR UPLOAD AN ATTACHMENT WITH THE ROSTER OF NAMES. GRANTEES CAN ADD AS MANY ADVISORY COUNCIL MEMBERS AS THEY NEED.

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council represen-tative	Aging and Disability Resource Center represen-tative	Protection & Advocacy agency represen-tative	Long-term care ombudsman represen-tative	TBI Model Systems represen-tative	Represen-tative from an Affiliate of National Brain Injury Organization	Other (describe)
Example: John Smith	☒Yes	☐Yes	☐Yes	☐Yes	☐Yes	☒Yes	☐Yes	☐Yes	
Judy Nichelson, Advisory Council Chair	■Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	NIBN Chapter Leader
Tiffany Armstrong	■Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Dale Johannes	■Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council represen-tative	Aging and Disability Resource Center represen-tative	Protection & Advocacy agency represen-tative	Long-term care ombudsman represen-tative	TBI Model Systems represen-tative	Represen-tative from an Affiliate of National Brain Injury Organization	Other (describe)
Emaly L. Ball	☒Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	NIBN Board of Directors President
Sarvinoz Kadyrova	☒Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	NIBN Board of Directors Vice President
Cindy Hoffschneider	☒Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Shawna Thompson	☒Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Zoe Olson	☒Yes	☒Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Ashley J. Davis	☐Yes	☒Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council represen-tative	Aging and Disability Resource Center represen-tative	Protection & Advocacy agency represen-tative	Long-term care ombudsman represen-tative	TBI Model Systems represen-tative	Represen-tative from an Affiliate of National Brain Injury Organization	Other (describe)
Rhonda Alcorn	☐Yes	☑Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Frank Velinsky	☐Yes	☑Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Amy Levering	☑Yes	☐Yes	☑Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Randall S. Jones	☐Yes	☐Yes	☐Yes	☑Yes	☐Yes	☐Yes	☐Yes	☐Yes	
Tania Diaz	☐Yes	☐Yes	☐Yes	☐Yes	☑Yes	☐Yes	☐Yes	☐Yes	
Penny Clark	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☑Yes	☐Yes	☐Yes	

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council represen-tative	Aging and Disability Resource Center represen-tative	Protection & Advocacy agency represen-tative	Long-term care ombudsman represen-tative	TBI Model Systems represen-tative	Represen-tative from an Affiliate of National Brain Injury Organization	Other (describe)
Peggy Reisher	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	■Yes	
Karen Houseman	■Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Medicaid & Long-term Care Waivers
Carla Lasley	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Nebraska VR
Jo Gunderson	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Dept. of Ed, Office of Special Education
Peg Ogea-Ginsburg	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Injury Prevention & Control
Brooke Murtaugh	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Madonna Rehabilitatio n Hospital

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council represen-tative	Aging and Disability Resource Center represen-tative	Protection & Advocacy agency represen-tative	Long-term care ombudsman represen-tative	TBI Model Systems represen-tative	Represen-tative from an Affiliate of National Brain Injury Organization	Other (describe)
Tamara Snider	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Goodwill Industries of Greater Nebraska
Michelle Ploeger	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Quality Living, Inc.
Jerry L. Bryan	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Client Assistance Program
Joni Dulaney	■Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	Council on Developmen tal Disabilities
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	

Advisory Council Member Name	Person who has experienced a TBI (Survivor)	Family member of person who has experienced a TBI	Center for Independent Living/State Independent Living Council represen-tative	Aging and Disability Resource Center represen-tative	Protection & Advocacy agency represen-tative	Long-term care ombudsman represen-tative	TBI Model Systems represen-tative	Represen-tative from an Affiliate of National Brain Injury Organization	Other (describe)
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	
	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	☐Yes	

10. Estimate the number of people in your state who have experienced a TBI and are getting some kind of Medicaid Home and Community Based Services or supports.

a. Estimate how many people living in your state have experienced a TBI: 39,051

i. Of the total in 'a' above, estimate how many people who have experienced a TBI are currently receiving HCBS through a Medicaid TBI waiver: 20

ii. Of the total in 'a' above, estimate how many people who have experienced a TBI are in your grant's target population (e.g. based on where they live in the state, their age, setting in which they live or some other demographic or criteria): 39,051

(a) Of the total in 'aii' above, estimate how many people in your target population are currently receiving services or supports that help them live in a home or community setting through a Medicaid waiver or some other kind of publicly funded program (e.g. state HCBS program, Rehabilitation Services Act, Older Americans Act): 705

b. Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Please see the Supplemental Narrative Responses attachment for our answer to this question.

11. What planning and infrastructure accomplishments or activities of the last six months do you think have been or will be most impactful? Consider how you are working toward systems change and what progress you are seeing.

Please see the Supplemental Narrative Responses attachment for our answer to this question.

12. Is there anything else you would like to let ACL know about your planning and infrastructure activities during this reporting period? These activities may include needs assessments, state plans, and registries *This question is not mandatory.*

No, thank you.

D. Information and Referral/Assistance (if applicable to grant activities)

13. How many I&R/A contacts were made in this reporting period (across all funded partners providing grant-related I&R/A?

a. How many people live in the collective service areas of the organization or organizations providing I&R/A with grant funding?: 1,952,570

Total number of contacts made to organizations that use program funds to support some or all of their I&R/A activities: Total Number of contacts is unknown.

Total number of contacts made to these funded partners regarding TBI in reporting period: 3

b. Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Please see the Supplemental Narrative Responses attachment for our answer to this question

14. How often are different types of services referred for I&R/A callers who have experienced a TBI, their family members, or other professionals and service providers during this reporting period across all funded partners providing grant-related I&R/A? Please select an option for each type of referral.

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
a. Grant-funded resource facilitation, service coordination	☐	☐	■	☐
b. Other type of resource facilitation, service coordination (provided by other unfunded partners or other organizations such as an affiliate of national brain injury organization, ADRC, CIL, other ABI association, or other organization)	■	☐	☐	☐
c. Older Americans Act services (e.g., nutrition services, LTC Ombudsman)	☐	☐	■	☐
d. Behavioral health services	☐	☐	■	☐
e. Brain injury support groups	■	☐	☐	☐
f. Caregiver supports	☐	☐	■	☐
g. Independent living services	☐	☐	■	☐
h. Domestic violence help services	☐	☐	■	☐
i. Employment counseling	☐	☐	■	☐

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
j. Educational counseling or school disability services	☐	■	☐	☐
k. Health insurance information or counseling (e.g. SHIP, Medicaid eligibility)	☐	■	☐	☐
l. General medical services	■	☐	☐	☐
m. Specialized TBI/ABI services	■	☐	☐	☐
n. Homeless services provider	☐	☐	■	☐
o. Housing supports	☐	■	☐	☐
p. Medicaid waiver services	■	☐	☐	☐
q. Physical, occupational, recreational or speech therapy	☐	☐	■	☐
r. Legal or advocacy services	■	☐	☐	☐
s. Transportation services	☐	■	☐	☐
t. Social Security	☐	■	☐	☐
u. Veteran's hospital or clinic	☐	☐	■	☐
v. Vocational rehabilitation services	■	☐	☐	☐
w. In-home services and supports	☐	☐	■	☐
x. Other 1 (Specify) Neuropsychologist	■	☐	☐	☐
y. Other 2 (Specify)	☐	☐	☐	☐
z. Other 3 (Specify)	☐	☐	☐	☐

15. Is there anything else you would like to let ACL know about your I&R/A activities during this reporting period? *This question is not mandatory.*

Please see the Supplemental Narrative Responses attachment for our answer to this question.

E. Screening (if applicable to grant activities)

16. How many unduplicated people did you and your funded partners screen to identify a history of TBI during this reporting period (across all funded partners providing grant-related screening)? Please enter a number, or select zero or unknown, for each row.

SCREENING	NUMBER	ZERO	UNKNOWN
a. Total number of unduplicated people screened this reporting period	629	☐	☐
b. Number of people screened who were identified as having a history of TBI	54	☐	☐
Number of people under age 22		☐	■
Number of people between 22-59		☐	■
Number of people 60 or older		☐	■
Number of veterans of any age		☐	■

17. Select which standardized instruments you or your partners used for screening procedures during this reporting period. (Select all that apply)

Instrument	Yes	No
a. The Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID)	☐YES	■NO
b. A modified version of the OSU TBI-ID	■YES	☐NO
c. The Brain Injury Screening Questionnaire (BISQ)	☐YES	■NO
d. Defense and Veterans Brain Injury Center TBI Screening Tool (DVBIC TBI), also called The Brief Traumatic Brain Injury Screen (BTBIS)	☐YES	■NO
e. The Traumatic Brain Injury Screening Instrument (TBISI)	☐YES	■NO
f. HELPS	☐YES	■NO
g. Military Acute Concussion Evaluation (MACE)	☐YES	■NO
h. Automated Neuropsychological Assessment Metrics (ANAM)	☐YES	■NO
i. Other 1 (Specify):		
j. Other 2 (Specify):		
k. Other 3 (Specify):		

18. Of the people who have experienced a TBI whom you screened in this reporting period, how many were living in these following settings at the time of their screening? Please enter a positive number, or select zero or unknown, for each row.

LIVING SETTING	NUMBER	ZERO	UNKNOWN
a. On their own/independent		☐	■
b. Homeless		☐	■
c. With parent or grandparent		☐	■
d. With immediate family		☐	■
e. With friends or other extended family		☐	■
f. Group home		☐	■
g. Prison or Jail/Justice involved setting		☐	■
h. Transitional living program or temporary housing		☐	■
i. Community Based Neurobehavioral Rehabilitation Services		☐	■
j. Nursing facility or in-patient rehab setting		☐	■
k. Supervised living program		☐	■
l. Assisted-living settings		☐	■
m. Other 1 (Specify):		☐	☐
n. Other 2 (Specify):		☐	☐
o. Other 3 (Specify):		☐	☐

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Please see the Supplemental Narrative Responses attachment for our answer to this question.

19. Of the people who have experienced a TBI whom you screened during this reporting period, how many were in competitive, integrated employment and/or in school at the time of the screening? Please enter a number, or select zero or unknown, for each row.

	NUMBER	ZERO	UNKNOWN
a. Competitive, integrated employment		☐	■
b. In school or training		☐	■

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.)**:**

Please see the Supplemental Narrative Responses attachment for our answer to this question.

20. Is there anything else you would like to let ACL know about your screening activities this reporting period? *This question is not mandatory.*

Please see the Supplemental Narrative Responses attachment for our answer to this question.

F. Resource Facilitation (if applicable to grant activities)

21. For how many unduplicated people who have a TBI did you or your partners provide resource facilitation in this reporting period (across all funded partners providing grant-related resource facilitation)? Please enter a number, or select zero or unknown, for each row.

RESOURCE FACILITATION	NUMBER	ZERO	UNKNOWN
Total number of unduplicated people who have experienced a TBI who were provided with resource facilitation in this reporting period		☐	☐
Number of people under age 22		☐	☐
Number of people between 22-59		☐	☐
Number of people 60 or older		☐	☐
Number of veterans of any age		☐	☐

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

22. What types of referrals did those providing Resource Facilitation make for people who have experienced a TBI and who received resource facilitation during this reporting period? Please select a response for each type of referral.

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
a. Grant-funded resource facilitation, service coordination	☐	☐	☐	☐
b. Other type of resource facilitation, service coordination (provided by other unfunded partners or other organizations such as an affiliate of national brain injury organization, ADRC, CIL, other ABI association, or other organization)	☐	☐	☐	☐
c. Older Americans Act services (e.g., nutrition services, LTC Ombudsman)	☐	☐	☐	☐
d. Behavioral health services	☐	☐	☐	☐
e. Brain injury support groups	☐	☐	☐	☐
f. Caregiver supports	☐	☐	☐	☐
g. Independent living services	☐	☐	☐	☐
h. Domestic violence help services	☐	☐	☐	☐

Type of Referral	COMMONLY	OCCASIONALLY	NEVER	UNKNOWN
i. Employment counseling	☐	☐	☐	☐
j. Educational counseling or school disability services	☐	☐	☐	☐
k. Health insurance information or counseling (e.g. SHIP, Medicaid eligibility)	☐	☐	☐	☐
l. General medical services	☐	☐	☐	☐
m. Specialized TBI/ABI services	☐	☐	☐	☐
n. Homeless services provider	☐	☐	☐	☐
o. Housing supports	☐	☐	☐	☐
p. Medicaid waiver services	☐	☐	☐	☐
q. Physical, occupational, recreational or speech therapy	☐	☐	☐	☐
r. Legal or advocacy services	☐	☐	☐	☐
s. Transportation services	☐	☐	☐	☐
t. Social Security	☐	☐	☐	☐
u. Veteran's hospital or clinic	☐	☐	☐	☐
v. Vocational rehabilitation services	☐	☐	☐	☐
w. In-home services and supports	☐	☐	☐	☐
x. Other 1 (Specify):	☐	☐	☐	☐
y. Other 2 (Specify):	☐	☐	☐	☐
z. Other 3 (Specify):	☐	☐	☐	☐

23. Of the people who have experienced a TBI for whom you provided resource facilitation this reporting period, how many were living in these different settings at the time you worked with them? Please enter a number, or select zero or unknown, for each row.

LIVING SETTING	NUMBER	ZERO	UNKNOWN
a. On their own/independent		☐	☐
b. Homeless		☐	☐
c. With parent or grandparent		☐	☐
d. With immediate family		☐	☐
e. With friends or other extended family		☐	☐
f. Group home		☐	☐
g. Prison or Jail/Justice involved setting		☐	☐
h. Transitional living program or temporary housing		☐	☐
i. Community Based Neurobehavioral Rehabilitation Services		☐	☐

LIVING SETTING	NUMBER	ZERO	UNKNOWN
j. Nursing facility or in-patient rehab setting		☐	☐
k. Supervised living program		☐	☐
l. Assisted-living settings		☐	☐
m. Other (Specify):		☐	☐

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

24. Of the people who have experienced a TBI for whom you provided resource facilitation this reporting period, how many were in competitive, integrated employment and/or in school while receiving resource facilitation? Please enter a number or select zero or unknown, for each row.

	NUMBER	ZERO	UNKNOWN
a. Competitive, integrated employment		☐	☐
b. In school or training		☐	☐

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

25. Of the people who have experienced a TBI for whom you provided resource facilitation this reporting period, how many did you support through a transition from an institutional setting (e.g. criminal justice system, nursing facility) into the community? Please enter a number—or select zero, unknown, or not applicable—for each row.

	NUMBER	ZERO	UNKNOWN	N/A
a. Number transitioning from criminal justice system to community (with or without HCBS)		☐	☐	☐
b. Number transitioning from nursing facility/medical facility to community (with or without HCBS)		☐	☐	☐
c. Number transitioning from another setting to community (with or without HCBS) Describe:		☐	☐	☐

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

No data is provided as Resource Facilitation is not a funded activity under this grant.

26. Is there anything else you would like to let ACL know about your resource facilitation efforts during this period? *This question is not mandatory.*

N/A

G. Training, Outreach and Awareness (if applicable to grant activities)

27. How many different types of people received grant-supported training in this reporting period (across all funded partners that provide training with program funds)? Please enter a number—or select zero, unknown, or not applicable—for each row.

	NUMBER	ZERO	UNKNOWN	N/A
a. Staff providing grant-related services		☐	☐	■
Staff providing, I&R/A		☐	■	☐
Staff conducting Screenings		☐	■	☐
Staff providing Resource Facilitation		☐	■	☐
b. Clinical/medical providers		☐	■	☐
Physicians		☐	■	☐
Emergency medical services providers/first responders		☐	■	☐
Other clinical/medical providers		☐	■	☐
c. Coaches or other athletics personnel		☐	■	☐
d. Domestic violence services staff		☐	■	☐
e. Family, friends, informal caregivers		☐	■	☐
f. Homeless services organization staff		☐	■	☐
g. Individuals who have experienced a TBI		☐	■	☐
h. In-home services and supports staff		☐	■	☐
i. Law enforcement personnel		☐	■	☐
j. Prison or criminal justice system staff		☐	■	☐
k. Protection and advocacy staff		☐	■	☐
l. Residential rehabilitation center staff		☐	■	☐
m. Nursing home staff		☐	■	☐

	NUMBER	ZERO	UNKNOWN	N/A
n. Universities, colleges, or school staff (excluding school coaches)		☐	■	☐
o. Veterans & military organization staff		☐	■	☐
p. Other 1 (Describe): Unknown individuals completed TBI Modules	6	☐	☐	☐
q. Other 2 (Describe):		☐	☐	☐
r. Other 3 (Describe):		☐	☐	☐

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Six individuals completed the Nebraska Traumatic Brain Injury Online Training sponsored by Nebraska VR with TBI grant funds during the reporting period. Unfortunately, the online training host does not capture data on the individual's role.

28. Please provide the number of grant-sponsored trainings that took place this reporting period, by topic area and include the number of attendees. Please enter either a positive number, zero (0), unknown, or not applicable in every field.

Note: "grant-sponsored trainings" refers to those using program funds or state matching funds.

Topic Area	Number of Trainings	Number of Attendees
a. TBI Basics	1	5
b. Aging and TBI		
c. Assistive technology		
d. Athletics		
e. Behavioral health and TBI		
f. Caregiving		
g. Children and TBI	1	4
h. Concussions & mild TBI		
i. Criminal justice and TBI		
j. Diagnosis		
k. Educational issues		
l. Employment and training of people with TBI		
m. Identification, screening, assessment		
n. Independent living		
o. Substance Use and TBI	1	2
p. Neurobehavioral aspects of TBI	1	4
q. Public Policy		
r. Person Centered Planning/Counseling		
s. Community-based services and support resources		
t. Treatment and therapies		
u. Other 1(Specify):		
v. Other 2(Specify):		
w. Other 3(Specify):		

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Six individuals completed the Nebraska Traumatic Brain Injury Online Training sponsored by Nebraska VR with TBI grant funds during the reporting period. Data are reported for these six participants.

29. Please list and describe any training materials, outreach materials, fact sheets or other products you produced during this reporting period.

Nebraska VR created a flier for outreach during the Annual Brain Injury Conference to recruit new Brain Injury Advisory Council members. The flier is attached.

30. Is there anything else you would like to let ACL know about your training activities during this reporting period? *This question is not mandatory.*

No, thank you.

H. Other (if applicable to grant activities)

31. Describe what activities you undertook in this area this reporting period.

Please see the Supplemental Narrative Response attachment for our answer to this question.

32. How many unduplicated people did you work with or support through the activity identified in 31 during this reporting period? Please enter a number, or select zero or unknown, for each row.

OTHER	NUMBER	ZERO	UNKNOWN
Total number of people who have experienced a TBI who participated in the **activity identified in 31**	21	☐	☐
Number of people under age 22		☐	■
Number of people between 22-59	18	☐	☐
Number of people 60 or older	3	☐	☐

Notes about data provided (e.g., unknown because none of our partners collect this information, data are incomplete because only some of our partners collect this information. Please describe.):

Please see the Supplemental Narrative Responses attachment for our answer to this question.

List "Other" activities, as needed, in the field below:

None.

I. Narrative Responses (all grantees respond)

33. Please describe the TBI mentoring and work group activities your program led or participated in during this reporting period.

Please see the Supplemental Narrative Responses attachment for our answer to this question.

34. Please describe the extent to which the mentoring and work group activities you participated in added value to your program, the national program, and/or any other aspect of your TBI work.

Please see the Supplemental Narrative Responses attachment for our answer to this question.

35. Did you use the services of the TBI Technical Assistance and Resource Center (TARC) during this reporting period? [Yes/No] *If yes, please describe these services.* *If you did not use the services of the TBI TARC during this reporting period, please explain why not.*

Please see the Supplemental Narrative Responses attachment for our answer to this question.

36. How would you describe the quality of services you received from the TBI TARC during this reporting period?

Excellent!

37. Is there anything else you would like to let ACL know about your project or the TBI State Partnership Program?

Nebraska VR appreciates the high level of collaboration among the state grantees, the TBI State Partnership Program team, and TBI TARC that was afforded us in this grant cycle.. The topic-based workgroup activities were especially beneficial. We appreciate the responsiveness of our federal partners to our requests and concerns.

Public Burden Statement:

ACL Traumatic Brain Injury State Partnership Grants Performance Measurement Reporting
Nebraska VR Supplemental Narrative Responses for December, 2020 – May, 2021

Section C. Planning and Infrastructure Development

10. b. Notes about data provided:

Data are incomplete because very little is collected or available. Regarding the figure in 10.a., an estimated 39,051 people living in Nebraska have experienced a TBI. This number represents 2% of Nebraska's 2020 population of 1,952,570 and very likely falls short of the number of actual injuries that have occurred. Actual data are not available on the prevalence of TBI in Nebraska. According to the National Center for Injury Prevention and Control, an estimated cumulative 5.3 million individuals are living with a TBI-related disability in the United States, representing a prevalence of approximately 2% of the U.S. population.

Regarding the figure in 10.a.i., this figure is the number of people with TBI currently receiving HCBS through the state's TBI Waiver. No data are available on the number of people with TBI receiving HCBS through the state's other Waivers.

Regarding the figure in 10.a.ii., although some of Nebraska's TBI grant activities target rural and underserved populations, most are statewide in scope, thus targeting every person in the state with TBI, which was estimated to be 39,051.

Regarding the figure in 10.a.ii.(a), data for all publicly funded programs are not available, as few of our state agencies and programs collect data specific to people with TBI. Data for the three programs that capture this data are as follows:

- Nebraska VR (Vocational Rehabilitation) = 573
- Aging & Disability Resource Center (ADRC) = 112
- Medicaid TBI Waiver = 20
- Total estimate = 705

11. What planning and infrastructure accomplishments or activities of the last six months do you think have been or will be most impactful?

Nebraska completed work on our Brain Injury Advisory Council (BIAC) New Member Toolkit. The Toolkit will be valuable in educating new BIAC members on the work of the BIAC. The Toolkit includes a Mentor program for new members. The first cohort of BIAC mentors and mentees was launched in May 2021. All the Mentors are individuals with TBI.

Section D. Information and Referral/Assistance

13. b. Notes about data provided:

The 3 contacts made to *funded* partners regarding traumatic brain injury (TBI) were made to the Brain Injury Alliance of Nebraska. These were calls received in response to TBI Registry mailings. A number of *unfunded* partners also provide TBI-related I&R/A services to individuals with brain injury, family

members and professionals. They include the Hotline for Disabilities, Disability Rights Nebraska, the League of Human Dignity and Independence Rising, among others.

15. Is there anything else you would like to let ACL know about your I&R/A activities during this reporting period?

Nebraska VR partners with the Department of Health and Human Services (DHHS), Division of Public Health to mail a letter and brochure to all individuals reported by the Nebraska Hospital Association (NHA) as having been diagnosed with a TBI. This is how Nebraska VR uses the TBI Registry data to connect people to services. During this reporting period, 1,103 letters were mailed, 10 letters were returned, and 1,093 letters were delivered to newly injured individuals placed on the TBI Registry. The Covid 19 pandemic and NHA database issues delayed the mailing of registry letters this year. For these reasons, *the total does not include mailings to individuals placed on the TBI Registry from January-May of 2021. Mailings for individuals placed on the TBI Registry from January-May 2021 were sent out after the reporting period.*

A total of nine different brochures are utilized in the mailings; for ages 0-21, 22-59 and 60+, across three regions of the state (western, central and eastern). Each brochure lists statewide resources along with regional and local organizations that provide assistance "close to home". The purpose of customizing the brochures is to more quickly connect individuals with TBI to resources in their region or in their community.

An email is sent to each of the organizations listed in the brochures when the letters and brochures are mailed. The email includes the number of letters sent for each of the three geographic regions of the state, but does not list the names or addresses of individuals receiving the mailings. The email may also include information on upcoming training events and new resources. Our objective is to call attention to the number of individuals in each area of the state who were diagnosed with a brain injury, and to prepare the organizations to respond to callers. The email also provides an opportunity to continue building awareness of TBI.

Section E. Screening

18. Notes about data provided:

Data on the individual's age and living setting are not collected on the screening instrument used in this activity. Data are available, however it would require a review of each individual's application form to glean, and that task is too time-consuming to complete.

19. Notes about data provided:

Data on employment and school status are not collected on the screening instrument used in this activity. Data are available, however it would require a review of each individual's application form to glean, and that task is too time-consuming to complete.

20. Is there anything else you would like to let ACL know about your screening activities this reporting period?

The Nebraska VR Acquired Brain injury (ABI) Screen is conducted with individuals who apply for services with Nebraska VR and indicate a history of possible ABI. The agency application form includes the following pre-screening question; "In your lifetime (including childhood) have you ever injured your head, face or neck, or experienced repeated impacts to your head (e.g., from shaking, car accident, fall, fight, gunshot, explosion, contact sports or military service, etc.) OR have you ever experienced an illness that affected your brain (e.g., cancer, stroke, meningitis, tumor, drowning, poisoning, etc.)? __ Yes __ No __ Not sure." Nebraska VR staff are instructed to schedule a follow-up conversation with applicants who answer "Yes" or "Not Sure" to that question, using the ABI Screen as an interview guide to document a lifetime history of possible brain injury incidents and resulting functional challenges that may pose barriers to employment. During this reporting period, 629 individuals applied for Nebraska VR services and completed the pre-screening question. Of those individuals, 54 indicated a possible history of ABI and were screened in more detail by Nebraska VR staff for a lifetime history of ABI and any associated barriers to employment that may have resulted from the ABI(s).

Section H. Other

31. Describe what activities you undertook in this area this reporting period.

The centerpiece of Nebraska VR's TBI grant is the Voice-driven Network Capacity Building project. The goal for this project is to build leadership capacity across a statewide network of people with the lived experience of brain injury and their family members. Network members will be connected with each other to provide support, and they will be equipped to advocate with one voice for policy, program and service changes that will benefit Nebraskans impacted by brain injury. With technical assistance provided by a contracted consultant, the Nebraska Injured Brain Network (NIBN) demonstrated continued growth and progress in both personal and organizational capacity, as illustrated by the following milestones achieved during this reporting period:

1. Consistent capacity-building and Board growth for the individual leaders and the organization as a whole.
2. NIBN worked with a contractor to design and build a website with interactive and connectivity capability to support the statewide injured brain community. The site went live in March 2021. NIBN sent a press release through the Nebraska Newspaper Association to all newspapers across the state.
3. NIBN successfully planned and proposed an approach to implement the Peer to Peer Support pilot, and was awarded a planning contract with Nebraska VR. The organization submitted a proposal and was contracted to implement the Peer to Peer Support pilot over the next 11 months.
4. As part of its Peer to Peer Support effort, NIBN partnered with the National Association of State Head Injury Administrators (NASHIA) and Independence Rising for implementation assistance.
5. NIBN began hosting its online Learning Communities as a follow up to the 2020 *Living with an Injured Brain* Summit.
6. NIBN is positioned to expand its Chapters via its website and Peer to Peer Support pilot.

32. Notes about data provided.

Figures listed are for participants with TBI. The NIBN Chapters also include family members.

Per request from Dana Fink with ACL, we are providing the following additional data on the NIBN Chapter members with TBI:

Participant Living Setting (Individuals with TBI only)	**Number**	**Zero**	**Unknown**
On their own/independent	17		
Homeless		x	
With parent or grandparent	2		
With immediate family	2		
With friends or other extended family		x	
Group Home		x	
Prison or Jail/Justice involved setting		x	
Transitional living program or temporary housing		x	
Community Based Neurobehavioral Rehabilitation Services		x	
Nursing facility or inpatient rehabilitation setting		x	
Supervised living setting		x	
Other (Specify):			
Other (Specify):			
Other (Specify):			
Employment/School setting	**Number**	**Zero**	**Unknown**
Competitive, integrated employment	1		
In school or training		x	

Section I. Narrative Responses

33. Please describe the TBI mentoring and work group activities your program led or participated in during this reporting period.

Transition and Employment Workgroup

The *Transition and Employment* Workgroup was comprised of representatives from Indiana, Nebraska, North Carolina and Vermont. Representatives from Iowa and Colorado also participated. Mentor grantee states, Indiana and Nebraska, provided leadership and administrative support for workgroup activities. The members met monthly via a virtual meeting platform. During the reporting period, work continued on the VRC Competencies and self-assessment tool. Workgroup members identified several strategies for promoting the tool to state VR programs; explaining its usefulness for identifying education and training gaps among front-line VR staff and increasing VR success rates with clients who experience TBI. The group collaborated with Dr. Christina Dillahunt-Aspillaga to draft a sample letter for VR Administrators to introduce the tool to staff. Workgroup members collaborated with the VR programs in their respective states to disseminate the self-assessment survey to VRCs and in some cases, to other program personnel, such as office supervisors and administrators. Aggregate survey

results from Indiana, Nebraska, North Carolina and Vermont are described in the report titled *VRC Self-Assessment Overall Descriptive Results, March 2021*. Each of the four states also received a report of their own state-level results, and guidance on how to use the assessment results. Workgroup members collaborated with Dr. Christina Dillahunt-Aspillaga and Dr. Lance Trexler to draft an article on the assessment results, and implications for training and practice that will be submitted for publication in the summer of 2021.

In May 2021, Nebraska VR administered a satisfaction survey to members of the workgroup to solicit feedback about the workgroup's activities and gather information about the future of the workgroup in ACL's next grant cycle. The survey was sent to 12 members of the workgroup and 6 responded (response rate: 50%). The full report titled *ACL Workgroup Satisfaction Survey: Transition and Employment Results – May 2021* is attached as a Nebraska VR grant product. Overall, the results were positive:

- All of the respondents indicated that they were very satisfied overall with being a member of the workgroup and that they were very satisfied with the virtual meeting platform.
- All four individuals who received individual assistance from a mentor indicated they were satisfied or very satisfied with the assistance they received.
- Four out of six workgroup members indicated that they plan to continue their participation in the workgroup during the next grant cycle.

Nebraska submits the following products on behalf of the workgroup:

- VRC Self-Assessment for Serving Individuals with a Brain Injury – FINAL 7-21-2020
- VRC Self-Assessment Overall Descriptive Results, March 2021
- VRC Self-Assessment Nebraska Descriptive Results, March 2021
- How to Use State-Level Results from the Vocational Rehabilitation Counselor (VRC) Self-Assessment for Serving Individuals with a Brain Injury
- PowerPoint Presentation: Administration for Community Living (ACL), Transition and Employment Workgroup, Vocational Rehabilitation Competencies, VRC Competency Self-Assessment, for the Iowa Brain Injury Conference
- PowerPoint Presentation: The Vocational Rehabilitation Counselor (VRC) Competencies and the Competency Self-Assessment, for the AoD National Community of Practice Monthly Webinar – The Power of Partnerships
- VRC Competency Project Power Point template, 508 Compliant Version
- Transition and Employment Workgroup Education and Training Resources: Excel List of Legacy Materials and Resources from Dr. Christina Dillahunt-Aspillaga and Dr. Lance Trexler. The Excel document can be found here: https://drive.google.com/drive/folders/10BrNjANq5d-PeZmT5BKgcwAqsayRBO9N?usp=sharing

Using Data to Connect People to Services Workgroup

The *Using Data to Connect People to Services* workgroup met monthly via a virtual platform. Mentor grantee states, Virginia and Nebraska, facilitated each meeting. The workgroup includes Partner state representatives from Alabama, Alaska, California, Georgia, Idaho, Kansas, Maine, Maryland, Minnesota, Missouri, North Carolina, Rhode Island, Utah and Vermont. All meetings were recorded and archived for the benefit of members who could not attend. The group is very large, but very productive. During this reporting period, the workgroup accomplished the following activities:

- Mentor states worked with the National Association of State Head Injury Administrators (NASHIA) to distribute the TBI Registry questionnaire link to the remaining TBI grantee states, as well as other unfunded states within their network of members. Virginia contracted with NASHIA to write and finalize a white paper of the questionnaire results and recommendations which will be widely distributed and made available to the public. Nebraska contracted with Virginia to cover a portion of the costs as well.
- Mentor states worked with the TBI Technical Assistance and Resource Center (TARC) to complete a literature review on best practices for developing and using statewide TBI Registries. This product is an attachment to the *TBI Registries White Paper*.
- Workgroup members shared products and information with TBI TARC representatives and other Mentor states.

In May 2021, Nebraska VR administered a satisfaction survey to members of the workgroup to solicit feedback about the workgroup's activities and gather information about the future of the workgroup in ACL's next grant cycle. The survey was sent to 42 members of the workgroup and 16 responded (response rate: 38%). The full report titled *ACL Workgroup Satisfaction Survey: Using Data to Connect People to Services – May 2021* is attached as a Nebraska VR grant product. Overall, the results were positive:

- Nearly all of the respondents indicated that they were very satisfied overall with being a member of the workgroup and that they were very satisfied with the virtual meeting platform.
- All individuals who received individual assistance from a mentor indicated they were satisfied or very satisfied with the assistance they received.
- Most (12 out of 16) respondents indicated that they plan to continue their participation in the workgroup during the next grant cycle.

Nebraska submits the following products on behalf of the workgroup:

- The Final TBI Registries White Paper, which includes results of the TBI Registries Questionnaire that was distributed to both funded and unfunded states. The document is titled B*est Practices for Using TBI Registries to Connect People to Services.*
- The link to the recording of a presentation by CB Eagye, Data Analyst at the Craig Hospital TBI Model Systems National Data and Statistical Center, at the Data Workgroup meeting during NASHIA's Annual State of the States Conference (reported in Year 3, Part 1 Semi-Annual Report). The recording can be found here: https://www.youtube.com/watch?v=8OKuoqECgmk

Mentor State Workforce Development Workgroup

The TBI Workforce Development workgroup met monthly via videoconference to coordinate on several tasks, including technical assistance needs and workforce training competencies for the following domains (1) Return-to-Learn/Return-to-Play, (2) Criminal and Juvenile Justice, (3) Opioid Use and Mental Health, (4) Transition and Employment (VRC) and (5) Underserved Populations. The Mentor work group did not meet during March, 2021 due to the "Tuesday Engagement Days" series of webinars as part of Hill Day activities.

The table below provides a brief status update on each of the competency domains as the 2018-2021 funding cycle ends. These updates were documented during the final meeting of the Mentor work

group on Tuesday, May 4. No conclusions were drawn as to the primary contacts for continuation of the work, where the documents might "live" to ensure they are available to grantees across funding cycles (e.g., ACL, NASHIA, HSRI) or how the competencies might be used (e.g., incorporated into training programs, publications, etc.).

Competency Domain	**Status**	**Final steps – this funding cycle**	**Recommended next steps – next funding cycle**	**Primary contact for questions**
Return to Learn/Return to Play	Complete	Wrap up self-assessment tool; finalize introduction to competencies; begin dissemination	Continue to disseminate and get feedback via Qualtrics survey	To be determined (TBD)
Transition and Employment	Complete	IN, NE, VT, NC sharing results w/ VR leadership w/in each state. Continued work on a drafted article for submission.	Consider generating a version 2 of the competency survey for VRC, and other providers, in the employment and pre-employment transition arenas, based on lessons learned from version 1. Additional ideas for carrying the work forward have been solicited from NASHIA.	TBD
Criminal & Juvenile Justice	Complete	HSRI is completing a *Findings on the Relevancy of the Criminal and Juvenile Justice Competency* report.	Review and finalize the *Findings on the Relevancy of the Criminal and Juvenile Justice Competency Report.* Consider drafting a publication for submission to a journal	TBD
Opioid Use and Mental Health	DRAFT	The draft competencies are out for SME Review. Several responses have come in and reminders will go out this week. Workgroup members are also being asked to reach out to their state's SMEs urging them to participate.	We are discussing next steps at this week's regularly workgroup meeting.	TBD

Underserved populations	Did not initiate this funding cycle	N/A	Consider separate competencies for different Underserved groups (e.g., survivors of domestic violence, rural frontier).	TBD

34. Please describe the extent to which the mentoring and work group activities you participated in added value to your program, the national program, and/or any other aspect of your TBI work.

The workgroup experiences offered an excellent venue for states to share information, resources, strategies and best practices with each other. Nebraska benefitted from discussions in the *Using Data to Connect People to Services* work group to identify additional TBI data sources that will help us "tell the story" of TBI in our state. The *Transition and Employment* work group's collaboration on vocational rehabilitation counselor (VRC) Competencies has been most rewarding, and will be a great contribution to development of a national TBI workforce training program. The results of our self-assessment survey for VRCs have been useful in planning strategies for increasing our staff's capacity to successfully serve our clients with TBI.

35. Did you use the services of the TBI Technical Assistance and Resource Center (TARC) during this reporting period? If yes, please describe these services.

Yes, Nebraska VR utilized the services of the TBI TARC during this reporting period. The TARC representative assisted with a review of our State Plan and a presentation of the results to our BIAC. As a Mentor state for the Transition and Employment Workgroup, Nebraska engaged the TARC in developing recommendations for continuing the VRC Competencies work done by the workgroup members.

The Brain Injury Advisory Council (also referred to as Council or BIAC) acts as the forum for all brain injury stakeholders in the state to collectively identify needs and service gaps, and to recommend policy and system changes to improve the lives of people impacted by brain injury. The Council is sponsored by the Nebraska Department of Education (NDE), Office of Vocational Rehabilitation (Nebraska VR).

Volunteer members from across the state include people living with brain injury, their family members, and a variety of state agency and service provider representatives. Members are appointed by the Nebraska VR Director and the NDE Commissioner of Education.

Ways you can get involved

- Sign up for email messages to receive the latest information on brain injury, events, and resources
- Apply to be a Council member (application on next page)
- Attend a Council meeting and serve on a committee
- Participate in surveys, summits, webinars and other opportunities
- Invite a speaker to your workplace or civic organization to learn more about brain injury and explore employee training opportunities

For more information

braininjury.nebraska.gov

vr.infobiac@nebraska.gov

(308) 224-7571

This project was supported, in part by grant number 90TBSG0036-03-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

March 2021

Nebraska Brain Injury Advisory Council

The mission of the Council is to engage, integrate and inspire brain injury stakeholders to help achieve the Statewide Vision for Brain Injury Policies and Services.

Council Initiatives

- Helping to develop the Voice of Brain Injury in Nebraska
- Gathering data on brain injury in Nebraska by surveying individuals, their families, stakeholders, and hosting statewide summits
- Championing pilot projects to develop and provide resource facilitation and peer to peer supports
- Partnering with Nebraska VR to carry out the Annual Living with Brain Injury State Plan objectives
- Advocating for system and service provider changes that benefit individuals with brain injury and their families

BRAIN INJURY ADVISORY COUNCIL

APPLICATION FOR MEMBERSHIP

The mission of the Brain Injury Advisory Council (BIAC) is to engage, integrate and inspire brain injury stakeholders to help achieve the Statewide Vision for Brain Injury Policies and Services.

Members are appointed to the BIAC by the Nebraska VR Director and the Commissioner of Education for a term of three years.

Individuals are required to disclose all employment and organizational affiliations as part of the application process.

Nebraska VR and the Brain Injury Advisory Council support the full and meaningful participation of individuals with brain injury and other disabilities. Requests for accommodations should be directed to Keri Bennett, Nebraska VR, (308) 224-7571 or keri.bennett@nebraska.gov.

I. PERSONAL INFORMATION:

_____ ___ _____
First Name MI Last Name

_____
Street/Mailing Address

_____ _____ _____ _____
City State Zip Code County

_____ _____
Home Phone # Cell Phone #

_____
Email Address

II. ARE YOU:

An Individual who experiences a brain injury? Yes ____ No ____

A family member of an individual who experiences a brain injury? Yes ____ No ____

III. YOUR INTEREST IN APPOINTMENT: Describe in detail why you are interested in serving on the BIAC. Include especially information about your background and experiences or elements of your personal history relating to brain injury that supports your interest and qualifies you for appointment. (You may complete this section on a separate sheet of paper.)

_____

IV. YOUR EMPLOYMENT/ORGANIZATIONAL AFFILIATIONS:
(especially relating to brain injury) (attach a separate sheet of paper if needed)

Current employment (Employer/Organization, City & State, Phone #, Title/Position)
(A current resume may be submitted):

_____

_____

_____

_____

Current association memberships, appointments to boards and commissions, and offices you hold:

_____

_____

_____

Volunteer activities:

_____

_____

Higher education achieved:

_____

_____

Professional licenses held:

_____

V. REFERENCES: List three persons who have known you well within the past five (5) years. Include a current telephone number and your relationship to the individual:

_____

First and Last Name Telephone # Relationship

_____

First and Last Name Telephone # Relationship

_____

First and Last Name Telephone # Relationship

VI. DIVERSITY INFORMATION: The BIAC wishes to reflect the diversity of the population of the state with regard to race, ethnicity, gender, and disability characteristics. (Optional)

Gender _____ Racial/Ethnic background: _____

Veteran: Yes ____ No ____ Person with a Disability: Yes ____ No ____

Other information you wish to share: _____

_____

VII. MEMBERSHIP RESPONSIBILITIES:

I acknowledge that I have read and understand the BIAC member responsibilities as outlined in the **BIAC Operating Procedures.**

- Be a representative for Nebraskans with BI and represent their interests.
- Be actively involved in Council initiatives and activities.
- Adhere to the Conflict/Duality of Interest Policy as stated in Article IV of the BIAC Operating Procedures Manual.
- Maintain a broad view of and the willingness to learn about BI and the service options needed by and available to individuals with BI and their families.

- Gather concerns from and report back to organizations or constituencies (liaison role).
- Be willing to gather and share information with consumer organizations, agencies and others.
- Be willing and able to attend at least four in-person Council meetings during the year and serve on sub-committees when requested.

_____ _____

Applicant's Name **Date**

NE Brain Injury Advisory Council (BIAC) Mentor Program

The BIAC is invested in ensuring each member has the opportunity to be fully engaged in Council activities. We know that joining a council like the BIAC can be a bit daunting, especially when you do not know other members and are new to the work of the Council. Therefore, we developed the BIAC Mentor Program. The intent of this program is to match you, as a new Council member, with a more experienced member so that you have a mentor to help orient you to the work of the Council and answer any questions you might have.

Are you interested in being matched with a mentor in the BIAC Mentor Program? *(Please note that marking yes does not commit you to the program. If you mark yes, we will follow up with you to provide more information.)*

Yes ____ **No____**

Please complete the entire form and return via email to:

keri.bennett@nebraska.gov

Or by mail:
Nebraska Brain Injury Advisory Council
Attn: Keri Bennett
Program Director for Acquired Brain Injury
Nebraska VR
315 W 60th Street, Ste 400
Kearney, NE 68845-1504

For Council Use Only:

Applicant was interviewed on _____

Applicant has attended a Council meeting on _____

Action taken by the Council: _____

ACL Workgroup Satisfaction Survey: Transition and Employment Results – May 2021

In May 2021, a satisfaction survey was administered to members of the ACL Transition and Employment Workgroup in order to receive feedback about the workgroup's activities and gather important information about the future of the workgroup in ACL's next grant cycle. The survey was sent to 12 members of the workgroup and 6 responded (response rate: 50%) (Table 1).

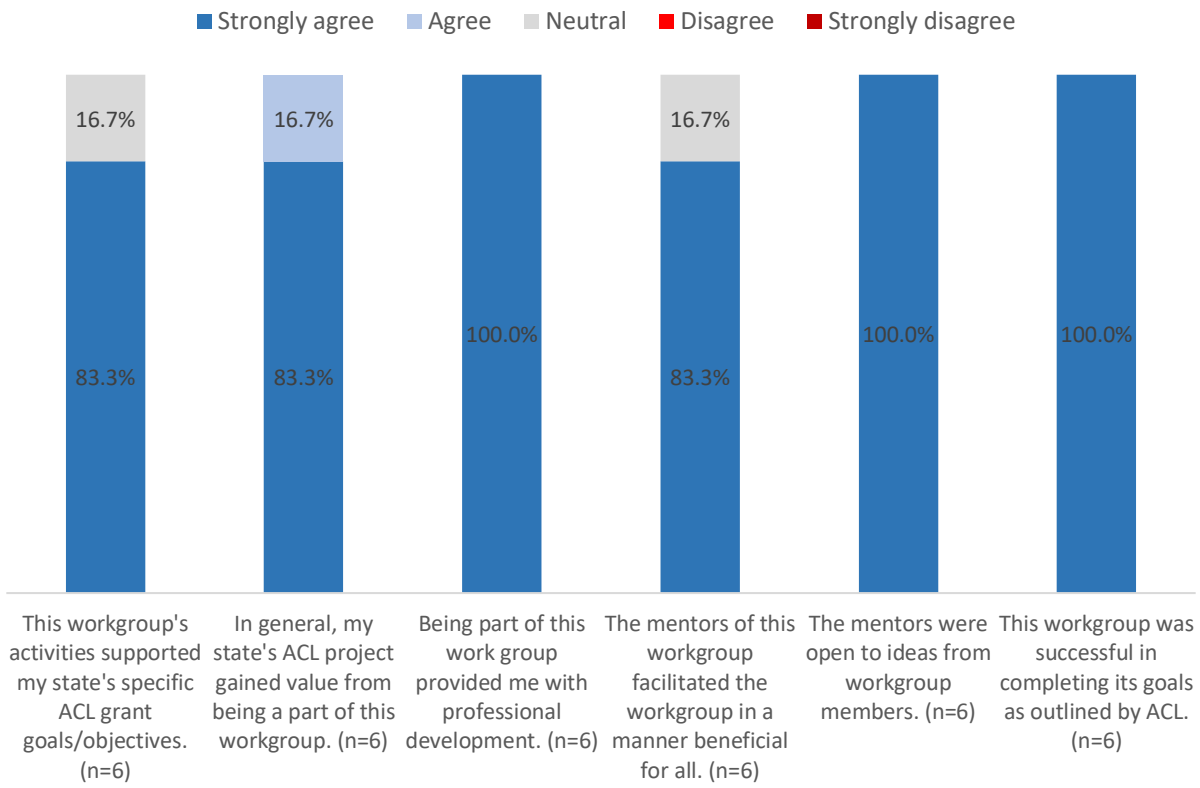
Table 1	**Response rate**	
Surveys sent	**Surveys received**	**Response rate**
12	6	50.0%

Table 1 presents the demographics of the respondents.

Table 2	**Respondent Demographics**	
	Total number of surveys collected	***6***
State (n=6)	*Nebraska*	33.3%
	North Carolina	33.3%
	Indiana	16.7%
	Iowa	16.7%
Participant type (n=6)	*Mentor*	50.0%
	Partner	33.3%
	Guest	16.7%
Role (n=6)	*Active contributor to content*	83.3%
	Minor contributor to content	16.7%
	Primarily listened in	0.0%

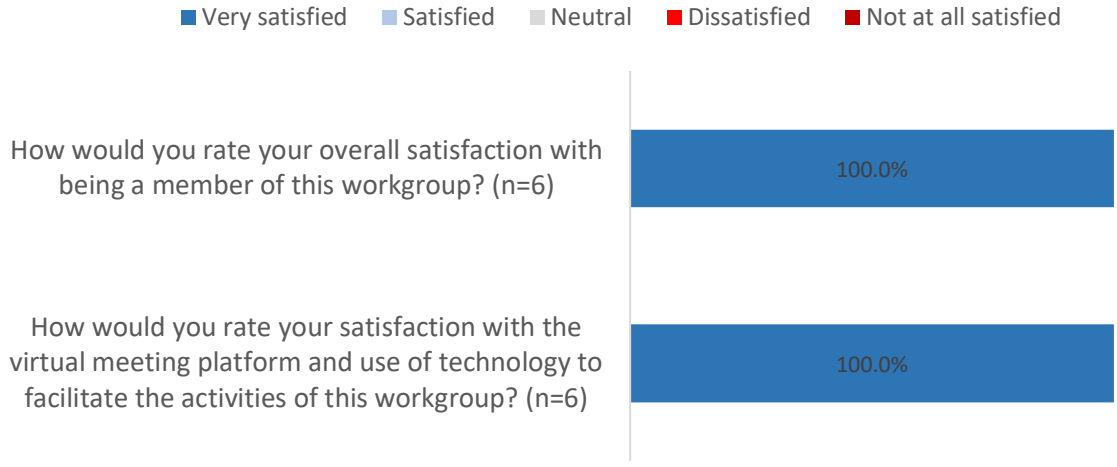
Nearly all of the respondents agreed or strongly agreed with the six statements regarding their perceptions of the workgroup's activities, indicating a positive experience (Figure 1).

FIGURE 1. Perceptions of the workgroup's activities



All of the respondents indicated that they were very satisfied overall with being a member of the workgroup and that they were very satisfied with the virtual meeting platform (Figure 2).

FIGURE 2. Satisfaction

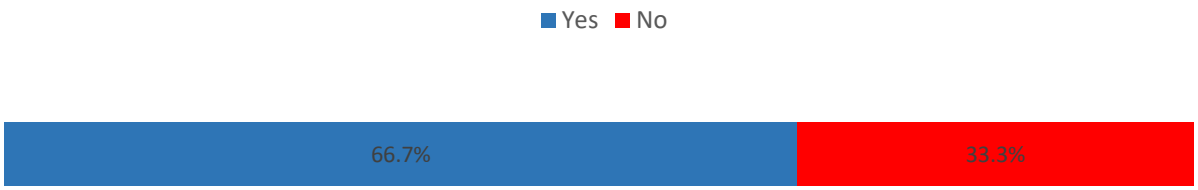


Comments about the use of technology:

- The GoToMeeting platform seemed to work well for most participants.
- Platform was easily accessible and conducive to group discussions.

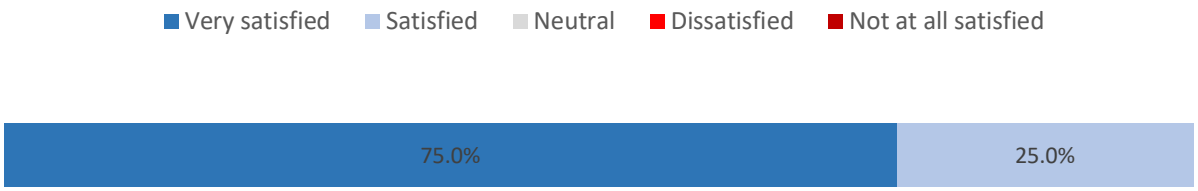
Four out of the six respondents indicated that they received individual assistance from a mentor of this workgroup (Figure 3).

FIGURE 3. Did you receive individual assistance from a mentor of this workgroup? (n=6)



All four individuals who received individual assistance from a mentor indicated they were satisfied or very satisfied with the assistance they received (Figure 4).

FIGURE 4. How would you rate your satisfaction with the individual assistance you received from a mentor of this workgroup? (n=6)

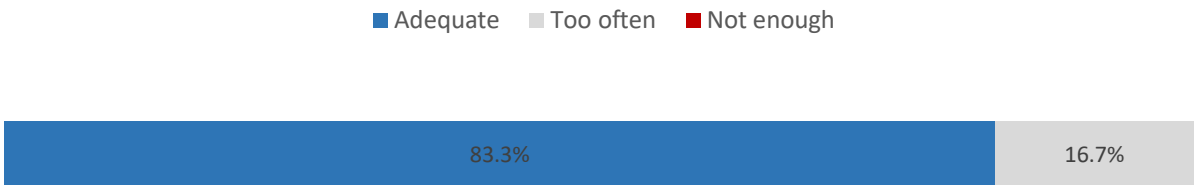


Comments about the individual assistance from a mentor:

- Periodic questions to clarify status, tasks, materials, and plans were always addressed in a very helpful thorough manner. A request to speak about this project at our state BIAIA conference was accepted and completed.
- Very helpful insight into better understanding VR employment systems and how to effectively network with them.

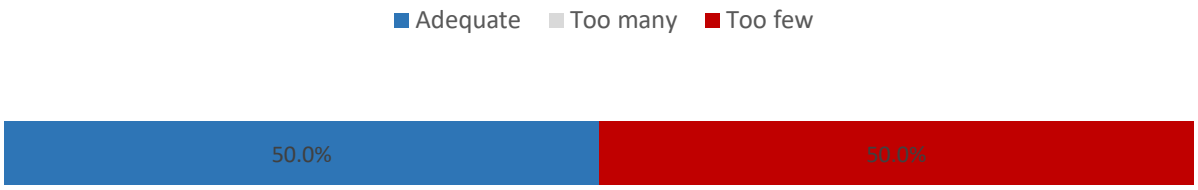
Five out of the six respondents felt that the monthly meetings were adequate. One respondent felt that the meetings were too often (Figure 5).

FIGURE 5. This workgroup met monthly. How would you rate the frequency of the meetings for this workgroup? (n=6)



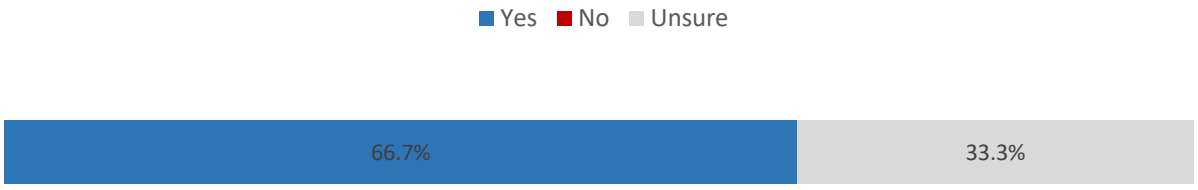
Half of the respondents felt that there was an adequate number of participants in the workgroup. The other half felt there were too few participants (Figure 6).

FIGURE 6. How would you rate the number of participants in this workgroup? (n=6)



Four out of six workgroup members indicated that they plan to continue their participation in the workgroup during the next grant cycle. The other two were unsure (Figure 7).

FIGURE 7. Do you plan to continue participation in this workgroup in the next grant cycle? (n=6)



Comments:

- Not sure how it fits with the next grant, but definitely appreciate the relationships forged with people in this group so may confer on other topics.
- We are unsure of our goals at this time, if we were to get a contract for some of this funding.
- Absolutely. This has been an extremely productive and beneficial work group for all participants and others in the overall SPP.

Tables 2 through 4 present open-ended comments of this workgroup. All of the respondents indicated that the work around VR competencies was the major accomplishment of the group (Table 2).

Table 2	What are the major accomplishments of this workgroup?
• Development of competencies for VR counselors, development of self-assessment of competency • The development of the Core Competencies for brain injury for employment specialists and VR counselors, and the development of the template for utilization in each state for work with your VR's is very helpful. • Development of survey for VR employees. • The VRC Competencies and VRC Self-Assessment Survey are major accomplishments for this workgroup. They will be valuable to any state wishing to improve their state-federal VR program services to clients with TBI. • The development of the VRC Competencies and all products associated with this. • Too many to list all here. Some include core competency survey development/implementation/results reviews, lit. reviews, guest attendees providing pertinent information	

Table 3	Was there anything the workgroup was unable to accomplish? If so, please describe any barriers that impeded this accomplishment.
• Would have liked to get further into defining elements of competencies, though this is a huge task. Also, would have liked to identify competencies by position--what do placement staff need to know, what do employment specialists need to know to exhibit competency in serving people with BI • Ongoing process • Time limits were the only barrier we encountered. However, the workgroup will continue into the next grant cycle, so we should be able to accomplish more in the next 5 years. • Quote from the ACL kick-off webinar: "Mentors will work together and with the TBI Coordinating Center to assess legacy resources, identify gaps and promising practices, and develop training materials and a training infrastructure." The lack of time and size of the group (small) limited our capacity to address this domain. • I believe that this work group accomplished all goals/objectives established and then some! Such a pleasure working all my colleagues in this extremely productive group. The addition of Will who was able to synthesize the data for us was a critical and welcomed addition to group activity.	

Table 4	**In some workgroups the Mentor/Partner designations played a significant role in the administration of the workgroup (e.g., drafting an agenda, leading and co/leading the workgroup, tracking and circulating minutes, and tracking action steps). Without this designation moving forward, do you have suggestions regarding how to structure workgroups and serve these essential functions?**
• Could simply seek a group leader, or define tasks and assign them based on expertise or willingness to serve in the capacity. I did like the mentor/partner arrangement, but am not sure how states were designated that way. The partner states may not have had less knowledge or expertise than the mentors--and it's not apparent how it was decided which would serve as partners and which as mentors. • Workgroups structured according to interest and ACL grant awarded. Leadership of the workgroups could be based on experience (i.e. NC has 5 years experience with TBI Screening, etc.) • Leading these workgroups is time-consuming. I suggest the TBI TARC provide help with logistics, and provide meeting agenda and minutes templates so there is some consistency among the workgroups.I suggest that no one state be given or assigned more than one workgroup to lead. • Rotational leadership, with a state designated as the responsible party for tracking updates to the membership list serve • I have no idea. Perhaps ACL could provide group facilitators?	

ACL Workgroup Satisfaction Survey:
Using Data to Connect People to Services
Results – May 2021

In May 2021, a satisfaction survey was administered to members of the ACL Using Data to Connect People to Services in order to receive feedback about the workgroup's activities and gather important information about the future of the workgroup in ACL's next grant cycle. The survey was sent to 42 members of the workgroup and 16 responded (response rate: 38%) (Table 1).

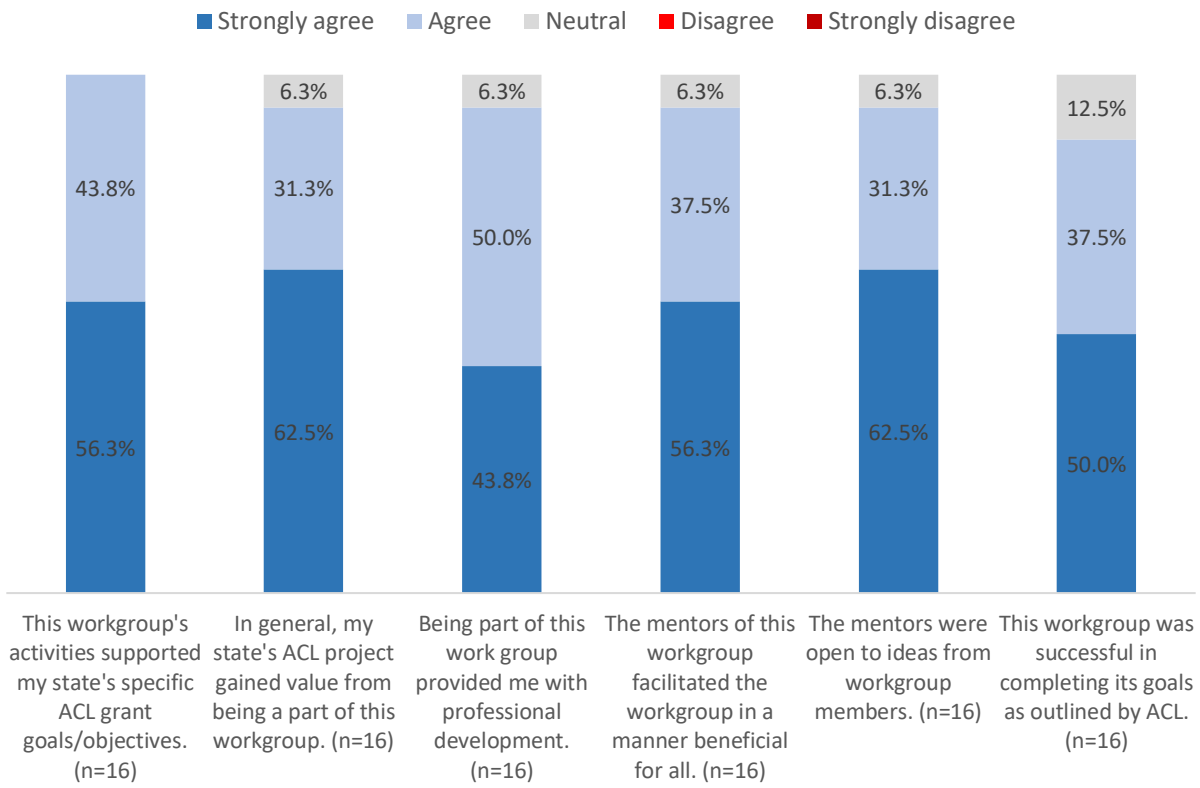
Table 1	**Response rate**	
Surveys sent	**Surveys received**	**Response rate**
42	16	38.1%

Table 1 presents the demographics of the respondents.

Table 2	**Respondent Demographics**	
	Total number of surveys collected	***16***
State (n=16)	*Georgia*	18.8%
	Virginia	12.5%
	Utah	12.5%
	Minnesota	6.3%
	Vermont	6.3%
	Rhode Island	6.3%
	Alabama	6.3%
	Kansas	6.3%
	Nebraska	6.3%
	Indiana	6.3%
	Idaho	6.3%
	North Carolina	6.3%
Participant type (n=16)	*Mentor*	18.8%
	Partner	75.0%
	Guest	6.3%
Role (n=16)	*Active contributor to content*	43.8%
	Minor contributor to content	18.8%
	Primarily listened in	37.5%

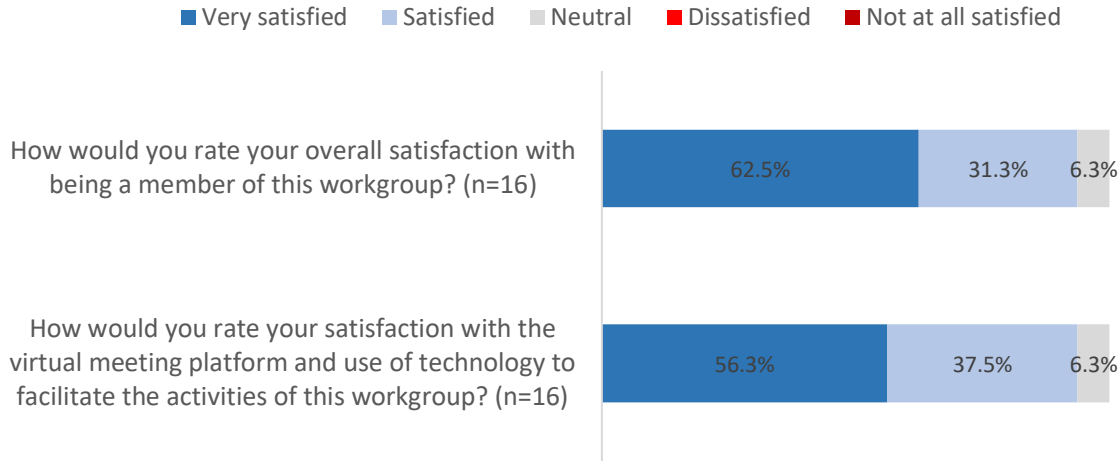
Nearly all of the respondents agreed or strongly agreed with the six statements regarding their perceptions of the workgroup's activities, indicating a positive experience (Figure 1).

FIGURE 1. Perceptions of the workgroup's activities



Neatly all of the respondents indicated that they were very satisfied overall with being a member of the workgroup and that they were very satisfied with the virtual meeting platform (Figure 2).

FIGURE 2. Satisfaction

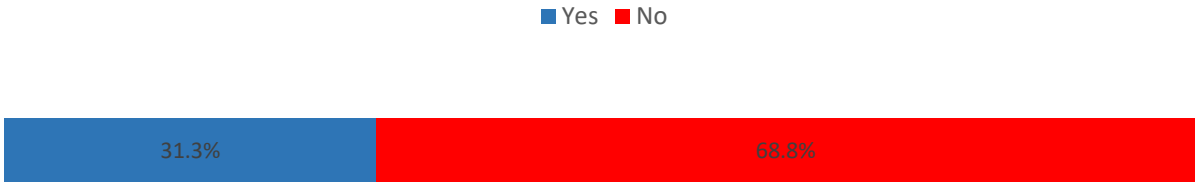


Comments about the use of technology:

- The technology used for group meetings was always reliable and really came in handy over the last year.
- Worked well enough.
- We used GoToMeeting, but any platform is OK.
- I had no problems during any of the meetings connecting remotely. On occasions there were times when someone's video or audio may not have been working property but by having two mentor states participating this never caused enough of a problem to impede progress of the work group.
- No issues. Work group meetings were easily accessible and conducive to productive group discussion.

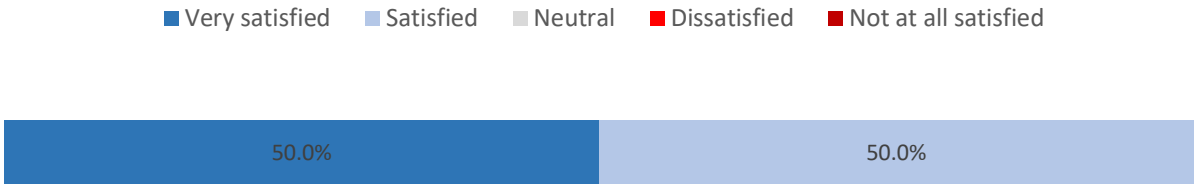
Five out of the 16 respondents indicated that they received individual assistance from a mentor of this workgroup (Figure 3).

FIGURE 3. Did you receive individual assistance from a mentor of this workgroup? (n=16)



All individuals who received individual assistance from a mentor indicated they were satisfied or very satisfied with the assistance they received (Figure 4).

FIGURE 4. How would you rate your satisfaction with the individual assistance you received from a mentor of this workgroup? (n=4)



Comments about the individual assistance from a mentor:

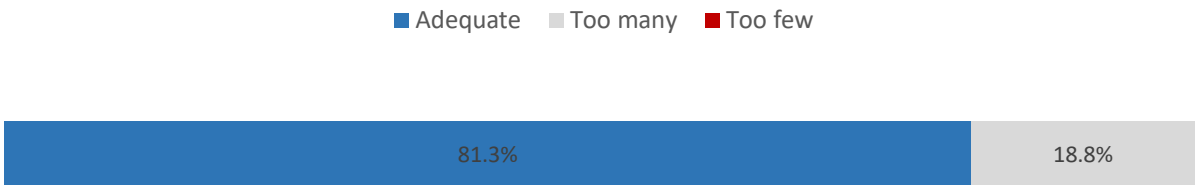
- Very prompt replies to questions, friendly.
- TN provided assistance with ICD 10 CM codes for RI registry update

Most (12 out of 16) respondents felt that the monthly meetings were adequate. Four respondents felt that the meetings were too often (Figure 5).

FIGURE 5. This workgroup met monthly. How would you rate the frequency of the meetings for this workgroup? (n=16)

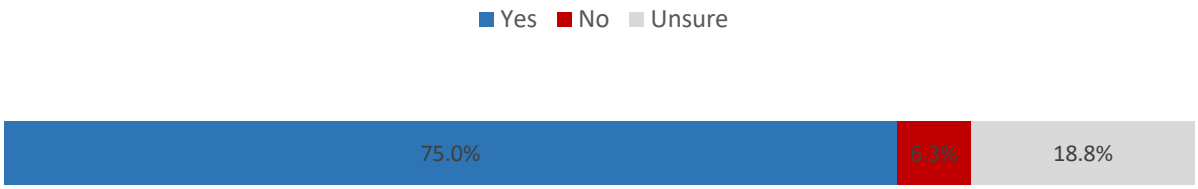
Most (13 out of 16) respondents felt that there was an adequate number of participants in the workgroup. Three respondents felt that there were too many participants (Figure 6).

FIGURE 6. How would you rate the number of participants in this workgroup? (n=16)



Most (12 out of 16) respondents indicated that they plan to continue their participation in the workgroup during the next grant cycle. One indicated that they do not plan to continue participation and three were unsure (Figure 7).

FIGURE 7. Do you plan to continue participation in this workgroup in the next grant cycle? (n=16)



Comments:

- If workgroup continues will participate.
- We are proposing to shift the focus of the workgroup to exploring common data elements that will help states measure prevalence and 'tell the story' of TBI in their state.

- I believe the issue of data collection to be important to the work we do. This was the largest work group with I think about 18 states represented. Having that many participants on a call can make it difficult for everyone to be heard.
- If we are awarded a grant we will definitely continue participating in this work group. Data is such a critical piece of program/infrastructure development.

Tables 2 through 4 present open-ended comments of this workgroup.

Table 2	What are the major accomplishments of this workgroup?

- This workgroup has helped bring states together to look at the different data systems that are in place or could be in place to track and help individuals with brain injury be connected to services. I believe it also helped some states, such as Vermont determine if a registry would be useful or not.
- different ideas on way data can be collected
- Proposal for new workgroup, White Paper on Registries, Relationship-building with other members. I felt this workgroup accomplished a lot and could have done more with a longer grant-cycle.
- The White Paper
- Whitepaper.
- Information sharing
- Defining data source for TBI
- Registry Questionnaire Literature Study
- The TBI Registries white paper is a major accomplishment and will be useful to many other states who are trying to establish a registry. Our state survey will also be a useful tool. This group produced a lot of products!
- I did not attend consistently but am aware of the Registry survey that went to states, and a report summarizing results
- -The White paper, The Data Survey, The document created to share our information from each stated. Discussions on prevalence and how to gain access to more data (specific programs) I could look into for my state from ideas of the group.
- TBI/Trauma Registry Survey and White Paper Report Coming away with an understanding of how a state could move forward in determining prevalence at the state level Recognizing that state health data information exchanges exist in many states Having baseline data for the types of data collection that states have access to
- Some accomplishments include creating a baseline of understanding where states are at in terms of TBI data collection and analysis.

Table 3	Was there anything the workgroup was unable to accomplish? If so, please describe any barriers that impeded this accomplishment.

- There was a lot of discussion about adding core brain injury questions to the BRFSS. Unfortunately, this will not be possible based on information and feedback from ACL and CDC.
- n/a

- None.
- The major barrier was COVID and getting CDC to create a validated brain injury module for BRFSS
- Not sure
- I don't think there is anything the group wanted to do that we didn't accomplish.
- I don't have enough information to answer.
- I think this group brought together some remarkable ideas and products despite the distraction of COVID. COVID was the barrier to many things this go round.
- Data is such a broad issue for states. I thought this group did a good job in prioritizing a couple of areas to focus on within the framework of data and produced products that will enhance the field

Table 4	**In some workgroups the Mentor/Partner designations played a significant role in the administration of the workgroup (e.g., drafting an agenda, leading and co/leading the workgroup, tracking and circulating minutes, and tracking action steps). Without this designation moving forward, do you have suggestions regarding how to structure workgroups and serve these essential functions?**

- If this designation does not exist, the group may need to see if there are volunteers to take on the different roles within the group. Maybe the individuals within these roles could change on an annual basis, so it does not fall to the same people or the same states for the entire grant period- sort of a "shared governance" model.
- A mentor was key in the success of the groups as they were the lead on the group's activities and there was a go to person. There needs to be a way they are compensated for this work.
- I have heard that TARC may assist with facilitation in the next grant cycle, and I think that's a great idea. The Mentor role was a LOT of work.
- I do not and wonder how that will be accomplished.
- ACL could contract with NASHIA to act as a key player in the transitioning process for each workgroup. limiting the products required of each workgroup will help with the transition as well.
- Good question. Don't have any suggestions right now.
- This will be difficult unless there are assigned leaders or the TBI TARC staff provide administrative and logistical help. The groups may wish to assign roles and responsibilities, and use templates for agendas, meeting minutes and work plans so that we maintain structure from year to year. It will be difficult to juggle participation in 3 or more workgroups.
- Rotational leadership with a different state to partner as designated note taker. Time set aside in each workgroup at the end to collaboratively determine prioritized, drafted agenda for next meeting.
- I am not sure how the mentors had time to do all the roles they were assigned. We were grateful. I am sorry I do not have ideas of how to make it easier or restructure although I do believe it does need a administrator for the group.
- I think personnel from the two mentor states did a nice job in facilitating meetings. Someone(s) has to be accountable in moving the group forward. Having 18 states at times felt too large a group so forming 2 groups or having subcommittees (which we did at the

end) proved to be helpful. Maybe trying to have different people rotating leading the meetings might be helpful but recognize that not everyone wants this role/responsibility. Sharing responsibility is fine but someone still has to be responsible.

- I do not.

Vocational Rehabilitation Counselor Self-Assessment for Serving Individuals with a Brain Injur

This self-assessment is based on a set of competencies for vocational rehabilitation counselors who serve individuals with a brain injury (BI) as they re-enter the workforce. The competencies were designed by the U.S. Administration for Community Living, Traumatic Brain Injury State Partnership Program's Transition and Employment Workgroup.

The purpose of this self-assessment is to gauge vocational rehabilitation counselors' self-perceptions of their level of expertise within each competency as it relates to serving individuals with BI. There is widespread interest among various stakeholders in the brain injury field to learn what VR counselors perceive to be their own strengths, as well as areas where more training may be desired or needed. Future education and training opportunities may be informed by the results of this self-assessment.

This self-assessment is not intended to be a review of your work performance. No one will be able to connect your answers back to you personally. Please give your honest opinions.

This self-assessment should take approximately 10 to 15 minutes to complete. Thank you for your time.

Vocational Rehabilitation Counselor Self-Assessment for Serving Individuals with a Brain Injur

1. Please describe your professional role(s).

2. Do any of the following descriptions apply to your professional role? (select all that apply)

- [ ] Intake counselor
- [ ] Perform vocational assessments
- [ ] Specialize in brain injury
- [ ] Serve as educator, mentor, or supervisor to new vocational rehabilitation counselors
- [ ] None of the above apply to my professional role

3. In what state do you work?

4. How many years of experience have you had in your role(s) described in question 1?

- ○ Less than 1 year
- ○ 1-2 years
- ○ 3-5 years
- ○ 6+ years

5. What is your highest level of education?

- ○ High school or GED
- ○ Associate Degree
- ○ Some College no degree
- ○ Bachelor’s Degree
- ○ Master Degree
- ○ PhD
- ○ Other (please specify)

6. (If Bachelor's Degree or higher) What was your major of your highest level of education?

- ◯ Social work
- ◯ School counseling
- ◯ Psychology
- ◯ Other (please specify)

Please review the competencies on the subsequent pages of this self-assessment. For each competency, please rate your own level of expertise using the following scale:

0 – None

1 – Limited - ***limited understanding of the competency, limited opportunity to apply the competency, competency has been minimally demonstrated***

2 – Basic - ***basic understanding sufficient enough to handle routine tasks, requires some guidance and supervision when applying this competency, can discuss terminology and concepts related to this competency***

3 – Proficient - ***detailed knowledge, understanding, and application of the competency; requires minimal guidance or supervision, consistency demonstrates success in the competency, able to assist others in the application of the competency***

4 – Advanced - ***highly developed knowledge, understanding, and application of the competency; is able to coach or teach others on the competency; can help develop materials and resources in the competency***

5 – Expert - ***specialist/authority level knowledge, understanding, and application of the competency; recognized by others an expert in the competency and is sought by others throughout the organization; able to explain issues in relation to broader organizational issues; creates new applications or processes; has a strategic focus***

Brain Injury Medical and Rehabilitation Concepts

7. Please rate your level of expertise in the following areas.

	None	Limited	Basic	Proficient	Advanced	Expert
Understands medical and rehabilitation terminology pertaining to BI	○	○	○	○	○	○
Understands how BI screening tools (e.g. OSU-TBI ID, BISQ, HELPS) may assist in the identification of potentially undiagnosed BI	○	○	○	○	○	○
Able to implement and interpret agency-sanctioned BI screening tools	○	○	○	○	○	○
Understands that BI may be categorized along a spectrum from mild to severe	○	○	○	○	○	○
Understands that categorization of initial injuries may not predict long-term outcomes	○	○	○	○	○	○
Understands that recovery from BI, and long-term outcomes are individualized and based on many variables	○	○	○	○	○	○
Understands how BI affects the following functional systems: cognition (memory, attention, executive skills, problem solving, etc.), speech and language production and comprehension, physical, motor, and sensory abilities (strength, endurance, range of motion, vision, perception, hearing, balance, etc.), behavior and mood regulation (awareness, adjustment, mood, interpersonal skills, etc.)	○	○	○	○	○	○
Recognizes how symptoms (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) of BI can affect work performance in a variety of ways (e.g., interpersonal interactions, personal and home independence, and community re-entry)	○	○	○	○	○	○
Understands the importance of individual education in preventing secondary BI	○	○	○	○	○	○
Understands the risks of substance use disorders	○	○	○	○	○	○
Knows the resources to support abstinence from substance use	○	○	○	○	○	○
Understands the prevalence, effects, and support needs presented when a person has co-occurring disorders (such as a mental illness or substance misuse)	○	○	○	○	○	○
Able to identify the range of specialists, professionals, and services in their state (e.g. home and community-based waivers, county- or regionally-funded programs, resource facilitation services, etc.) that may address BI needs, challenges and impairments.	○	○	○	○	○	○

	None	Limited	Basic	Proficient	Advanced	Expert
Understands the implications of BI as a chronic condition, including aging with BI, and the implications for future rehabilitative and community-based employment supports, and is familiar with the long and short term rehabilitation needs & life care planning	○	○	○	○	○	○
Stays abreast of best practices/research related to treatment approaches (Motivational Interviewing, Person Centered Planning, etc.), pharmacology, and more, and is able to refer to specialists for same	○	○	○	○	○	○

Employment Concepts

8. Please rate your level of expertise in the following areas.

	None	Limited	Basic	Proficient	Advanced	Expert
Understands and accounts for factors, such as reduced self-awareness and memory impairment, that must be considered with other functional skills information in determining eligibility for Vocational Rehabilitation services	○	○	○	○	○	○
Understands how BI may impact an individual's ability to participate in, and benefit from, vocational rehabilitation services	○	○	○	○	○	○
Partners with the individual to identify and employ accommodations to ensure success in vocational rehabilitation services	○	○	○	○	○	○
Understands factors that contribute to poor employment outcomes in persons with BI	○	○	○	○	○	○
Uses a comprehensive, "team" approach to vocational assessment and evaluation for individuals with a BI, synthesizing information from multiple sources, including but not limited to, information on the individual's pre- and post-injury functioning, strengths, expressed preferences and interests, vocational experience and abilities, education and training accomplishments, and need for workplace accommodation and supports.	○	○	○	○	○	○
Understands the importance of integrating support persons and professional recommendations in employment planning and goal development	○	○	○	○	○	○
Understands and identifies appropriate workplace supports to help a worker with BI	○	○	○	○	○	○
Understands the similarities and differences between the following concepts: accommodations, restoration, assistive technologies, and demonstrates skills in triaging for same	○	○	○	○	○	○
Recognizes when an individual with a BI requires an accommodation, titration (gradual return) to return to work activities or post-secondary or other training	○	○	○	○	○	○
Understands how BI may impact an individual in the work setting and understands how to pair necessary and reasonable accommodations with individual challenges or impediments	○	○	○	○	○	○
Understands how post-injury interventions and compensatory strategies must be tailored to an individual's needs	○	○	○	○	○	○
Able to facilitate access to employment-related advocacy, legal remedies, resources, etc.	○	○	○	○	○	○
Understands how public benefits may be impacted by employment	○	○	○	○	○	○

State and Local Systems, Resources and Service Coordination

9. Please rate your level of expertise in the following areas.

	None	Limited	Basic	Proficient	Advanced	Expert
Understands state-specific initiatives and mandates related to employment (Governor proclamations, priorities, goals, etc.)	○	○	○	○	○	○
Able to explain State Vocational Rehabilitation services available for persons with disability	○	○	○	○	○	○
Understands how BI services are delivered by the VR system, including state policies and procedures	○	○	○	○	○	○
Understands the vocational rehabilitation role is to identify, coordinate, and provide services to the individual	○	○	○	○	○	○
Understands the importance of case management and system's navigation to facilitate goal attainment	○	○	○	○	○	○
Understands the importance of resource facilitation to facilitate goal attainment (if it exists in the state)	○	○	○	○	○	○
Knows state, district, and local community employment support resources and associated referral processes	○	○	○	○	○	○
Knows funding resources to support pre-employment and employment activities	○	○	○	○	○	○
Possesses skills in developing and sustaining collaborative relationships to benefit individual clients	○	○	○	○	○	○
Understands the importance of providing BI resources to employers and other partners in the employment process, based on individual client disclosure preferences	○	○	○	○	○	○

National Systems, Research and Best Practices

10. Please rate your level of expertise in the following areas.

	None	Limited	Basic	Proficient	Advanced	Expert
Understands relevant federal legislation, including but not limited to, the Americans with Disabilities Act (ADA), Workforce Innovation and Opportunities Act (WIOA), and any state-specific legislation related to return to work and work supports	○	○	○	○	○	○
Understands a wide variety of evidence-based vocational rehabilitation models and return-to-work approaches for persons with BI	○	○	○	○	○	○

11. Describe how you learn a new skill best and then apply it.

Thank you for completing this self-assessment!

This project was supported, in part by grants from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

Vocational Rehabilitation Counselor Self-Assessment for Serving Individuals with a Brain Injury

Overall Descriptive Results
March 2021

Transition and Employment Workgroup

→ Indiana
→ Nebraska
→ Vermont
→ North Carolina

Purpose

The Administration for Community Living (ACL) Traumatic Brain Injury (TBI) State Partnership Grants work aim to "create and strengthen a system of services and supports that maximize the independence, well-being, and health of persons with TBI across the lifespan, their families and their caregivers." The 2018-2021 cohort of ACL TBI State grantees developed competencies that describe knowledge, skills and abilities needed by professionals who serve individuals with brain injury (BI) in a number of areas based on subject matter expert vetting. The competencies are designed to serve as a general guide for professional development. Under the grant, the Transition and Employment work group developed competencies for vocational rehabilitation counselors serving individuals who are working to enter or re-enter the workforce following a BI. This work group consists of representatives from Nebraska, Indiana, North Carolina, and Vermont.

Workforce competencies were developed by the ACL Transition and Employment Workgroup through a five-step process:

1. Workgroup members and vocational rehabilitation counselors (VRCs) from Nebraska and Indiana drafted a list of professional core competencies for VRCs based on their own knowledge and experience.
2. A review of 26 relevant articles citations was conducted by the workgroup to determine whether any additional competencies were identified in the literature.
3. A first-tier subject matter expert review was conducted by 43 vocational rehabilitation professionals (direct service staff).
4. A second-tier subject matter expert review was conducted by six individuals with extensive clinical, academic and/or clinical expertise in the field of brain injury and vocational rehabilitation, including neuropsychologists, researchers in TBI, a rehabilitation counselor/psychologist, and a former administrator of brain injury services.
5. A final list of 40 core competencies within four domains was drafted, incorporating feedback from the subject matter experts.

With the final set of core competencies for VRCs serving individuals with brain injury in hand, a self-assessment survey for VRCs was created. The purpose of this self-assessment is (1) to gauge VRC's self-perceptions of their level of expertise within each competency as it relates to serving individuals with brain injury, (2) to understand differences in self-perceived competence between the four domains within which the competencies are organized, and (3) to search for correlations between self-perceived competence and education, role, experience, and, potentially, state in which the VRC is employed. Future professional education and training opportunities may be informed by the results of this self-assessment.

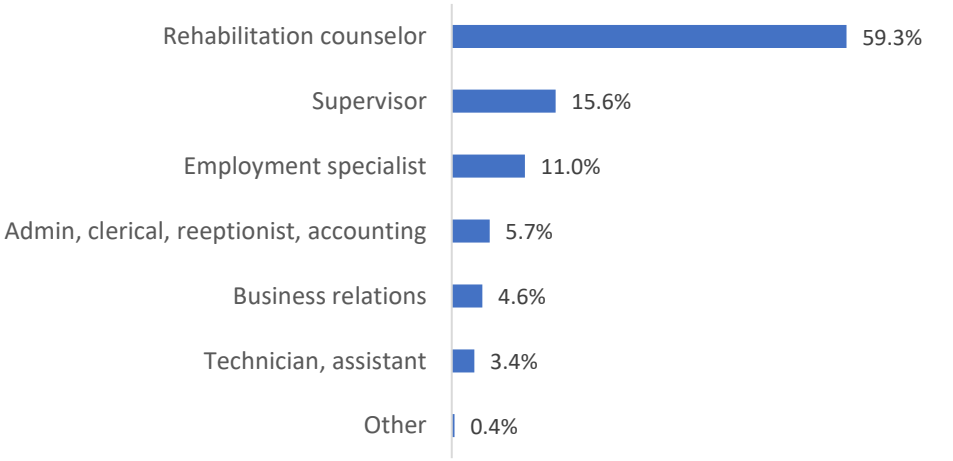
Participants

VRCs from states participating in the ACL Transition and Employment Workgroup (Nebraska, Indiana, North Carolina, and Vermont) were asked to compete the self-assessment in late 2020 and early 2021. The timing of administration varied from state to state. The self-assessment was conducted online using SurveyMonkey. Each State was responsible for administering the survey to its VRCs. Furthermore, each state administered the survey in different ways. Therefore, a comparison between states, or a comparison between one state and the overall results, is not possible.

The initial dataset included 304 respondents. A rule was applied whereby all individuals who assessed themselves on less than 80% of the competencies were excluded from the final dataset. After applying this rule, there were 269 individuals in the final dataset.

A majority (59%) of respondents identified themselves as rehabilitation counselors. A variety of professional roles were represented among the respondents (Figure 1).

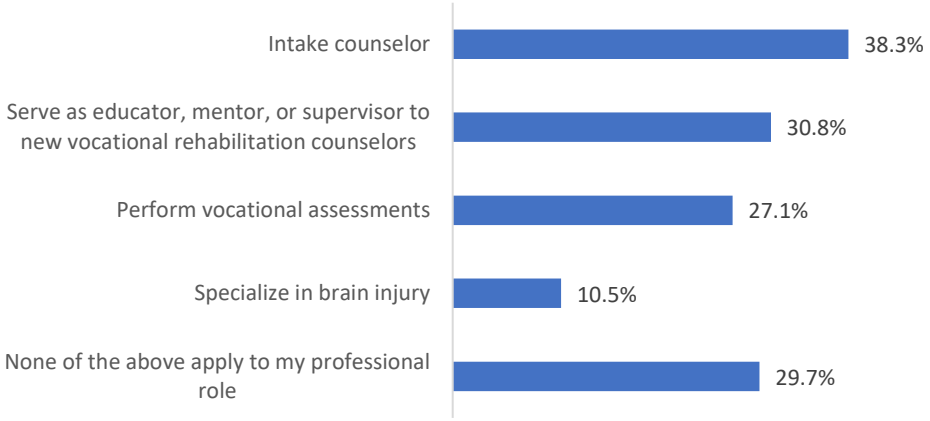
Figure 1. Professional role* (n=263)



*Categorization of open-ended responses

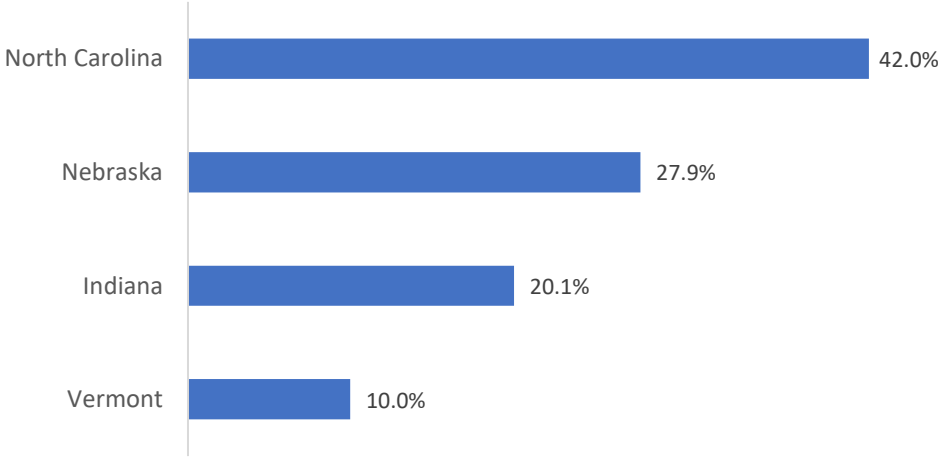
Respondents were asked about their professional responsibilities. Respondents reported a mix of responsibilities related to the work of a VRC. However, 30% indicated that intake counselor, education for new VRCs, vocational assessments, and specialization in brain injury **do not** apply to their role (Figure 2).

Figure 2. Professional responsiblities (multiple responses) (n=266)



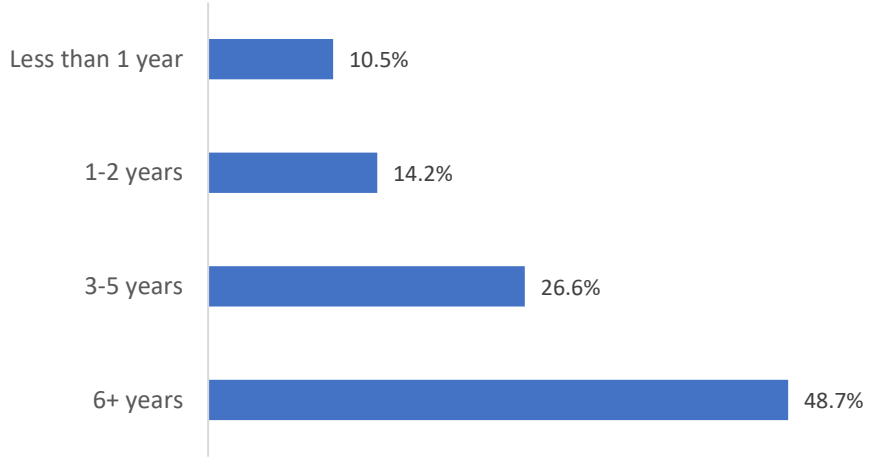
A plurality (42%) of respondents were from North Carolina (Figure 3).

Figure 3. State (n=269)



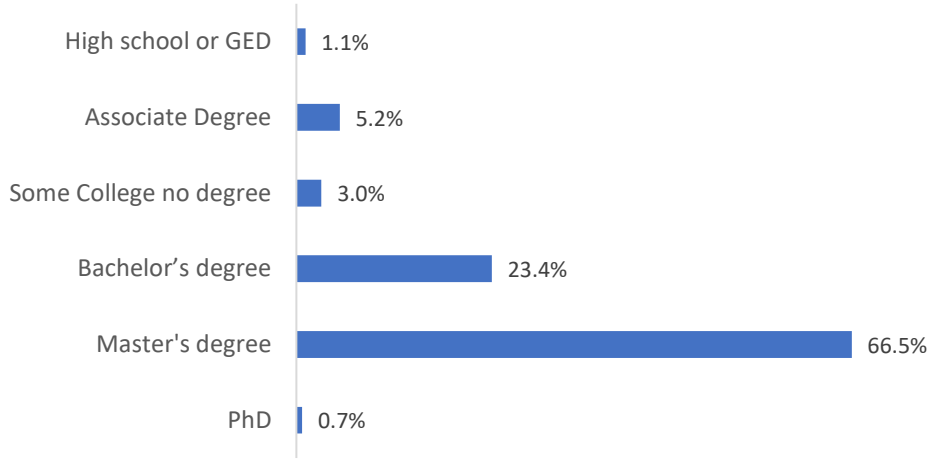
Nearly half (49%) of respondents indicated six or more years in their current role (Figure 4).

Figure 4. Years of experience in current role (n=267)



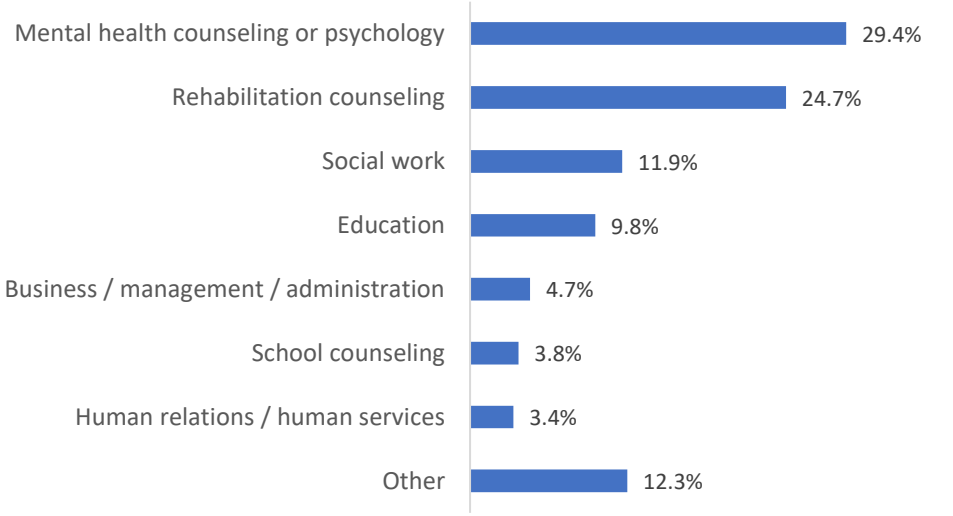
Two-thirds (67%) of respondents indicated that they have a master's degree and one-fourth (23%) indicated that they have a bachelor's degree. A relatively small minority (9%) indicated that they have a degree less than a bachelor's (Figure 5).

Figure 5. Highest level of education (n=269)



Among those with a bachelor's degree or higher, a wide variety of majors were reported with mental health counseling or psychology and rehabilitation counseling being the top two responses (Figure 6).

Figure 6. Major (among those with a bachelor's degree or higher)* (n=235)



*Categorization of open-ended responses

Measures

The self-assessment is based on the final set of 40 competencies created by the ACL Transition and Employment Workgroup. VRCs are asked to assess their level of expertise on each competency using the following rubric, based on a model created by Dario Russo[1]:

- **0 – None** - no understanding of the competency.
- **1 – Limited** - limited understanding of the competency, limited opportunity to apply the competency, competency has been minimally demonstrated.
- **2 – Basic** - basic understanding sufficient enough to handle routine tasks, requires some guidance and supervision when applying this competency, can discuss terminology and concepts related to this competency.
- **3 – Proficient** - detailed knowledge, understanding, and application of the competency; requires minimal guidance or supervision, consistency demonstrates success in the competency, able to assist others in the application of the competency.
- **4 – Advanced** - highly developed knowledge, understanding, and application of the competency; is able to coach or teach others on the competency; can help develop materials and resources in the competency.
- **5 – Expert** - specialist/authority level knowledge, understanding, and application of the competency; recognized by others an expert in the competency and is sought by others throughout the organization; able to explain issues in relation to broader organizational issues; creates new applications or processes; has a strategic focus.

The competencies are organized within four domains as follows:

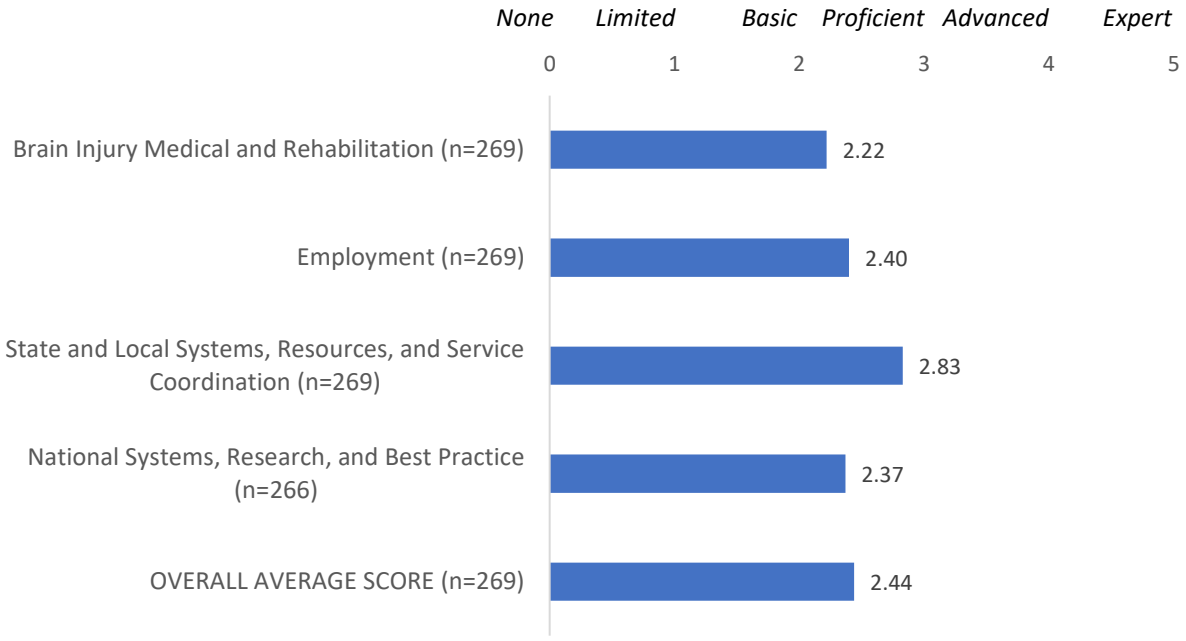
- Brain Injury Medical and Rehabilitation Concepts (15 competencies)
- Employment Concepts (13 competencies)
- State and Local Systems, Resources, and Service Coordination (10 competencies)
- National Systems, Research and Best Practice (2 competencies)

[1] Russo, J.D (2016). Competency Measurement Model. *European Conference on Quality in Official Statistics (pp. 7-8).*

Aggregate Scores

Aggregate scores for the four domains plus the overall average score revealed that on average respondents rated their competency somewhere between basic and proficient. The domain with the highest aggregate score was State and Local Systems, Resources, and Service Coordination. The lowest aggregate score was in the domain of Brain Injury Medical and Rehabilitation (Figure 7).

Figure 7. Aggregate Scores* by Domain and Overall (on a scale from 0 to 5)



*Respondents must respond to at least 80% of the competencies within each domain to receive an aggregate score.

Individual Competency Ratings

This report uses a color coding system to serve as a rough guide for those interpreting the results of the survey. The 40 competencies were grouped into quartiles based on a ranking of the average rating as follows.

GOLD	**1st quartile (competencies ranked 1-10 in average rating)**
BLUE	**2nd quartile (competencies ranked 11-20 in average rating)**
GRAY	**3rd quartile (competencies ranked 21-30 in average rating)**
RED	**4th quartile (competencies ranked 31-40 in average rating)**

Overall, the Brain Injury Medical and Rehabilitation domain received the lowest ratings of competency. Six of the 15 competencies within this domain were in the bottom quartile. Just one competency within this domain was in the top quartile (Table 1).

Table 1 **Self-assessed expertise within BRAIN INJURY MEDICAL AND REHABILITATION competencies**

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
1. Understands medical and rehabilitation terminology pertaining to BI (n=264)	5.3%	15.9%	40.2%	29.9%	8.3%	0.4%	***2.21***	***38.6%***	***32***
2. Understands how BI screening tools (e.g. OSU-TBI ID, BISQ, HELPS) may assist in the identification of potentially undiagnosed BI (n=269)	24.9%	28.6%	22.7%	19.0%	4.1%	0.7%	***1.51***	***23.8%***	***39***
3. Able to implement and interpret agency-sanctioned BI screening tools (n=267)	31.5%	22.8%	20.2%	20.2%	4.5%	0.7%	***1.46***	***25.4%***	***40***
4. Understands that BI may be categorized along a spectrum from mild to severe (n=266)	3.0%	11.7%	36.5%	32.3%	13.2%	3.4%	***2.51***	***48.9%***	***16***
5. Understands that categorization of initial injuries may not predict long-term outcomes (n=268)	3.0%	14.2%	35.8%	31.3%	13.8%	1.9%	***2.44***	***47.0%***	***20***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
6. Understands that recovery from BI, and long-term outcomes are individualized and based on many variables (n=268)	3.0%	9.3%	29.9%	39.6%	13.8%	4.5%	***2.65***	***57.9%***	***8***
7. Understands how BI affects the following functional systems: cognition (memory, attention, executive skills, problem solving, etc.), speech and language production and comprehension, physical, motor, and sensory abilities (strength, endurance, range of motion, vision, perception, hearing, balance, etc.), behavior and mood regulation (awareness, adjustment, mood, interpersonal skills, etc.) (n=269)	1.5%	13.4%	34.6%	36.4%	12.3%	1.9%	***2.50***	***50.6%***	***17***
8. Recognizes how symptoms (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) of BI can affect work performance in a variety of ways (e.g., interpersonal interactions, personal and home independence, and community re-entry) (n=268)	1.9%	13.1%	34.0%	37.7%	12.3%	1.1%	***2.49***	***51.1%***	***18***
9. Understands the importance of individual education in preventing secondary BI (n=268)	5.6%	17.5%	36.9%	28.0%	10.1%	1.9%	***2.25***	***40.0%***	***30***
10. Understands the risks of substance use disorders (n=269)	3.0%	16.0%	28.6%	34.6%	14.1%	3.7%	***2.52***	***52.4%***	***14***
11. Knows the resources to support abstinence from substance use (n=265)	3.0%	16.6%	35.1%	30.6%	11.3%	3.4%	***2.41***	***45.3%***	***23***
12. Understands the prevalence, effects, and support needs presented when a person has co-occurring disorders (such as a mental illness or substance misuse) (n=268)	3.0%	19.4%	31.3%	33.2%	10.1%	3.0%	***2.37***	***46.3%***	***25***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
13. Able to identify the range of specialists, professionals, and services in their state (e.g. home and community-based waivers, county- or regionally-funded programs, resource facilitation services, etc.) that may address BI needs, challenges and impairments (n=269)	7.1%	23.8%	36.1%	25.3%	5.9%	1.9%	***2.05***	***33.1%***	***36***
14. Understands the implications of BI as a chronic condition, including aging with BI, and the implications for future rehabilitative and community-based employment supports, and is familiar with the long and short term rehabilitation needs & life care planning (n=269)	8.2%	18.6%	34.6%	29.4%	8.6%	0.7%	***2.14***	***38.7%***	***35***
15. Stays abreast of best practices/research related to treatment approaches (Motivational Interviewing, Person Centered Planning, etc.), pharmacology, and more, and is able to refer to specialists for same (n=269)	12.6%	26.4%	34.2%	20.8%	4.8%	1.1%	***1.82***	***26.7%***	***38***

Most (9 out of 13) of the competencies within the Employment domain were ranked in the 2nd and 3rd quartiles (Table 2).

Table 2	**Self-assessed expertise within EMPLOYMENT competencies**								
	None (0)	**Limited (1)**	**Basic (2)**	**Proficient (3)**	**Advanced (4)**	**Expert (5)**	***AVERAGE RATING (0-5)***	***% PROFICIENT OR HIGHER***	***RANK***
1. Understands and accounts for factors, such as reduced self-awareness and memory impairment, that must be considered with other functional skills information in determining eligibility for Vocational Rehabilitation services (n=268)	3.7%	15.7%	28.4%	39.2%	10.4%	2.6%	***2.45***	***52.2%***	***19***
2. Understands how BI may impact an individual's ability to participate in, and benefit from, vocational rehabilitation services (n=269)	1.9%	10.4%	31.6%	40.9%	12.6%	2.6%	***2.60***	***56.1%***	***11***
3. Partners with the individual to identify and employ accommodations to ensure success in vocational rehabilitation services (n=267)	4.5%	12.4%	34.5%	36.0%	9.7%	3.0%	***2.43***	***48.7%***	***21***
4. Understands factors that contribute to poor employment outcomes in persons with BI (n=268)	3.7%	11.2%	37.3%	35.8%	9.7%	2.2%	***2.43***	***47.7%***	***22***
5. Uses a comprehensive, "team" approach to vocational assessment and evaluation for individuals with a BI, synthesizing information from multiple sources, including but not limited to, information on the individual's pre- and post-injury functioning, strengths, expressed preferences and interests, vocational experience and abilities, education and training accomplishments, and need for workplace accommodation and supports. (n=268)	5.2%	14.6%	34.0%	34.7%	9.0%	2.6%	***2.35***	***46.3%***	***26***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
6. Understands the importance of integrating support persons and professional recommendations in employment planning and goal development (n=268)	3.0%	13.1%	26.9%	41.8%	13.4%	1.9%	***2.55***	***57.1%***	***13***
7. Understands and identifies appropriate workplace supports to help a worker with BI (n=267)	4.5%	19.1%	30.3%	33.0%	12.0%	1.1%	***2.32***	***46.1%***	***28***
8. Understands the similarities and differences between the following concepts: accommodations, restoration, assistive technologies, and demonstrates skills in triaging for same (n=268)	4.5%	19.4%	30.6%	31.3%	11.2%	3.0%	***2.34***	***45.5%***	***27***
9. Recognizes when an individual with a BI requires an accommodation, titration (gradual return) to return to work activities or post-secondary or other training (n=269)	6.3%	18.6%	32.3%	32.0%	8.9%	1.9%	***2.24***	***42.8%***	***31***
10. Understands how BI may impact an individual in the work setting and understands how to pair necessary and reasonable accommodations with individual challenges or impediments (n=268)	4.1%	17.9%	35.4%	30.2%	10.1%	2.2%	***2.31***	***42.5%***	***29***
11. Understands how post-injury interventions and compensatory strategies must be tailored to an individual's needs (n=269)	4.5%	15.6%	33.5%	31.6%	12.3%	2.6%	***2.39***	***46.5%***	***24***
12. Able to facilitate access to employment-related advocacy, legal remedies, resources, etc. (n=269)	5.9%	19.7%	38.7%	24.9%	8.9%	1.9%	***2.17***	***35.7%***	***33***
13. Understands how public benefits may be impacted by employment (n=269)	3.3%	11.9%	28.3%	37.5%	14.1%	4.8%	***2.62***	***56.4%***	***9***

The State and Local Systems, Resources, and Service Coordination domain was overwhelmingly the highest rated domain. There are ten competencies within this domain, and eight of those ten were ranked within the top 10 of all competencies (i.e., first quartile) (Table 3).

Table 3	**Self-assessed expertise within STATE AND LOCAL SYSTEMS, RESOURCES, AND SERVICE COORDINATION competencies**								
	None (0)	**Limited (1)**	**Basic (2)**	**Proficient (3)**	**Advanced (4)**	**Expert (5)**	***AVERAGE RATING (0-5)***	***% PROFICIENT OR HIGHER***	***RANK***
1. Understands state-specific initiatives and mandates related to employment (Governor proclamations, priorities, goals, etc.) (n=269)	10.0%	19.7%	36.8%	24.9%	6.7%	1.9%	***2.04***	***33.5%***	***37***
2. Able to explain State Vocational Rehabilitation services available for persons with disability (n=269)	1.9%	4.1%	9.7%	33.1%	30.5%	20.8%	***3.49***	***84.4%***	***1***
3. Understands how BI services are delivered by the VR system, including state policies and procedures (n=267)	6.0%	10.9%	24.7%	34.1%	14.6%	9.7%	***2.70***	***58.4%***	***6***
4. Understands the vocational rehabilitation role is to identify, coordinate, and provide services to the individual (n=269)	0.4%	5.6%	14.5%	36.4%	27.1%	16.0%	***3.32***	***79.5%***	***2***
5. Understands the importance of case management and system's navigation to facilitate goal attainment (n=268)	0.7%	4.9%	16.0%	40.3%	25.4%	12.7%	***3.23***	***78.4%***	***3***
6. Understands the importance of resource facilitation to facilitate goal attainment (if it exists in the state) (n=268)	4.1%	9.3%	26.9%	31.7%	20.5%	7.5%	***2.78***	***59.7%***	***5***
7. Knows state, district, and local community employment support resources and associated referral processes (n=269)	3.7%	9.3%	31.2%	33.5%	16.4%	5.9%	***2.67***	***55.8%***	***7***
8. Knows funding resources to support pre-employment and employment activities (n=268)	5.2%	12.3%	31.7%	31.0%	15.7%	4.1%	***2.52***	***50.8%***	***15***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
9. Possesses skills in developing and sustaining collaborative relationships to benefit individual clients (n=268)	2.2%	6.0%	23.5%	37.7%	20.5%	10.1%	***2.99***	***68.3%***	***4***
10. Understands the importance of providing BI resources to employers and other partners in the employment process, based on individual client disclosure preferences (n=269)	3.3%	10.4%	31.6%	36.4%	12.6%	5.6%	***2.61***	***54.6%***	***10***

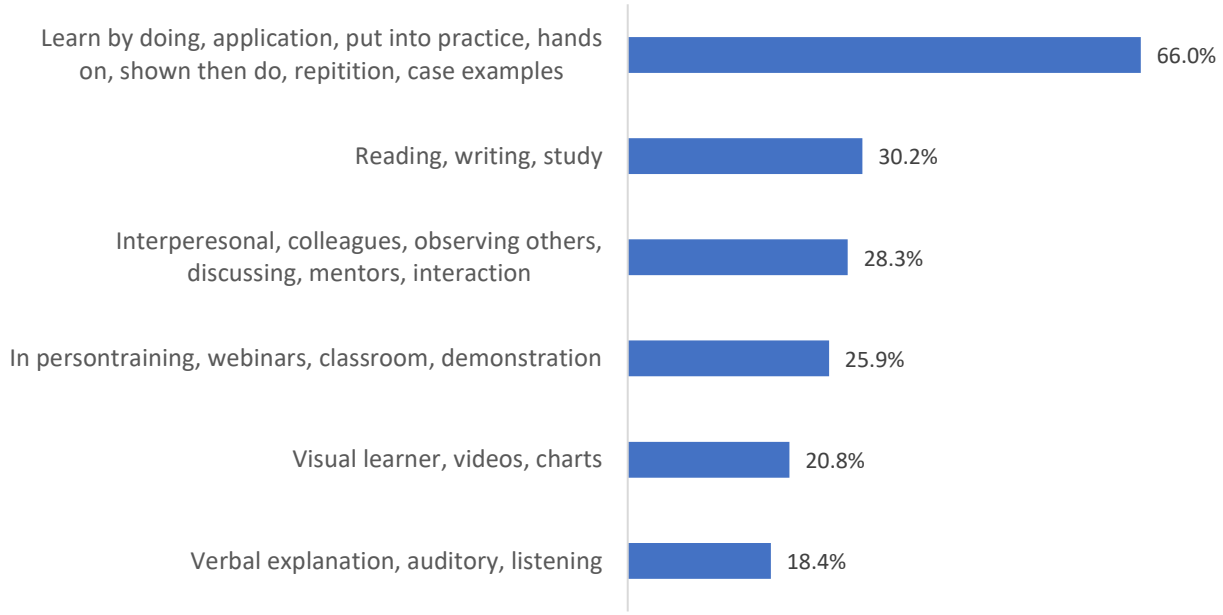
Just two competencies comprise the National Systems, Research, and Best Practices domain (Table 4).

Table 4	**Self-assessed expertise within NATIONAL SYSTEMS, RESEARCH, AND BEST PRACTICES competencies**								
	None (0)	**Limited (1)**	**Basic (2)**	**Proficient (3)**	**Advanced (4)**	**Expert (5)**	***AVERAGE RATING (0-5)***	***% PROFICIENT OR HIGHER***	***RANK***
1. Understands relevant federal legislation, including but not limited to, the Americans with Disabilities Act (ADA), Workforce Innovation and Opportunities Act (WIOA), and any state-specific legislation related to return to work and work supports (n=269)	3.7%	8.2%	33.5%	37.5%	13.0%	4.1%	***2.60***	***54.6%***	***12***
2. Understands a wide variety of evidence-based vocational rehabilitation models and return-to-work approaches for persons with BI (n=265)	7.2%	21.5%	34.3%	26.8%	7.5%	2.6%	***2.14***	***36.9%***	***34***

Learning Style

In an open-ended survey item, respondents were asked to describe how they learn a new skill best and then apply it. Two-thirds (66%) of respondents described a "hands on" or "learn by doing" way as how they learn best (Figure 8).

Figure 8. Describe how you learn a new skill best and then apply it* (multiple responses) (n=235)



*Categorization of open-ended responses

Vocational Rehabilitation Counselor Self-Assessment for Serving Individuals with a Brain Injury

Nebraska Descriptive Results
March 2021

Transition and Employment Workgroup

→ Indiana
→ Nebraska
→ Vermont
→ North Carolina

This report presents results from the 75 respondents from Nebraska.

Purpose

The Administration for Community Living (ACL) Traumatic Brain Injury (TBI) State Partnership Grants work aim to "create and strengthen a system of services and supports that maximize the independence, well-being, and health of persons with TBI across the lifespan, their families and their caregivers." The 2018-2021 cohort of ACL TBI State grantees developed competencies that describe knowledge, skills and abilities needed by professionals who serve individuals with brain injury (BI) in a number of areas based on subject matter expert vetting. The competencies are designed to serve as a general guide for professional development. Under the grant, the Transition and Employment work group developed competencies for vocational rehabilitation counselors serving individuals who are working to enter or re-enter the workforce following a BI. This work group consists of representatives from Nebraska, Indiana, North Carolina, and Vermont.

Workforce competencies were developed by the ACL Transition and Employment Workgroup through a five-step process:

1. Workgroup members and vocational rehabilitation counselors (VRCs) from Nebraska and Indiana drafted a list of professional core competencies for VRCs based on their own knowledge and experience.
2. A review of 26 relevant articles citations was conducted by the workgroup to determine whether any additional competencies were identified in the literature.
3. A first-tier subject matter expert review was conducted by 43 vocational rehabilitation professionals (direct service staff).
4. A second-tier subject matter expert review was conducted by six individuals with extensive clinical, academic and/or clinical expertise in the field of brain injury and vocational rehabilitation, including neuropsychologists, researchers in TBI, a rehabilitation counselor/psychologist, and a former administrator of brain injury services.
5. A final list of 40 core competencies within four domains was drafted, incorporating feedback from the subject matter experts.

With the final set of core competencies for VRCs serving individuals with brain injury in hand, a self-assessment survey for VRCs was created. The purpose of this self-assessment is (1) to gauge VRC's self-perceptions of their level of expertise within each competency as it relates to serving individuals with brain injury, (2) to understand differences in self-perceived competence between the four domains within which the competencies are organized, and (3) to search for correlations between self-perceived competence and education, role, experience, and, potentially, state in which the VRC is employed. Future professional education and training opportunities may be informed by the results of this self-assessment.

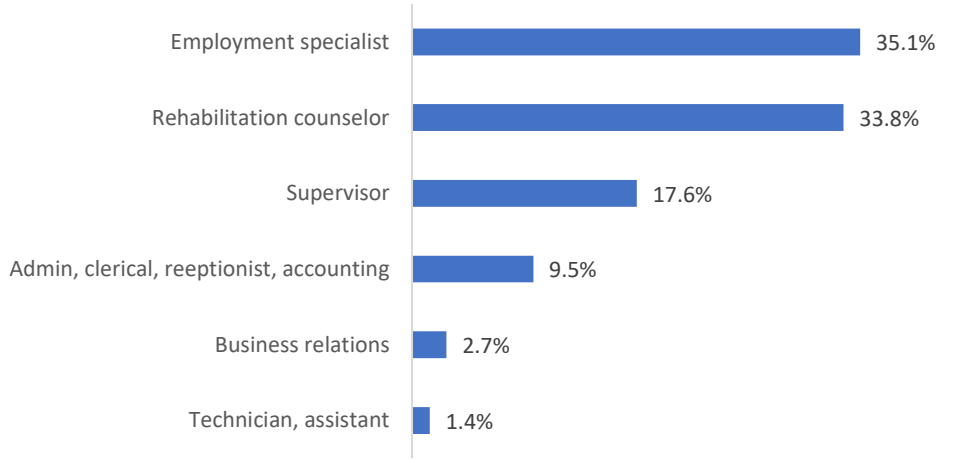
Participants

VRCs from states participating in the ACL Transition and Employment Workgroup (Nebraska, Indiana, North Carolina, and Vermont) were asked to compete the self-assessment in late 2020 and early 2021. The timing of administration varied from state to state. The self-assessment was conducted online using SurveyMonkey. Each State was responsible for administering the survey to its VRCs. Furthermore, each state administered the survey in different ways. Therefore, a comparison between states, or a comparison between one state and the overall results, is not possible.

The initial dataset included 83 respondents from Nebraska. A rule was applied whereby all individuals who assessed themselves on less than 80% of the competencies were excluded from the final dataset. After applying this rule, there were 75 individuals in the final dataset from Nebraska.

A majority (69%) of respondents from Nebraska identified themselves as an employment specialist or a rehabilitation counselor. A variety of professional roles were represented among the respondents (Figure 1).

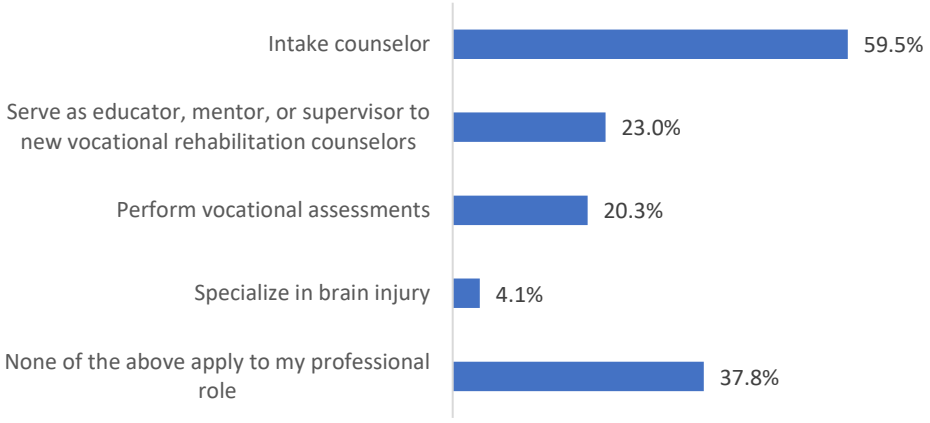
Figure 1. Professional role* (n=74)



*Categorization of open-ended responses

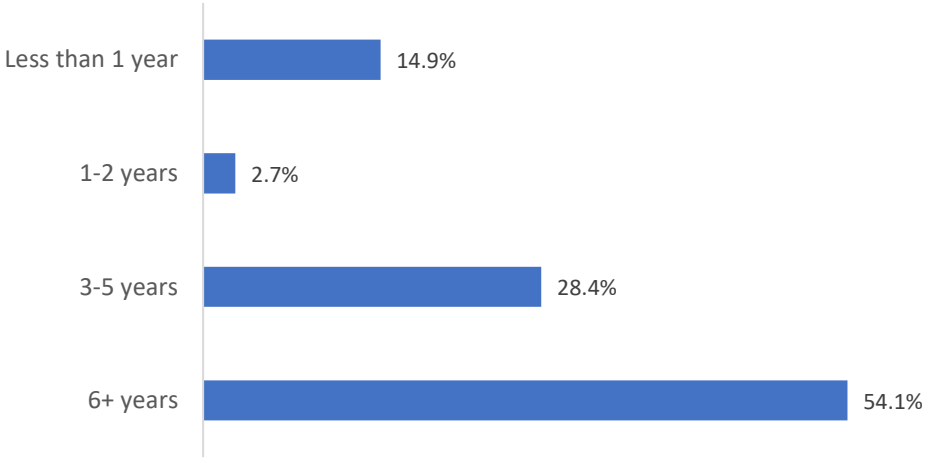
Respondents were asked about their professional responsibilities. Respondents reported a mix of responsibilities related to the work of a VRC. However, 38% from Nebraska indicated that intake counselor, education for new VRCs, vocational assessments, and specialization in brain injury **do not** apply to their role (Figure 2).

Figure 2. Professional responsiblities (multiple responses) (n=74)



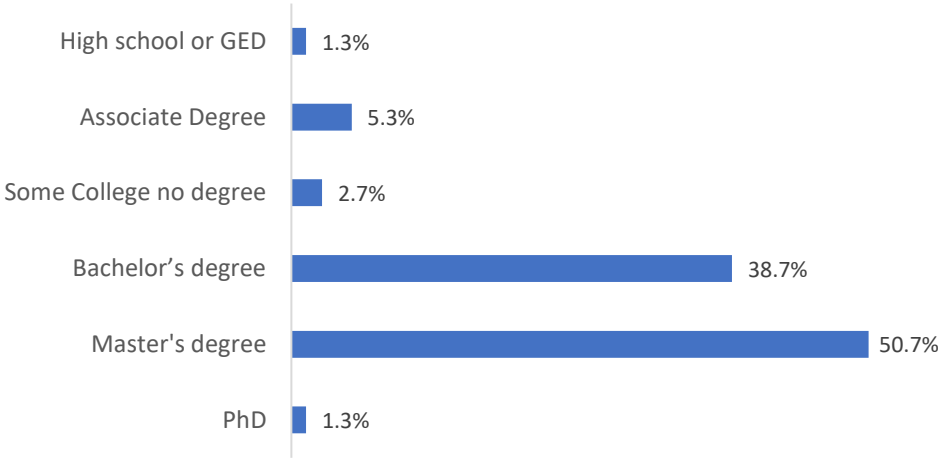
Just over half (54%) of respondents from Nebraska indicated six or more years in their current role (Figure 3).

Figure 3. Years of experience in current role (n=74)



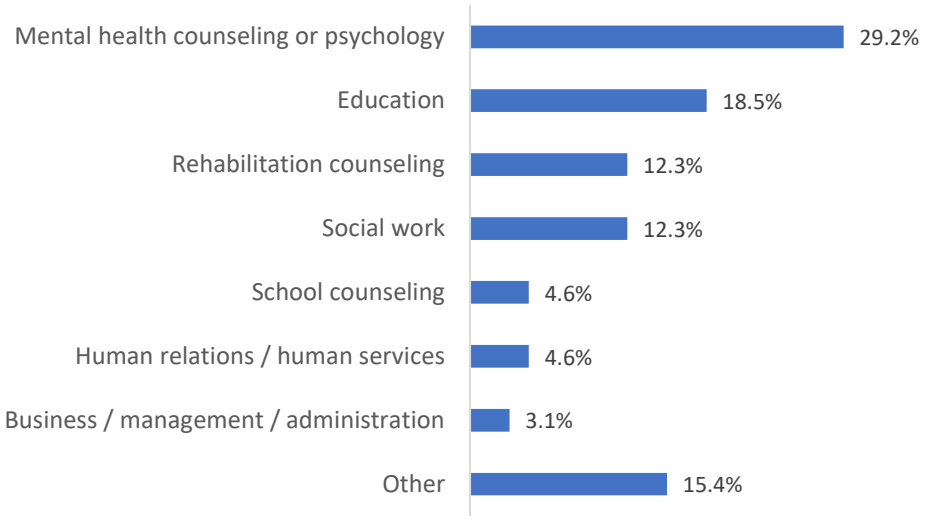
The vast majority (91%) of respondents from Nebraska indicated that they have a bachelor's degree or higher (Figure 4).

Figure 4. Highest level of education (n=75)



Among those with a bachelor's degree or higher, a wide variety of majors were reported with mental health counseling or psychology and education being the top two responses among Nebraska respondents (Figure 5).

Figure 5. Major (among those with a bachelor's degree or higher)* (n=65)



*Categorization of open-ended responses

Measures

The self-assessment is based on the final set of 40 competencies created by the ACL Transition and Employment Workgroup. VRCs are asked to assess their level of expertise on each competency using the following rubric, based on a model created by Dario Russo[1]:

- **0 – None** - no understanding of the competency.
- **1 – Limited** - limited understanding of the competency, limited opportunity to apply the competency, competency has been minimally demonstrated.
- **2 – Basic** - basic understanding sufficient enough to handle routine tasks, requires some guidance and supervision when applying this competency, can discuss terminology and concepts related to this competency.
- **3 – Proficient** - detailed knowledge, understanding, and application of the competency; requires minimal guidance or supervision, consistency demonstrates success in the competency, able to assist others in the application of the competency.
- **4 – Advanced** - highly developed knowledge, understanding, and application of the competency; is able to coach or teach others on the competency; can help develop materials and resources in the competency.
- **5 – Expert** - specialist/authority level knowledge, understanding, and application of the competency; recognized by others an expert in the competency and is sought by others throughout the organization; able to explain issues in relation to broader organizational issues; creates new applications or processes; has a strategic focus.

The competencies are organized within four domains as follows:

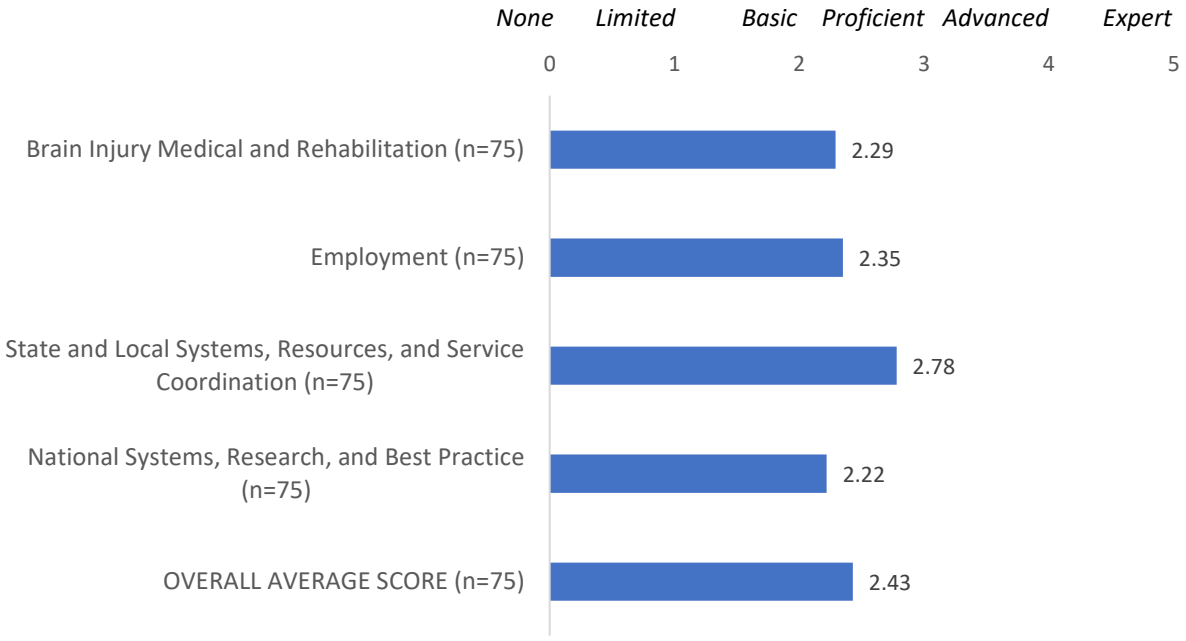
- Brain Injury Medical and Rehabilitation Concepts (15 competencies)
- Employment Concepts (13 competencies)
- State and Local Systems, Resources, and Service Coordination (10 competencies)
- National Systems, Research and Best Practice (2 competencies)

[1] Russo, J.D (2016). Competency Measurement Model. *European Conference on Quality in Official Statistics (pp. 7-8).*

Aggregate Scores

Aggregate scores for the four domains plus the overall average score revealed that on average respondents rated their competency somewhere between basic and proficient. Among Nebraska respondents, the domain with the highest aggregate score was State and Local Systems, Resources, and Service Coordination. The lowest aggregate score was in the domain of National Systems, Research, and Best Practice (Figure 6).

Figure 6. Aggregate Scores* by Domain and Overall (on a scale from 0 to 5)



*Respondents must respond to at least 80% of the competencies within each domain to receive an aggregate score.

Individual Competency Ratings

This report uses a color coding system to serve as a rough guide for those interpreting the results of the survey. The 40 competencies were grouped into quartiles based on a ranking of the average rating as follows.

GOLD	**1st quartile (competencies ranked 1-10 in average rating)**
BLUE	**2nd quartile (competencies ranked 11-20 in average rating)**
GRAY	**3rd quartile (competencies ranked 21-30 in average rating)**
RED	**4th quartile (competencies ranked 31-40 in average rating)**

Overall, the Brain Injury Medical and Rehabilitation domain received relatively low ratings of competency. Six of the 15 competencies within this domain were in the bottom quartile among Nebraska respondents (Table 1).

Table 1 **Self-assessed expertise within BRAIN INJURY MEDICAL AND REHABILITATION competencies**

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
1. Understands medical and rehabilitation terminology pertaining to BI (n=73)	4.1%	13.7%	47.9%	26.0%	8.2%	0.0%	***2.21***	***34.2%***	***31***
2. Understands how BI screening tools (e.g. OSU-TBI ID, BISQ, HELPS) may assist in the identification of potentially undiagnosed BI (n=75)	17.3%	26.7%	22.7%	28.0%	4.0%	1.3%	***1.79***	***33.3%***	***40***
3. Able to implement and interpret agency-sanctioned BI screening tools (n=75)	21.3%	17.3%	24.0%	26.7%	9.3%	1.3%	***1.89***	***37.3%***	***38***
4. Understands that BI may be categorized along a spectrum from mild to severe (n=74)	2.7%	10.8%	40.5%	28.4%	14.9%	2.7%	***2.50***	***46.0%***	***18***
5. Understands that categorization of initial injuries may not predict long-term outcomes (n=75)	4.0%	6.7%	41.3%	30.7%	13.3%	4.0%	***2.55***	***48.0%***	***14***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
6. Understands that recovery from BI, and long-term outcomes are individualized and based on many variables (n=75)	2.7%	8.0%	32.0%	34.7%	16.0%	6.7%	***2.73***	***57.4%***	***6***
7. Understands how BI affects the following functional systems: cognition (memory, attention, executive skills, problem solving, etc.), speech and language production and comprehension, physical, motor, and sensory abilities (strength, endurance, range of motion, vision, perception, hearing, balance, etc.), behavior and mood regulation (awareness, adjustment, mood, interpersonal skills, etc.) (n=75)	2.7%	8.0%	37.3%	34.7%	16.0%	1.3%	***2.57***	***52.0%***	***12***
8. Recognizes how symptoms (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) of BI can affect work performance in a variety of ways (e.g., interpersonal interactions, personal and home independence, and community re-entry) (n=75)	2.7%	6.7%	37.3%	36.0%	16.0%	1.3%	***2.60***	***53.3%***	***9***
9. Understands the importance of individual education in preventing secondary BI (n=75)	4.0%	10.7%	44.0%	26.7%	13.3%	1.3%	***2.39***	***41.3%***	***21***
10. Understands the risks of substance use disorders (n=75)	5.3%	13.3%	30.7%	29.3%	20.0%	1.3%	***2.49***	***50.6%***	***19***
11. Knows the resources to support abstinence from substance use (n=73)	8.2%	9.6%	41.1%	23.3%	15.1%	2.7%	***2.36***	***41.1%***	***23***
12. Understands the prevalence, effects, and support needs presented when a person has co-occurring disorders (such as a mental illness or substance misuse) (n=74)	6.8%	17.6%	31.1%	31.1%	12.2%	1.4%	***2.28***	***44.7%***	***26***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
13. Able to identify the range of specialists, professionals, and services in their state (e.g. home and community-based waivers, county- or regionally-funded programs, resource facilitation services, etc.) that may address BI needs, challenges and impairments (n=75)	8.0%	22.7%	40.0%	22.7%	6.7%	0.0%	***1.97***	***29.4%***	***37***
14. Understands the implications of BI as a chronic condition, including aging with BI, and the implications for future rehabilitative and community-based employment supports, and is familiar with the long and short term rehabilitation needs & life care planning (n=75)	9.3%	10.7%	44.0%	25.3%	10.7%	0.0%	***2.17***	***36.0%***	***33***
15. Stays abreast of best practices/research related to treatment approaches (Motivational Interviewing, Person Centered Planning, etc.), pharmacology, and more, and is able to refer to specialists for same (n=75)	10.7%	22.7%	38.7%	24.0%	4.0%	0.0%	***1.88***	***28.0%***	***39***

Most (10 out of 13) of the competencies within the Employment domain were ranked in the 2nd and 3rd quartiles among Nebraska respondents (Table 2).

Table 2	**Self-assessed expertise within EMPLOYMENT competencies**								
	None (0)	**Limited (1)**	**Basic (2)**	**Proficient (3)**	**Advanced (4)**	**Expert (5)**	***AVERAGE RATING (0-5)***	***% PROFICIENT OR HIGHER***	***RANK***
1. Understands and accounts for factors, such as reduced self-awareness and memory impairment, that must be considered with other functional skills information in determining eligibility for Vocational Rehabilitation services (n=75)	8.0%	9.3%	29.3%	41.3%	10.7%	1.3%	***2.41***	***53.3%***	***20***
2. Understands how BI may impact an individual's ability to participate in, and benefit from, vocational rehabilitation services (n=75)	4.0%	8.0%	36.0%	38.7%	12.0%	1.3%	***2.51***	***52.0%***	***16***
3. Partners with the individual to identify and employ accommodations to ensure success in vocational rehabilitation services (n=75)	8.1%	9.5%	36.5%	35.1%	9.5%	1.4%	***2.32***	***46.0%***	***25***
4. Understands factors that contribute to poor employment outcomes in persons with BI (n=74)	5.4%	5.4%	36.5%	40.5%	10.8%	1.4%	***2.50***	***52.7%***	***17***
5. Uses a comprehensive, "team" approach to vocational assessment and evaluation for individuals with a BI, synthesizing information from multiple sources, including but not limited to, information on the individual's pre- and post-injury functioning, strengths, expressed preferences and interests, vocational experience and abilities, education and training accomplishments, and need for workplace accommodation and supports. (n=75)	9.3%	6.7%	34.7%	38.7%	10.7%	0.0%	***2.35***	***49.4%***	***24***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
6. Understands the importance of integrating support persons and professional recommendations in employment planning and goal development (n=75)	8.0%	5.3%	30.7%	38.7%	17.3%	0.0%	***2.52***	***56.0%***	***15***
7. Understands and identifies appropriate workplace supports to help a worker with BI (n=75)	10.7%	14.7%	30.7%	28.0%	16.0%	0.0%	***2.24***	***44.0%***	***27***
8. Understands the similarities and differences between the following concepts: accommodations, restoration, assistive technologies, and demonstrates skills in triaging for same (n=75)	10.7%	12.0%	40.0%	21.3%	14.7%	1.3%	***2.21***	***37.3%***	***30***
9. Recognizes when an individual with a BI requires an accommodation, titration (gradual return) to return to work activities or post-secondary or other training (n=75)	13.3%	10.7%	38.7%	26.7%	9.3%	1.3%	***2.12***	***37.3%***	***34***
10. Understands how BI may impact an individual in the work setting and understands how to pair necessary and reasonable accommodations with individual challenges or impediments (n=75)	9.3%	13.3%	37.3%	25.3%	13.3%	1.3%	***2.24***	***39.9%***	***28***
11. Understands how post-injury interventions and compensatory strategies must be tailored to an individual's needs (n=75)	8.0%	10.7%	34.7%	30.7%	14.7%	1.3%	***2.37***	***46.7%***	***22***
12. Able to facilitate access to employment-related advocacy, legal remedies, resources, etc. (n=75)	10.7%	10.7%	44.0%	20.0%	12.0%	2.7%	***2.20***	***34.7%***	***32***
13. Understands how public benefits may be impacted by employment (n=75)	8.0%	8.0%	26.7%	37.3%	16.0%	4.0%	***2.57***	***57.3%***	***10***

The State and Local Systems, Resources, and Service Coordination domain was overwhelmingly the highest rated domain among Nebraska respondents. There are ten competencies within this domain, and seven of those ten were ranked within the top 10 of all competencies (i.e., first quartile) (Table 3).

Table 3	**Self-assessed expertise within STATE AND LOCAL SYSTEMS, RESOURCES, AND SERVICE COORDINATION competencies**								
	None (0)	**Limited (1)**	**Basic (2)**	**Proficient (3)**	**Advanced (4)**	**Expert (5)**	***AVERAGE RATING (0-5)***	***% PROFICIENT OR HIGHER***	***RANK***
1. Understands state-specific initiatives and mandates related to employment (Governor proclamations, priorities, goals, etc.) (n=75)	13.3%	13.3%	42.7%	24.0%	4.0%	2.7%	***2.00***	***30.7%***	***36***
2. Able to explain State Vocational Rehabilitation services available for persons with disability (n=75)	1.3%	6.7%	9.3%	37.3%	29.3%	16.0%	***3.35***	***82.6%***	***1***
3. Understands how BI services are delivered by the VR system, including state policies and procedures (n=74)	10.8%	6.8%	25.7%	35.1%	14.9%	6.8%	***2.57***	***56.8%***	***11***
4. Understands the vocational rehabilitation role is to identify, coordinate, and provide services to the individual (n=75)	0.0%	5.3%	17.3%	40.0%	28.0%	9.3%	***3.19***	***77.3%***	***2***
5. Understands the importance of case management and system's navigation to facilitate goal attainment (n=75)	1.3%	4.0%	18.7%	41.3%	22.7%	12.0%	***3.16***	***76.0%***	***3***
6. Understands the importance of resource facilitation to facilitate goal attainment (if it exists in the state) (n=75)	5.3%	4.0%	28.0%	33.3%	25.3%	4.0%	***2.81***	***62.6%***	***5***
7. Knows state, district, and local community employment support resources and associated referral processes (n=75)	6.7%	9.3%	25.3%	36.0%	30.0%	2.7%	***2.61***	***68.7%***	***7***
8. Knows funding resources to support pre-employment and employment activities (n=75)	8.0%	6.7%	32.0%	32.0%	18.7%	2.7%	***2.55***	***53.4%***	***13***

	None (0)	Limited (1)	Basic (2)	Proficient (3)	Advanced (4)	Expert (5)	*AVERAGE RATING (0-5)*	*% PROFICIENT OR HIGHER*	*RANK*
9. Possesses skills in developing and sustaining collaborative relationships to benefit individual clients (n=75)	5.3%	4.0%	21.3%	38.7%	20.0%	10.7%	***2.96***	***69.4%***	***4***
10. Understands the importance of providing BI resources to employers and other partners in the employment process, based on individual client disclosure preferences (n=75)	8.0%	4.0%	26.7%	45.3%	13.3%	2.7%	***2.60***	***61.3%***	***8***

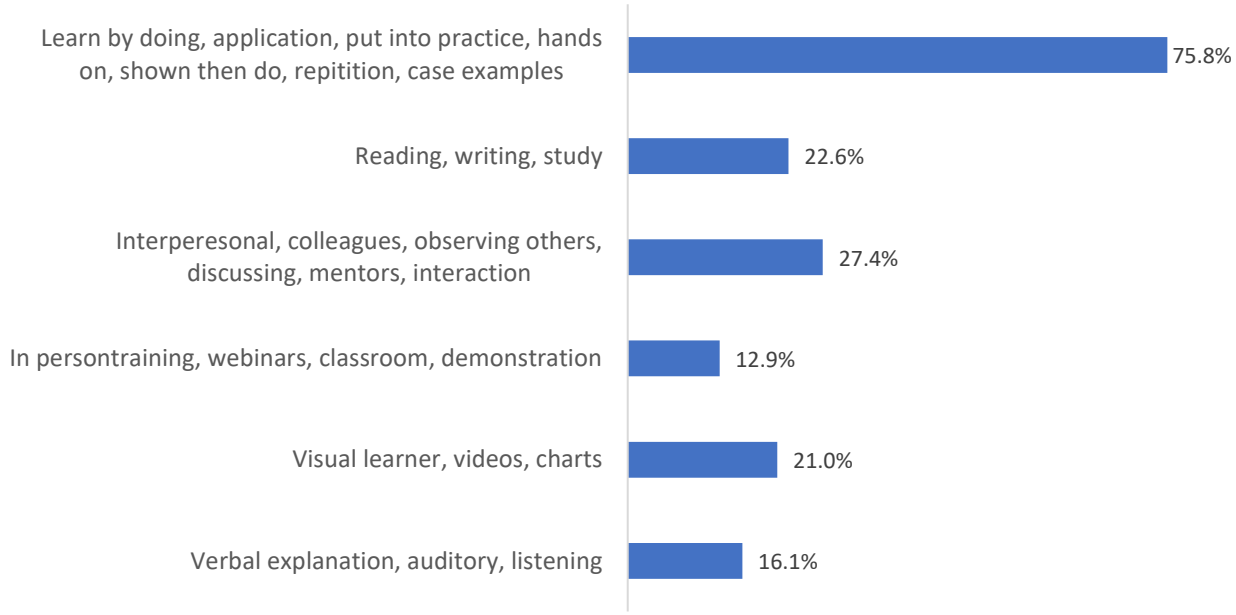
Just two competencies comprise the National Systems, Research, and Best Practices domain (Table 4).

Table 4	**Self-assessed expertise within NATIONAL SYSTEMS, RESEARCH, AND BEST PRACTICES competencies**								
	None (0)	**Limited (1)**	**Basic (2)**	**Proficient (3)**	**Advanced (4)**	**Expert (5)**	***AVERAGE RATING (0-5)***	***% PROFICIENT OR HIGHER***	***RANK***
1. Understands relevant federal legislation, including but not limited to, the Americans with Disabilities Act (ADA), Workforce Innovation and Opportunities Act (WIOA), and any state-specific legislation related to return to work and work supports (n=75)	5.3%	8.0%	40.0%	33.3%	10.7%	2.7%	***2.00***	***46.7%***	***35***
2. Understands a wide variety of evidence-based vocational rehabilitation models and return-to-work approaches for persons with BI (n=75)	12.0%	17.3%	38.7%	24.0%	6.7%	1.3%	***2.22***	***32.0%***	***29***

Learning Style

In an open-ended survey item, respondents were asked to describe how they learn a new skill best and then apply it. Three-fourths (76%) of respondents from Nebraska described a "hands on" or "learn by doing" way as how they learn best (Figure 7).

Figure 7. Describe how you learn a new skill best and then apply it* (multiple responses) (n=62)



*Categorization of open-ended responses

How to Use the State-Level Results from the Vocational Rehabilitation Counselor (VRC) Self-Assessment for Serving Individuals with a Brain Injury

Identifying strengths and gaps

The state-level results from the VRC Self-Assessment for Serving Individuals with a Brain Injury can be used to identify strengths and gaps within a state's VRC workforce. It is recommended that state leadership conduct a thorough review of how respondents from their state assessed themselves on each individual competency (see pages 7 through 15 of the state-level report). Use the sections of the tables that include the ranking and color-coding system, as well as data on the percentage identifying themselves as proficient or higher, to help identify strengths and gaps. Use these questions to guide your review of the results:

- What individual competencies demonstrate the strengths of our state's workforce? Are there any similarities or themes among these competencies showing strengths?
- What individual competencies demonstrate gaps in the abilities of our state's workforce? Are there any similarities or themes among these competencies showing gaps?
- What strategies can be implemented to address some of these gaps in our state's workforce?

Limitations

Each state that participated in this self-assessment administered the survey in a slightly different way. Slightly different types of professionals participated in the self-assessment within each state. Therefore, the state-level results are not currently able to be compared to each other, or to the overall result. Look at who participated in the self-assessment within your state by reviewing the demographic information of the respondents on pages 2 through 4 of your state-level report. Make especial note of the professional role of your state's respondents (Figure 1 on page 2). You may also find it interesting to see how the professional roles of respondents from your state differ from that of all of the respondents included in the overall results. This will give you an idea of why we currently are unable to compare states to each other.

Some states may feel that there are professionals who participated in this self-assessment for whom some or many of the competencies do not apply to their professional role. Other states may feel that the competencies apply to all or nearly all of the respondents from their state. Even if a state has some of these "other" professionals for whom some or many of the competencies may not apply to their professional role, it is likely a relatively small percentage. The guiding questions included in the "identifying strengths and gaps" section above can still be used to assess your state's workforce.

While there is not currently a way to compare states to each other, there may be a way to do this. One option might be to isolate only those who identified themselves as rehabilitation counselors and compare this subset of respondents across states on the self-assessment of competencies. Further discussion is needed to ensure that professionals identifying themselves as rehabilitation counselors can be reasonably assumed to have the same professional roles and responsibilities across states.

Administration for Community Living (ACL) Transition and Employment Workgroup Vocational Rehabilitation Competencies

ACL
Administration for Community Living
Indiana TBI State Partnership Program
Mentor State Funding Opportunity Grant
No. 90TBSG0034-01-00 June 1, 2018 - May 31, 2021
INDIANA STATE DEPARTMENT OF HEALTH
REHABILITATION HOSPITAL OF INDIANA

VR
NEBRASKA

Indiana Department of Health

March 4, 2021 | Welcome

Speakers:

Laura Trexler, OTR, CBIS
ACL Grant Clinical Program Manager
Rehabilitation Hospital of Indiana

Carla Lasley
Program Director of Community Services
Nebraska VR
Nebraska Department of Education

March 4, 2021 | Welcome

Objectives

Upon completion, participants will be able to:

1. Describe the purpose of the ACL Workforce Development Initiative

2. Describe the process utilized by the Transition and Employment Workgroup to identify and vet competencies

3. Describe the intended purpose of the Vocational Rehabilitation Counselor Competency Self-Assessment

Lets start with the  Picture

Background

- Administration for Community Living (ACL) awards (TBI) State Partnership Grants

- Purpose: "to create and strengthen a system of services and supports that maximize the independence, well-being, and health of persons with Traumatic Brain Injury (TBI) across the lifespan, their families and their caregivers."

ACL Grantee Workgroups

- States assigned to collaborative workgroups based on common initiatives

- Indiana, Nebraska, North Carolina, and Vermont, with guest membership from Iowa & Colorado, make up the **Transition and Employment Workgroup.**

The ACL Workforce Development Initiative

- "A critical component of the grant is **training** for service workers and other individuals who work in the system of support for people with TBI."

- "The training infrastructure will include a responsive training system aligned to ***core competencies*** that professionals need to know to assist individuals with TBI."

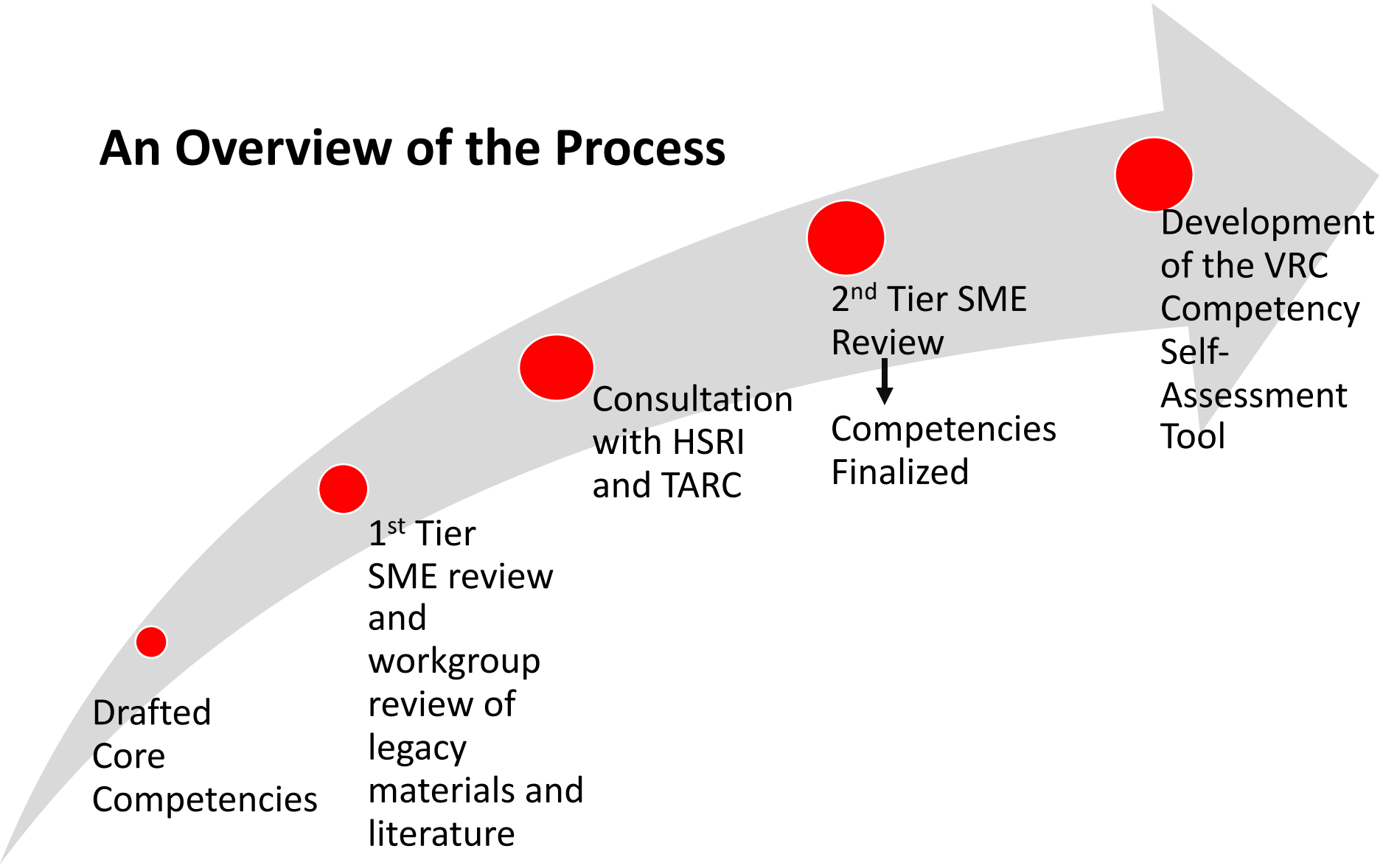
Transition & Employment Workgroup

Core Competencies

First Steps

The Transition and Employment Workgroup set out to identify a set of ***core competencies***, "intended to serve as a general guide for the professional development of the **knowledge, skills and abilities** needed by Vocational Rehabilitation Counselors (VRC) serving individuals who are working to enter or re-enter the workforce following a brain injury (BI). "

An Overview of the Process



Drafting Core Competencies

- Collected from Vocational Rehabilitation Counselors (VRC) and Transition & Employment Workgroup members

First Tier Subject Matter Expert (SME) Review

- Online survey of VRCs to rate importance of 40 competencies

- 4 competency domains
  - ✓ **Brain Injury – Medical and Rehabilitation**
  - ✓ **Employment**
  - ✓ **State and Local Systems, Resources, and Service Coordination**
  - ✓ **National Systems, Research, and Best Practices**

First Tier SME Review – continued

- Respondents rated importance of proposed competencies using Likert scale:
  - ✓ **not important**
  - ✓ **slightly important**
  - ✓ **moderately important**
  - ✓ **very important**
  - ✓ **extremely important**

- A total of **43** Vocational Rehabilitation Professionals, from IA, NC, VT, NE, IN responded to the survey.

Sample questions and responses

BRAIN INJURY MEDICAL AND REHABILITATION concepts

	Not important	Slightly important	Moderately important	Very important	Extremely important	*% VERY OR EXTREMELY IMPORTANT*
Understands medical & rehabilitation terminology pertaining to BI	0.0%	2.3%	11.6%	58.1%	27.9%	***86.1%***
Understands how BI screening tools (e.g. XXXX) may assist in the identification of potentially undiagnosed BI	2.3%	11.6%	14.0%	41.9%	30.2%	***72.1%***
Understands that BI may be categorized along a spectrum from mild to severe, and that categorization of initial injuries may not predict long-term outcomes	0.0%	2.3%	4.7%	37.2%	55.8%	***93.0%***
Understands that recovery from BI, and long-term outcomes are individualized & based on many variables	0.0%	0.0%	2.3%	27.9%	69.8%	***97.7%***

Domain	Competency Questions	Rating
Brain Injury Medical and Rehabilitation	16	**80% +** of the respondents indicated **12** of 16 items were very or extremely important
Employment	11	**All** respondents felt all **11** items were very or extremely important
State and Local Systems, Resources and Service Coordination	11	**80%+** of the respondents indicated **7** of 11 were very or extremely important
National Systems, Research and Best Practices	2	**80%+** of the respondents indicated **1** of 2 items was very or extremely important

Materials and Literature Review

- **23** articles and materials were reviewed to determine **alignment** with drafted competencies.
- The review included tallying the mention of any of the identified competencies present in the article or product.
- Many of the drafted competencies were noted in the literature and materials review

Literature and Materials Review - continued

- Examples of competencies **not** confirmed in any publication or material:

  "*Understands how BI screening tools may assist in the identification of potentially undiagnosed BI*"

  "Stays abreast of BI specialty certification opportunities; holds specialty certification such as Certified Brain Injury Specialist (CBIS)",

Human Services Research Institute (HSRI) Review

- Workgroup leadership consulted with HSRI, seeking guidance on competency wording, content, complexity, and validity.
- Editorial suggestion - break ‘double barreled ’ competencies down
- Competencies modified for the 2nd Tier SME review

Second Tier Subject Matter (SME) Review

- Second Tier Subject Matter Experts were consulted

- Forty-one competencies in the 4 domains
  - ✓ **Brain Injury – Medical and Rehabilitation**
  - ✓ **Employment**
  - ✓ **State and Local Systems, Resources, and Service Coordination**
  - ✓ **National Systems, Research, and Best Practices**

Second Tier Subject Matter (SME) Review
Continued

- 6 of 6 SME'S determined that 40 of 41 competencies were *relevant* or *highly relevant*

- Two open ended
  - Please provide any additional information you would like us to consider. Are you working on anything in this arena that you would be willing to share?

  - Do you have suggested resources to aid in the development of competency tests?

Second Tier Subject Matter Review and the Self-Assessment

- Following 2nd Tier SME feedback, a second literature search and review was conducted
- Added a competency on Vocational Evaluation
- Removed the competency related to holding a specialty certification
- Competencies were finalized

Vocational Rehabilitation Competency Self Assessment Fall 2020

- The VRC Competencies were converted to a ***VRC Competency Self-Assessment***

Vocational Rehabilitation Counselor Competency Self-Assessment

- Introduction - Purpose
- 40 listed competencies to respond to (scale listed on next slides)
- Anonymous participation
- 10 – 15 minutes to complete
- Included demographic questions

Vocational Rehabilitation Competency Self-Assessment

Rating	Level	Definition
0	None	**no understanding** of the competency
1	Limited	**limited understanding** of the competency, **limited opportunity** to apply the competency, competency has been minimally demonstrated
2	Basic	basic understanding **sufficient enough to handle routine tasks**, requires some **guidance & supervision** when applying this competency, can discuss terminology & concepts related to this competency
3	Proficient	detailed knowledge, understanding, & application of the competency; **requires minimal guidance or supervision**, **consistently demonstrates success** in the competency, able to **assist others** in the application of the competency

Vocational Rehabilitation Competency Self-Assessment

Rating	Level	Definition
4	Advanced	**highly developed** knowledge, understanding, & application of the competency; is **able to coach or teach others** on the competency; can help **develop materials & resources** in the competency
5	Expert	**specialist/authority level** knowledge, understanding, & application of the competency; recognized by others an expert in the competency and is **sought by others** throughout the organization; able to explain issues in relation to **broader organizational** issues; creates new applications or processes; has a **strategic focus**

Current Status

- The survey closed February 12, 2021
- We are currently in the process of analyzing data

Potential Next Steps – VRC

- Explore trends
- Inform future education and training initiatives
- Submit for publication

Potential Next Steps – Workforce Development

Thank you!

- To the Administration for Community Living (ACL)
- Our Lead State Agencies
- To the Transition & Employment Workgroup membership
- To the Human Services Research Institute
- The ACL Grant Technical Assistance Center
- Grant consultants including Dr. Christina Dillahunt-Aspillaga, Will Schmeeckle, Dr. Trexler and others
- To our State Departments of Vocational Rehabilitation leadership, counselors and support staff

Contact Information

Laura Trexler: laura.trexler@rhin.com

Carla Lasley: carla.lasley@Nebraska.gov

Keri Bennett: keri.bennett@Nebraska.gov

Funding for this presentation was made possible (in part) by the Administration for Community Living. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Nebraska TBI State Partnership Program Mentor State Funding Opportunity, Grant No. 90TBSG0036-02-00

and

Indiana TBI State Partnership Program Mentor State Funding Opportunity, Grant No. 90TBSG0034-01-00

Questions

DISABILITY EMPLOYMENT TA CENTER

ACL Administration for Community Living

AoD Administration on Disability

Community of Practice: The Power of Partnerships

March 15, 2021

LEWINGROUP®

TASH

This presentation was prepared by The Lewin Group/TASH under the Administration for Community Living (ACL), Administration on Disabilities (AoD) Contract HHSP233201500088I / 75P00120F37007

Agenda

- Welcome and Introductory Remarks
- South Carolina Team
- Tennessee Team
- Louisiana Representative
- Indiana Team
- Questions, Comments, and Interactive Discussion

Indiana Speaker Introductions

Peter Bisbecos,
Rehabilitation Hospital of Indiana

Laura Trexler,
Rehabilitation Hospital of Indiana

Higher Level Systems

Why Competencies are relevant

- The origin of Mental Health and Developmental Disabilities Systems versus Traumatic Brain Injury Systems.
- The explosion of knowledge regarding brain injury prevalence, chronicity, complexity, and treatment options.
- Why competencies are relevant to you.

Overview

Administration for Community Living (ACL)

Traumatic Brain Injury State Partnership Program Grants

- Overarching Aim
- Grant Workgroups and Partnerships
- Workforce Training Initiative
  - review grant legacy materials
  - identify gaps
  - develop new training materials aligned with core competencies

Historical Perspective

Historical perspective – Indiana as a leader in return-to-work outcomes

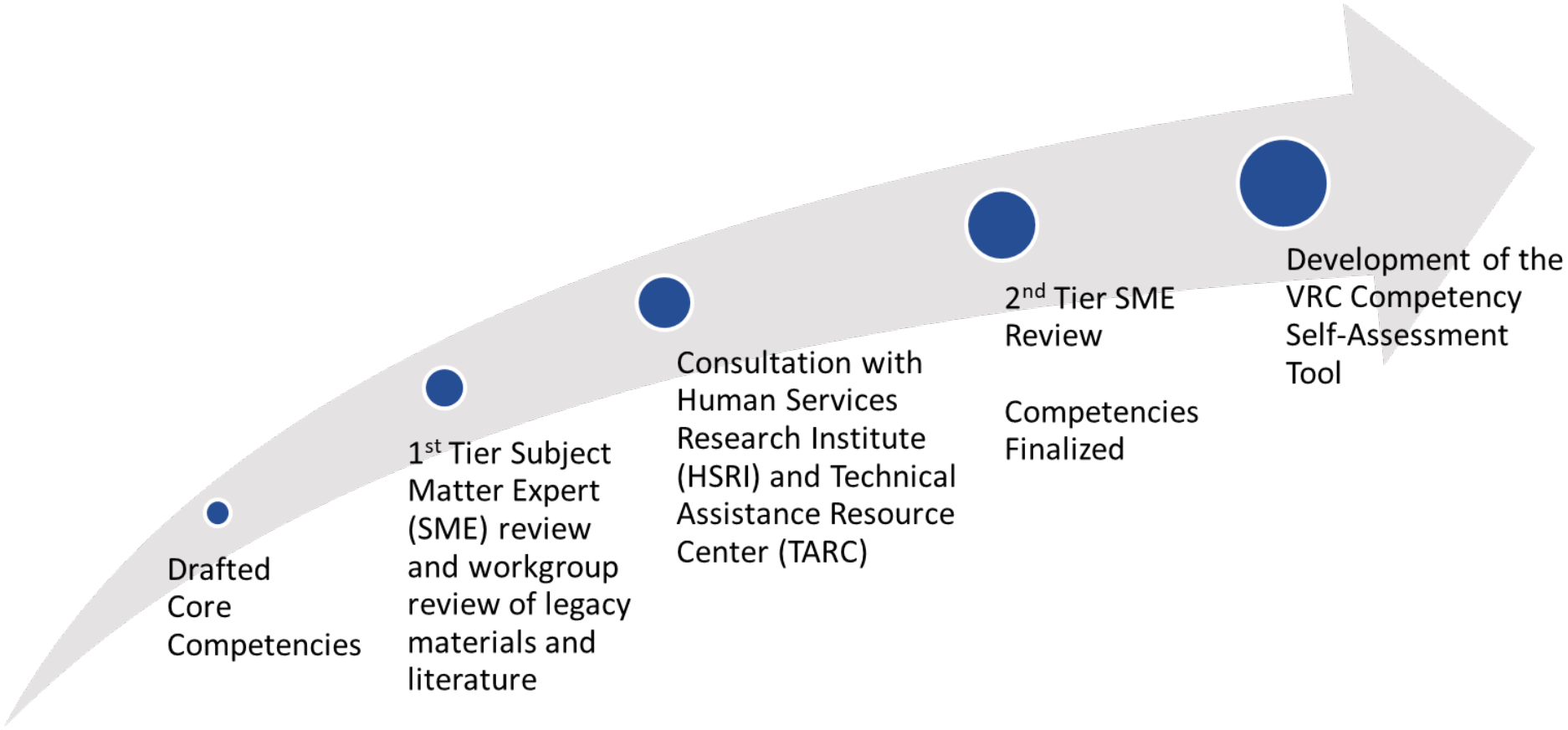
- 2008 Grant Award:
  - Lead Agency: Vocational Rehabilitation
  - Subcontractors:
    - Brain Injury Association of Indiana
    - Rehabilitation Hospital of Indiana

Workgroup Accomplishments

The Vocational Rehabilitation Counselor (VRC) Competencies and the Competency Self-Assessment

How did we get here?

The Process – an Overview

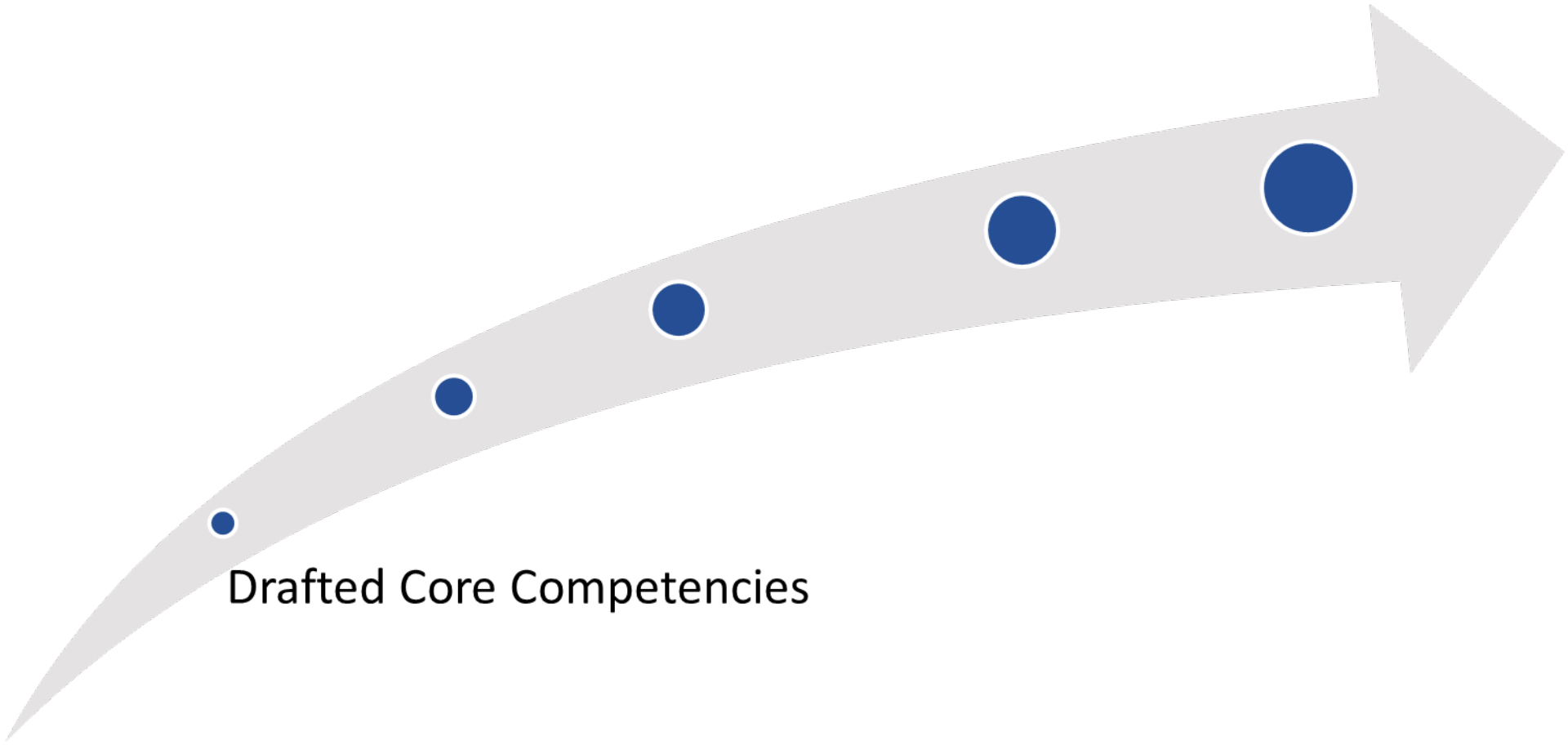


DISABILITY EMPLOYMENT TA CENTER

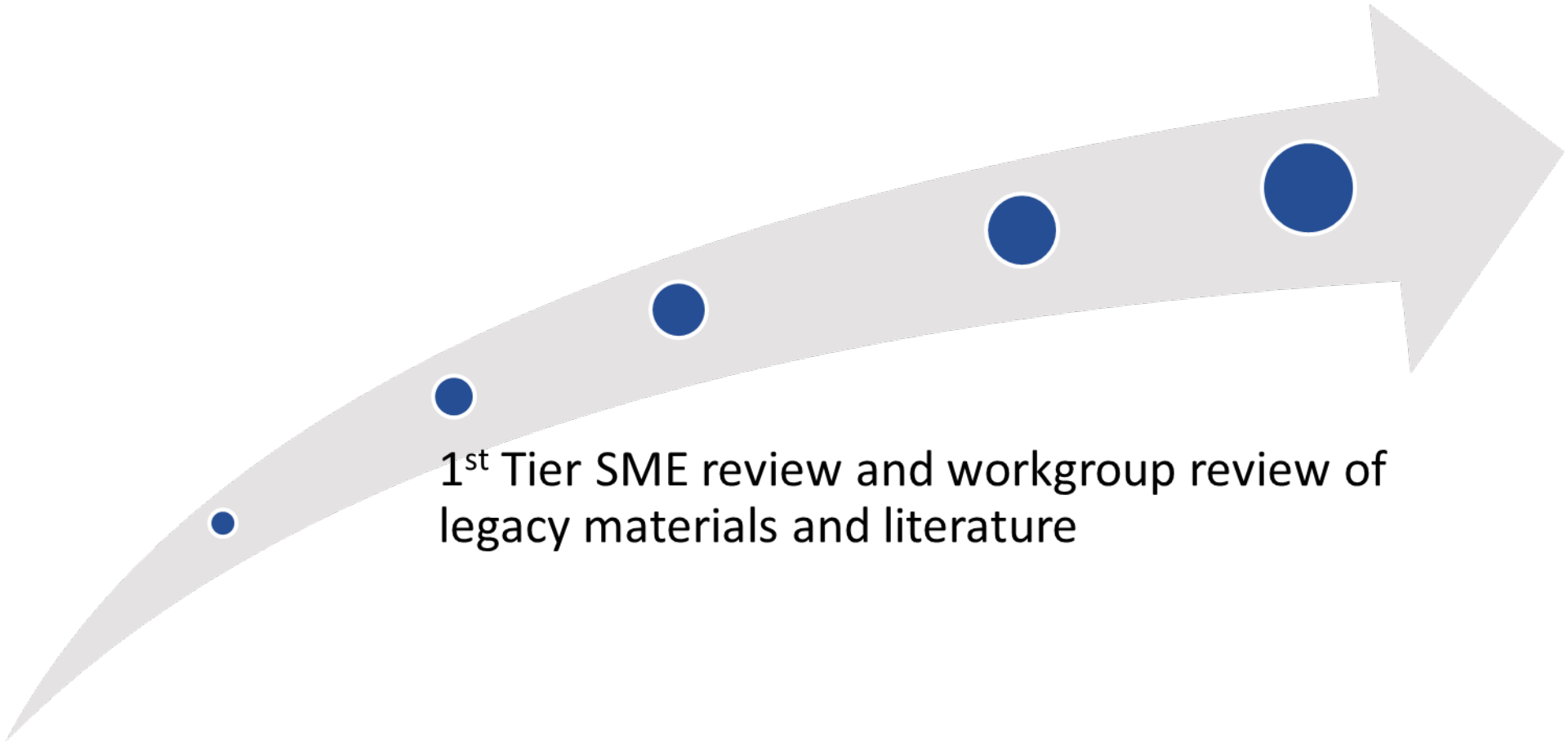
ACL Administration for Community Living

AoD Administration on Disability

First Step



Subject Matter Experts, Literature, Legacy Material Review

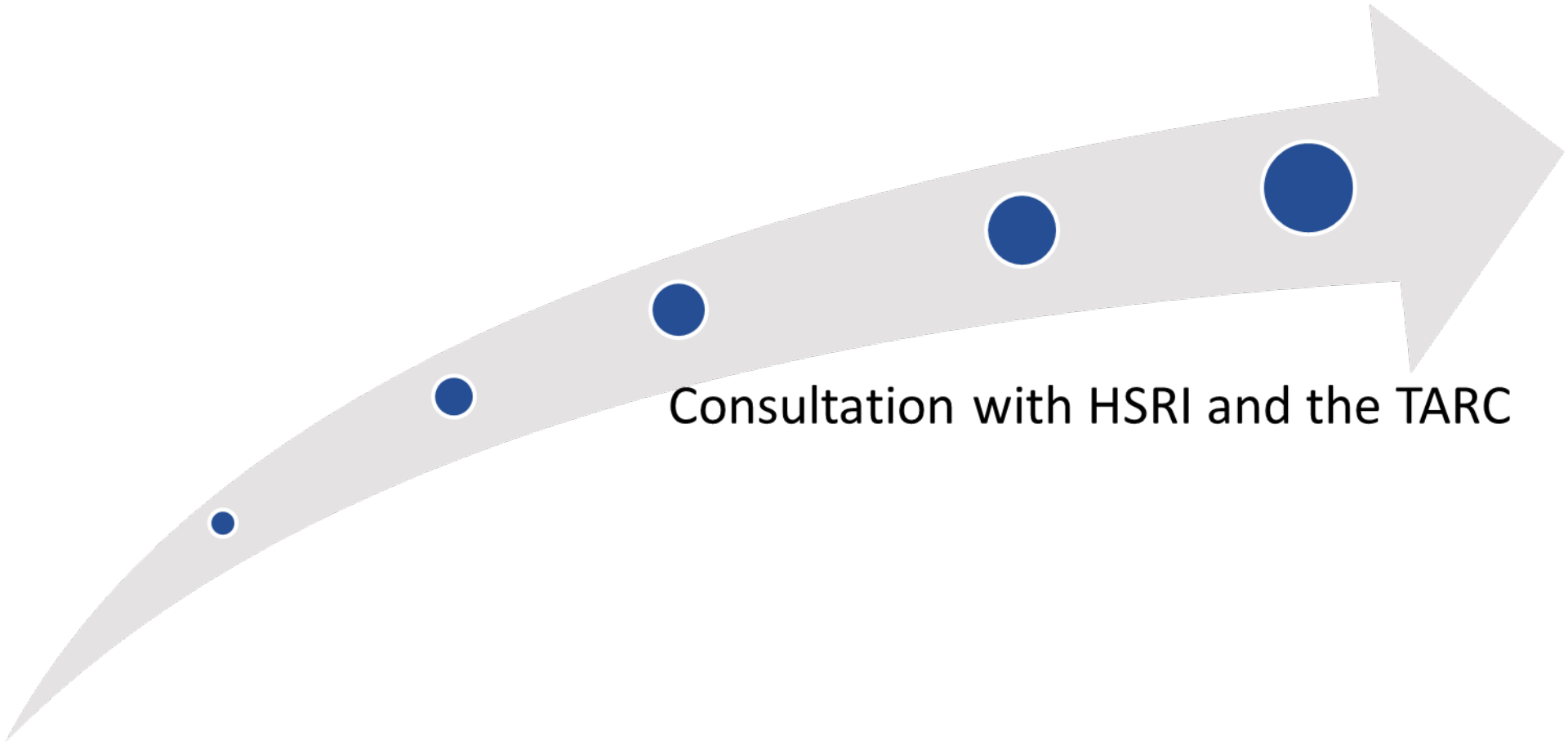


DISABILITY EMPLOYMENT TA CENTER

ACL Administration for Community Living

AoD Administration on Disability

Consultation with the Technical Assistance Center

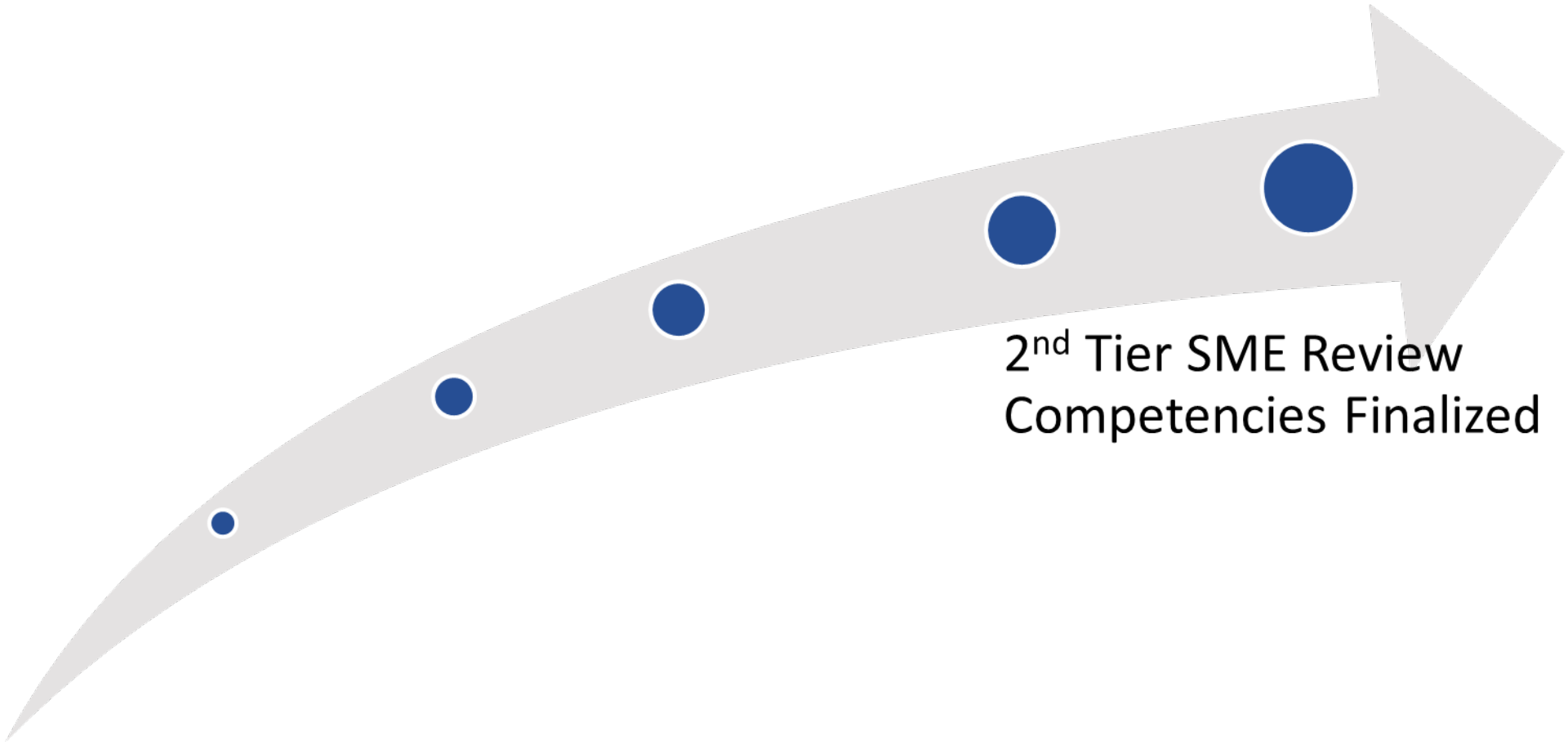


DISABILITY EMPLOYMENT TA CENTER

ACL Administration for Community Living

AoD Administration on Disability

Second Tier Subject Matter Experts

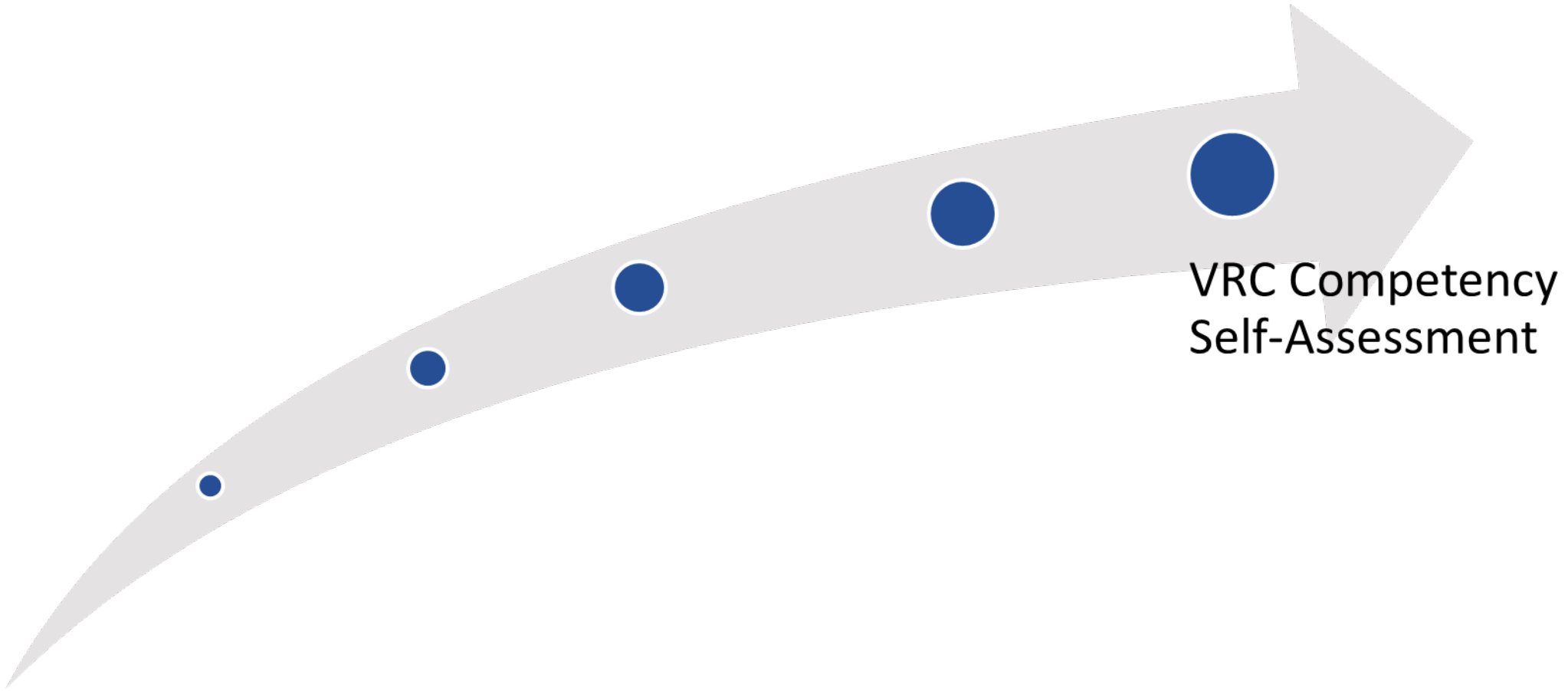


DISABILITY EMPLOYMENT TA CENTER

ACL Administration for Community Living

AoD Administration on Disability

The VRC Competency Self Assessment



VRC Competency Self-Assessment Rating Scale, 1/2

0 – None: no understanding of the competency.

1 – Limited: limited **understanding** of the competency, limited opportunity to apply the competency, competency has been **minimally demonstrated**.

2 – Basic: basic understanding sufficient enough to **handle routine tasks**, **requires** some **guidance** and **supervision** when applying this competency, can discuss terminology and concepts related to this competency.

VRC Competency Self-Assessment Rating Scale, 2/2

3 – Proficient: detailed knowledge, understanding, and application of the competency; requires minimal guidance or supervision, **consistently demonstrates success** in the competency, **able to assist others** in the application of the competency.

4 – Advanced: highly developed knowledge, understanding, and application of the competency; is able **to coach or teach others** on the competency; can help **develop materials and resources** in the competency.

5 – Expert: specialist/**authority level** knowledge, understanding, and application of the competency; recognized by others an expert in the competency and is **sought by others** throughout the organization; **able to explain issues in relation to broader organizational** issues; **creates new applications or processes**; has a strategic focus.

Sample Competencies:
Brain Injury Medical and Rehabilitation Domain

- Understands medical and rehabilitation terminology pertaining to TBI.
- Recognizes how symptoms (fatigue, reduced auditory comprehension, impaired attention, impaired memory, decreased executive skills, and more) of brain injury can affect work performance in a variety of ways (e.g., interpersonal interactions, personal and home independence, and community re-entry.

Sample Competencies: Employment

- Understands and accounts for factors, such as reduced self-awareness and memory impairment, that must be considered with other functional skills information in determining eligibility for Vocational Rehabilitation services.
- Partners with the individual to identify and employ accommodations to ensure success in Vocational Rehabilitation services.
- Understands the importance of integrating support persons and professional recommendations in employment planning and goal development.

Sample Competencies: State & Local Systems, Resources, Service Coordination

- Understands state-specific initiatives and mandates related to employment (e.g., Governor proclamations, priorities, goals).
- Understands the importance of case management and system's navigation to facilitate goal attainment.
- Knows state, district, and local community employment support resources and associated referral processes.

Sample Competencies: National Systems, Research, and Best Practices

- Understands relevant federal legislation, including but not limited to, the Americans with Disabilities Act (ADA), Workforce Innovation and Opportunities Act (WIOA), and any state-specific legislation related to return to work and work supports.
- Understands a wide variety of evidence-based vocational rehabilitation models and return-to-work approaches for persons with TBI.

Current Status

- Survey closed February 12, 2021.
- 269 respondents in the final data set:
  - State one: 57 respondents
  - State two: 82 respondents
  - State three: 133 respondents
  - State four: 29 respondents

Analyses Strategy for Publication, 1/2

Authors

Keri Bennett, NE

Dr. Dillahunt-Aspillaga, FL

Carla Lasley, NE

Will Schmeeckle, NE

Dr. Lance Trexler, IN

Laura Trexler, IN

Basic Analyses

- Are there differences between states for level of experience, education, & role?
- Are there differences for the total sample (n = 269) between the four domains (medical & rehabilitation, employment, state systems and services, national systems and best practices)?
- Are there differences between states for the four domains?

Analyses Strategy for Publication, 2/2

Statistical analysis

- To examine the relationship between experience, role, and education (separate) with perceived self-competency for the four domains.

Recommendations:

- VR staff training
- Establishing best practices
- Implementation of fidelity metrics

Indiana: Lessons Learned

The value of:

- Time
- Diversity
- Thoughtful Communication
- Flexible Approach

Questions, Comments, and Interactive Discussion

Administration for Community Living (ACL) Transition and Employment Workgroup Vocational Rehabilitation Competencies

Logos in this box

Welcome

Speakers:

Objectives

Upon completion, participants will be able to:

1. Describe the purpose of the ACL Workforce Development Initiative
2. Describe the process utilized by the Transition and Employment Workgroup to identify and vet competencies
3. Describe the intended purpose of the Vocational Rehabilitation Counselor Competency Self-Assessment

The BIG Picture

Background

- Administration for Community Living (ACL) awards (TBI) State Partnership Grants

- Purpose: "to create and strengthen a system of services and supports that maximize the independence, well-being, and health of persons with Traumatic Brain Injury (TBI) across the lifespan, their families and their caregivers."

ACL Grantee Workgroups

- States assigned to collaborative workgroups based on common initiatives

- Indiana, Nebraska, North Carolina, and Vermont, with guest membership from Iowa & Colorado, make up the **Transition and Employment Workgroup.**

The ACL Workforce Development Initiative

- "A critical component of the grant is **training** for service workers and other individuals who work in the system of support for people with TBI."

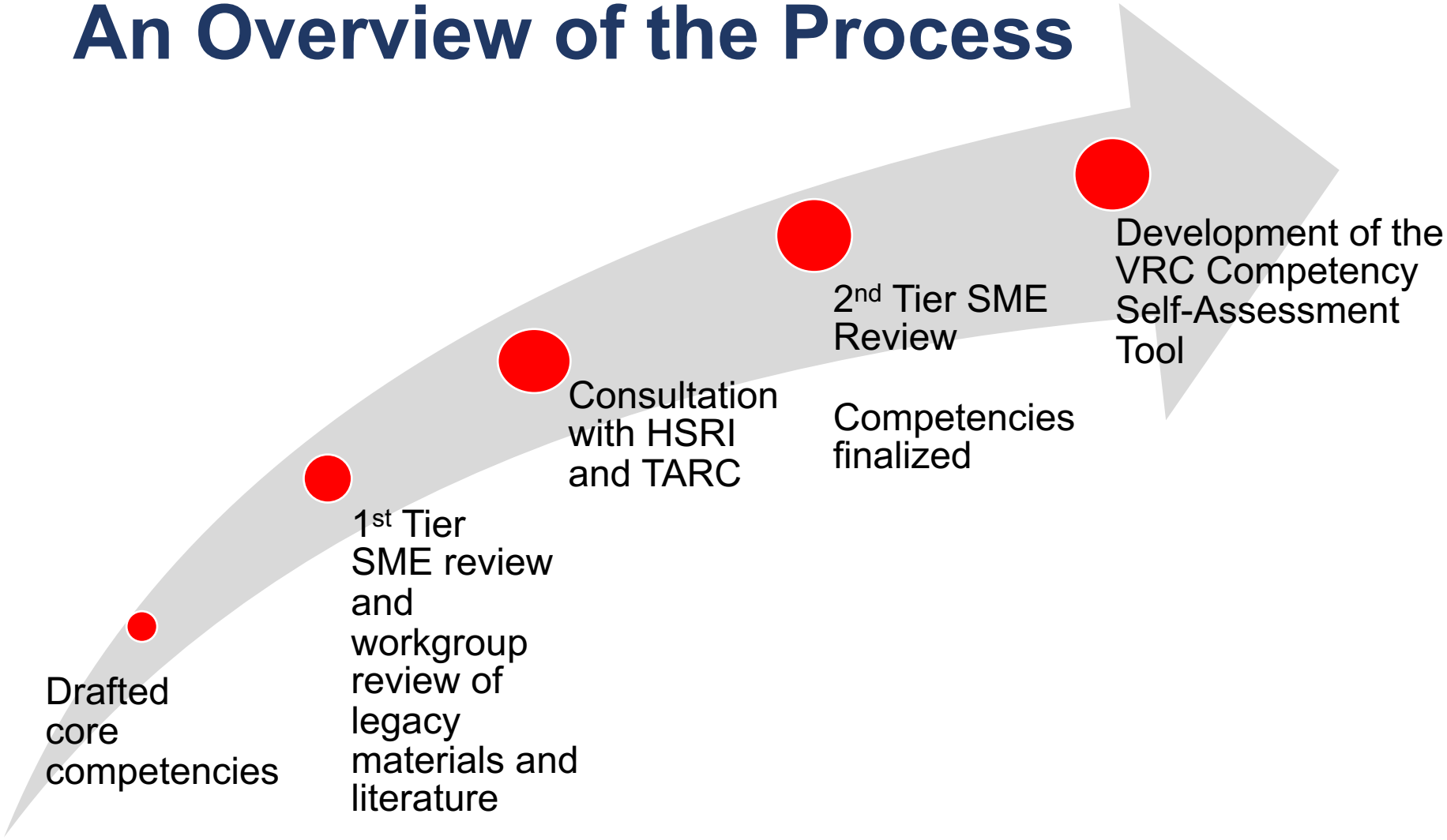
- "The training infrastructure will include a responsive training system aligned to ***core competencies*** that professionals need to know to assist individuals with TBI."

Transition & Employment Workgroup Core Competencies

First Steps

The Transition and Employment Workgroup set out to identify a set of ***core competencies***, "intended to serve as a general guide for the professional development of the **knowledge, skills and abilities** needed by Vocational Rehabilitation Counselors (VRC) serving individuals who are working to enter or re-enter the workforce following a brain injury (BI). "

An Overview of the Process



First Steps

Drafted Competencies
Suggested competencies were collected from Vocational Rehabilitation Counselors (VRC) and Transition & Employment Workgroup members

First Tier Subject Matter Expert (SME) Review
SME's completed an online survey of VRCs to rate importance of 40 competencies

4 competency domains

- ✓ Brain Injury – Medical and Rehabilitation
- ✓ Employment
- ✓ State and Local Systems, Resources, and Service Coordination
- ✓ National Systems, Research, and Best Practices

First Tier SME Review continued

- Respondents rated importance of proposed competencies using Likert scale:
  - ✓ **not important**
  - ✓ **slightly important**
  - ✓ **moderately important**
  - ✓ **very important**
  - ✓ **extremely important**

- A total of **43** Vocational Rehabilitation Professionals, from IA, NC, VT, NE, IN responded to the survey.

Sample Competencies
BI Medical & Rehabilitation Concepts

- Understands medical & rehabilitation terminology pertaining to BI
- Understands how BI screening tools may assist in the identification of potentially undiagnosed BI
- Understands that BI may be categorized along a spectrum from mild to severe, and that categorization of initial injuries may not predict long-term outcomes

Survey Results

Domain	Competency Questions	Rating
Brain Injury Medical and Rehabilitation	16	**80% +** of the respondents indicated **12** of 16 items were very or extremely important
Employment	11	**All** respondents felt all **11** items were very or extremely important
State and Local Systems, Resources and Service Coordination	11	**80%+** of the respondents indicated **7** of 11 were very or extremely important
National Systems, Research and Best Practices	2	**80%+** of the respondents indicated **1** of 2 items was very or extremely important

Materials and Literature Review

- **23** articles and materials were reviewed to determine **alignment** with drafted competencies.
- The review included tallying the mention of any of the identified competencies present in the article or product.
- Many of the drafted competencies were noted in the literature and materials review

Materials and Literature Review continued

Examples of competencies **not** confirmed in any publication or material:

"*Understands how BI screening tools may assist in the identification of potentially undiagnosed BI*"

"Stays abreast of BI specialty certification opportunities; holds specialty certification such as Certified Brain Injury Specialist (CBIS)"

Human Services Research Institute (HSRI) Review

- Workgroup leadership consulted with HSRI, seeking guidance on competency wording, content, complexity, and validity.
- Editorial suggestion - break ‘double barreled ’ competencies down
- Competencies modified for the 2nd Tier SME review

Second Tier Subject Matter (SME) Review

- Second Tier Subject Matter Experts were consulted

- Forty-one competencies in the 4 domains
  - ✓ **Brain Injury – Medical and Rehabilitation**
  - ✓ **Employment**
  - ✓ **State and Local Systems, Resources, and Service Coordination**
  - ✓ **National Systems, Research, and Best Practices**

Second Tier Subject Matter (SME) Review Continued

- 6 of 6 SME'S determined that 40 of 41 competencies were *relevant* or *highly relevant*

- Two open ended
  - Please provide any additional information you would like us to consider. Are you working on anything in this arena that you would be willing to share?

  - Do you have suggested resources to aid in the development of competency tests?

Second Tier Subject Matter Review and the Self-Assessment

Next Steps

- With the 2nd Tier SME feedback, a second literature search and review was conducted
- A Vocational Evaluation competency was added
- The competency related to holding a specialty certification was removed
- Competencies were finalized

Vocational Rehabilitation Competency Self-Assessment Fall 2020

- The VRC Competencies were converted to a ***VRC Competency Self-Assessment***

Vocational Rehabilitation Counselor Competency Self-Assessment

- Introduction and Purpose
- 40 listed competencies to respond to (scale listed on next slide)
- Anonymous participation
- 10 – 15 minutes to complete
- Included demographic questions

Vocational Rehabilitation Competency Self-Assessment

Rating	Level	Definition
0	None	**no understanding** of the competency
1	Limited	**limited understanding** of the competency, **limited opportunity** to apply the competency, competency has been minimally demonstrated
2	Basic	basic understanding **sufficient enough to handle routine tasks**, requires some **guidance & supervision** when applying this competency, can discuss terminology & concepts related to this competency
3	Proficient	detailed knowledge, understanding, & application of the competency; **requires minimal guidance or supervision**, **consistently demonstrates success** in the competency, able to **assist others** in the application of the competency

Vocational Rehabilitation Competency Self-Assessment

Rating	Level	Definition
4	Advanced	**highly developed** knowledge, understanding, & application of the competency; is **able to coach or teach others** on the competency; can help **develop materials & resources** in the competency
5	Expert	**specialist/authority level** knowledge, understanding, & application of the competency; recognized by others an expert in the competency and is **sought by others** throughout the organization; able to explain issues in relation to **broader organizational** issues; creates new applications or processes; has a **strategic focus**

Current Status

Current Status
- The survey closed February 12, 2021
- We are currently in the process of analyzing data

Potential Next Steps – VRC
- Explore trends
- Inform future education and training initiatives
- Submit for publication

Potential Next Steps – Workforce Development

Thank you!

- To the Administration for Community Living (ACL)
- Our Lead State Agencies
- To the Transition & Employment Workgroup membership
- To the Human Services Research Institute
- The ACL Grant Technical Assistance Center
- Grant consultants including Dr. Christina Dillahunt-Aspillaga, Will Schmeeckle, Dr. Trexler and others
- To our State Departments of Vocational Rehabilitation leadership, counselors and support staff

Contact Information

- Contact information listed here

Funding Information

Funding for this presentation was made possible (in part) by the Administration for Community Living. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

List you state Grant Title and Number here

Questions

BEST PRACTICES FOR USING TBI REGISTRIES TO CONNECT PEOPLE TO SERVICES: A NATIONAL GUIDE

Prepared by the
National Association of State Head Injury Administrators
Maria Crowley, MA, CRC
Director, Professional Development

For the Administration for Community Living
TBI State Partnership Grant Workgroup on
Using Data to Connect People to Services

April 2021

This project was supported, in part by Funding Announcement number HHS-2018-ACL-AOD-TBSG-0281, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C.

TBI SPP
Traumatic Brain Injury
State Partnership Program

NATIONAL ASSOCIATION OF STATE HEAD INJURY ADMINISTRATORS

Best Practices for Using TBI Registries to Connect People to Services: A National Guide

ACL Data Workgroup
April 2021

Table of Contents

Introduction

The U.S. Department of Health and Human Services Administration for Community Living (ACL) Traumatic Brain Injury (TBI) State Partnership Program awarded grants to states in 2018 in two categories: Mentors and Partners. These grantees were then assigned to workgroups established in accordance with topics relating to states' goals. The Mentor grantees who have expertise in each topic were to work with Partner states to help develop, implement and/or expand activities relating to these topics. Nebraska and Virginia were awarded Mentor Grants and lead the Workgroup on Using Data to Connect People to Services, working with Partner Grantees Alabama, Alaska, California, Georgia, Idaho, Kansas, Maine, Minnesota, Missouri, North Carolina Rhode Island, Utah, and Vermont. In addition, the workgroup opened an invitation to any state, both grantee and non-grantees, interested in this topic. Additional states in this work group include Indiana and Maryland.

Product development is one of the requirements by ACL for the workgroups. As a result, the Using Data workgroup determined state brain injury programs would benefit from a national guide related to how state governments can use data to connect individuals living with brain injury to services and best practices for creation, management, and reporting of collected data.

This guide includes:

- A history and purpose of TBI registries
- An overview of the systems using data to connect individuals with TBI to services
- Core elements and practices for development and support of a TBI data registry
- Common barriers that states face to obtain meaningful and accurate data
- An assessment of questions asked (data collected) by state registries across the US
- Other useful sources of data

Common Terms

Traumatic Brain Injury (TBI): Brain dysfunction caused by an outside force to the head. TBI can have wide-ranging physical and psychological effects. Some signs or symptoms may appear immediately after the traumatic event, while others may appear days or weeks later.[1]

Data Dictionary: collection of names, definitions, and attributes about data elements being used or captured in a database. It may also describe the meanings and purposes of data elements within the context of a project, and provides guidance on interpretation, accepted meanings and representation.[2]

Incidence: the rate of occurrence of new cases of a disease or condition.[3]

Prevalence: the proportion of cases in the population at a given time rather than rate of occurrence of new cases.[3]

Registry: a collection of data about a particular group of people who share a common personal characteristic, for example development of the same disease.[4]

Surveillance: Ongoing systematic collection, analysis, and interpretation of health data, essential to the planning, implementation, and evaluation of public health practice, closely integrated to the dissemination of these data to those who need to know and linked to prevention and control. The data collected typically includes demographic, socioeconomic and clinical characteristics of the population under surveillance, data on key outcomes such as disease complications and mortality, and data on potentially mitigating or aggravating behaviors or co-morbid conditions referred to as risk factors.[5]

Notes: The term state program is referenced throughout this guide. This term refers to the state agency designated as the lead agency for TBI via the state's governor or the entity that the lead agency designates to implement this work. State programs are the target audience of this guide.

As this document is supported by the ACL State Partnership Program, the term traumatic brain injury (TBI) is used throughout to refer to brain injury, even though some surveillance systems capture both TBI and other types of acquired brain injury such as strokes.

For the purposes of this guide, a TBI Registry is any mechanism used by a Lead State Agency (or representative) to collect data on individuals living with brain injury for the purpose of surveillance or to "connect people to services". This may include data collected from a state trauma registry, hospital association, or independently managed programs. We recognize that TBI registry efforts and methods vary state to state.

History and Purpose

Over the last forty years, states have been seeking accurate estimates of how many individuals sustain a TBI each year, and more importantly, what that means in terms of challenges, outcomes, and long-term recovery for state residents. In fact, a primary impetus behind creation and maintenance of a registry is to link individuals with challenges to services, and to establish statewide incidence to be able provide those services. For the purposes of this guide, a comprehensive literature review was conducted, but there is a dearth of current information related to the status, process, or impact of TBI registries.

Because TBI is the sudden onset of injury rather than a congenital or gradual change, incidence has historically been captured where and when people seek services for this new onset of injury, namely emergency departments and hospitals. As a result, states initially looked to trauma records located within hospitals, to create registries by accessing data from emergency departments and trauma centers admissions discharge data. However, not all injuries are captured this way, as many individuals do not seek medical attention right away or at all, due to economic or personal circumstances, or symptoms that are not readily linked to the injury (mild TBI, sports related concussions, intimate partner violence). Consequently, there are whole segments of state populations affected by TBI who are not captured by trauma data.

A general registry definition is included above. However, there is wide variation in the type and nature of registries, which can range from a simple list of people affected to a complex system of identifying, contacting, and providing case coordination to help people with the condition get the services they need."[5] This document is intended to provide an idea of the scope and nature of TBI registries across states and provide tools to equip states to secure the most comprehensive surveillance and linkage system as possible.

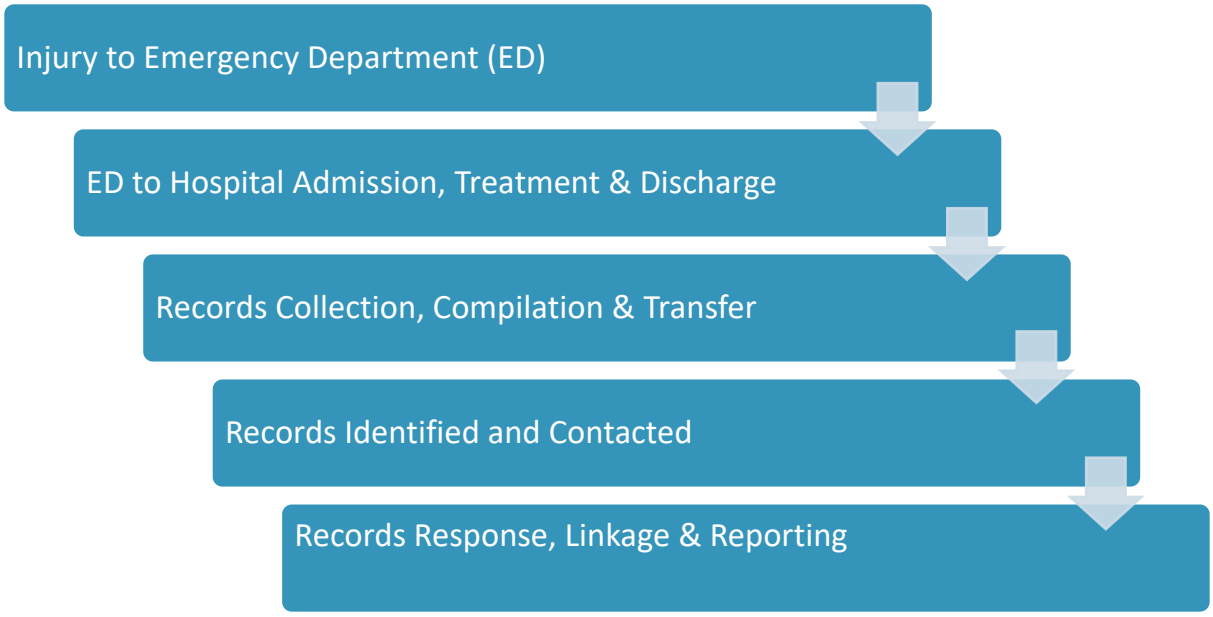
CDC further addressed the following areas regarding registry function and funding: data collection; identification; linkage to services; follow-up data collection (longer-term issues); and funding supports.

For many states, the purpose of a TBI registry is generally defined as a mechanism to:

- Identify how many residents in a state sustain a TBI each year.
- Know the number of individuals living with TBI and dealing with the challenges that accompany TBI.
- Connect these individuals and those who support them to the services they need to be successful in home, community, school, and work.

Registry Process

Typically for a significant TBI, the process looks similar across state Emergency Management Systems (EMS) and hospitals. States solely focused on surveillance implement steps 1-3, and states using registries to connect individuals to services implement steps 1-5:



When individuals sustain a TBI through causes such as a motor vehicle crash, a fall, or other blunt or penetrating blow to the head, they are taken to the hospital. If the injury is deemed serious enough to require emergency department and hospital admission, individuals are treated and the length of stay depends on several factors (level of severity, injury to other body systems, overall health, insurance, age, etc.). Once treated, individuals are discharged to a variety of settings: home, post-acute care, nursing homes, corrections, or other facilities. Hospital staff record trauma, diagnosis, demographic and treatment information, compile and securely transfer records to a data system managed by an entity allowed to receive it. This transfer usually involves state health departments, who in turn review and analyze data for surveillance and reporting purposes.

Beyond that, for states with agreements in place and the ability to receive and manage records, TBI data might then be transferred securely once more, or managed in-house, for contact and response regarding need. A letter and possibly other resource materials are mailed to eligible individuals, stating the purpose of the registry, and providing contact information in the event the individual would like to access information, resources or supports. The individual can then choose to respond, access, and receive services and supports, which vary state to state. The responsible entity collects information about the contact and response, as well as referral results, demographics, and injury specifics, and reports are disseminated to the state

department, advisory board and/or state legislature. States use this information to determine the amount and type of resources to provide, as well as mechanisms for support and service delivery.

The importance of linkage cannot be overstated. Depending on the complexity of their injuries, individuals and families are often overwhelmed by cognitive, physical, and emotional challenges that accompany a moderate or severe TBI. Once discharged, the ability to contact individuals with TBI is critical to connecting them to the services and supports that they and their families need to be successful at home, community, school, and work. Ideally, information about supports should be conveyed to survivors and caregivers at all points along the process, from hospital admission throughout treatment and discharge, and when home, but these connections are not always made. Funding plays a part in the ability to provide resources at all these points but is not the only barrier. Often individuals return home and do not know where to look or even what they need in order access services. Even if they receive information at the hospital about post-acute and community-based services, they might not access services immediately or at all. The individual may lose or be unable to retain the information provided, or they may believe that they will not need to access services as life and function will return to pre-injury management. An individual's support system might also have difficulties navigating services, and many times an individual has no support system at all. All the while, individuals with TBI may have an increased need for community-based services.

Reporting can occur for surveillance and for linkage and may be handled through the same or through different departments depending on who is collecting the data, who is providing the linkage, and what the state law mandates. Reporting might include information on incidence, injury, funding, information and referral and service delivery. There is great variety across state systems as to information collected and reported, the frequency and type of reporting, and additional activities based on the data. States can utilize results to generate funding and program requests, or impact legislation related to TBI broadly (helmet use, motor vehicle/driving laws, insurance, etc.).

Barriers to Success

While seemingly straightforward, the process from injury to service delivery intervention can involve numerous steps that can interfere with identification and connection to services. States participating in the workgroup reported on several barriers to effective surveillance and linkage:

- Registries can be an unfunded mandate. Even though staff work hard and invest time and energy, no one is dedicated fully towards operation, quality control, analysis, or reporting. A lack of financial support might cause difficulties in gaining traction or

securing agreements. Funding helps to ensure efficiency, accuracy, and analysis for future steps. State cuts make it even more challenging to have comprehensive data and linkage procedures in place.

- Although records are collected and compiled, they can be incomplete. Contact information might be inaccurate or missing. There is also no mechanism for gathering mild TBI records or data other than ED records. Physicians are not required to report TBI injuries treated in offices or clinics, nor is there a mechanism in place to capture non-hospital care. Individuals within underserved populations (such as those who are homeless, incarcerated, ethnically diverse) who are treated by hospitals are likely to be under-reported. Many do not seek treatment.

- Records can also be incomplete due to inaccurate/missing coding, or coding changes, which might screen in or screen out those needing contact. Smaller hospitals that do not often treat individuals with TBI might utilize different coding than larger hospitals.

- Many systems only allow for one contact per person per event. Individuals have the best chance for success if contacted multiple times along the recovery process. Individuals who live out of state, although injured in the state where the surveillance occurs, might be ineligible for contact. There are no official regional registry agreements in place to allow for contact.

- Data might be incomplete due to non-compliance of submission or existing regulations only allowing submission from certain hospitals (level 1 trauma centers only, for example). Many statutes are lacking consequences for non-compliance. If records are transferred from one agency to another for linkage purposes, states are dependent on the responsiveness of the data management agency.

- Inadequate or older data systems at hospitals or state agencies can cause challenges with timeliness and accuracy of contact as well as reporting.

- Response rates for linkage are low, impacting awareness and receipt of services and supports. Even though individuals and families might receive contact information in the mail, they might not read it, feel that they do not need it, or might be hesitant to respond. There might also be reading, language or cultural barriers impeding the receipt and processing of the letters. If individuals do not return to home, they might not be eligible for services (those in nursing homes, prison, etc.).

Registry Development and Implementation

With all the hurdles state surveillance/linkage systems can present, states are still supportive of maintaining their efforts. Registry data gives states an indication of incidence of TBI, and more importantly, a mechanism for connecting individuals to the services they need. For states who are trying to establish a registry, there are several points to consider, and several factors must be in place. These questions can be useful in determining how to proceed with registry planning and implementation:

Purpose

1. Why does your state need a registry?
2. Would your registry capture incidence for surveillance purposes only, or to plan and execute service linkage?

Data Sources and Protocols for Collection

1. What data sources are available in your state? Trauma, hospital admissions or discharge?
2. Are there other data sources that could be useful as well, at least in terms of surveillance? (Later in this document, additional data sources are presented).
3. If you are developing a formal registry system, then legislation might be necessary for required data collection. Will you need new legislation, or can you modify existing legislation to pursue collection? It might be possible to link a TBI registry with an existing data/trauma collection process (such as strokes or burns).
4. Who can help to support pursuit? Are there other organizations that need to be involved, such as the state department of health? Are there organizations that might be wary of data collection elements or results?
5. Is there a state agency designated to obtain and maintain data? Does that agency have the necessary infrastructure in place to support a system? Will a different agency be responsible for linkage?
6. What kinds of requirements would be necessary for collecting data, and what gets submitted? When? How often? Where will it be stored? How will it be managed? How will confidentiality be ensured? Who can have access to it and to what end? Is there a consequence for not submitting data?
7. Is there someone who can accurately analyze and interpret collective data findings? Is there a process and timeline in place to determining and conducting strong data analysis?

Linking Individuals to Services

1. How will individual records be contacted for linkage? When will contact occur and how often? Who is ineligible for contact? What are the best mechanisms to follow for contact? What procedures ensure the most response? How can confidentiality be maintained?

2. Once contact is made, what information is collected? What are the supports in place that will be provided? How will individuals be linked to those services?
3. Are all the agencies or organizations collecting or benefiting from TBI-related data willing to collaborate?[6]

Once a state can answer the questions above, these steps will be useful for establishing a process for implementing and maintaining a registry. Many states coordinate efforts with the TBI Advisory Board or Trust Fund Council as well as across department and systems:

1. Talk with other states about their registry process, data elements, collection, legislation, linkage and reporting, and lessons learned while implementing.
2. Ensure there is authority in place to implement the registry and to require healthcare providers to report. Certain elements such as the state agency responsible, agency uses for data, and mechanisms for service linkage to connect with resources will be conducted.
3. Ensure a protocol for assuring confidentiality through agreements or other formal processes. A sample is provided within *additional resources*.
4. Identify the entity to receive the data and how it will be used, such as the state department of health.
5. Determine what data elements will be collected, as well as a mechanism for collection and review and disseminate to data sources and agencies responsible for managing data.
6. Develop a process to collect and analyze data, as well as a process for linkage and reporting.
7. Develop a budget that covers all aspects of protocol, process and analysis as well as staffing, data storage, contact and outreach materials and data manipulation.
8. Consider a pilot project and then review findings before launching a statewide collection and linkage system.
9. Determine who will be responsible for responding to contacts and the level and type of information that will be shared, as well as how contact and referral will be documented, such as the state's lead agency for TBI.
10. Obtain and develop information on resources and assistance to provide to respondents when contacted, and materials needed and available for mailing or online access. Materials and resources should cover the recovery trajectory from home services, education, rehabilitation and beyond to community service provision.
11. Ensure that supports are in place, informed and prepared to receive and to document referrals in community, school, healthcare, or vocational services.
12. Determine how data will be analyzed for improving the system as well as for securing additional TBI-related funding and other mandates.

13. Disseminate registry reporting and results to establish incidence, cause, risk, vulnerable populations, and work towards increasing TBI awareness, prevention measures and improving state supports.

Other Considerations

In addition to how each state system collects and reviews its own data, there are other considerations for how to best implement and maintain a registry.

State Hospital Associations are a key player as they represent and serve all types of hospitals, health care networks, and their patients and communities. The role of hospital associations cannot be underestimated, and they can provide strong support for moving forward if informed. As protectors of the best interests of healthcare institutions there might be some concerns about how a registry could negatively impact patients, billing, insurance, or legal matters. One hospital might be compared to another one, which could have adverse effects as well. Certainly, a punitive or legal consequence of non-compliance for data collection or submission might not be viewed favorably. For these reasons, consider discussions with the state hospital association if seeking registry legislation so that passage goes smoothly.

Data elements are also especially important in terms of information collected. Carefully consider all the data elements that will help to provide the most comprehensive information and will be useful in terms of creating reporting to guide future enhancements in linkage or funding. Most states utilize a data dictionary, which outlines and describes the meaning and purpose of the data elements, and provides rules for usage, application guidance on interpretation, and accepted procedures related to them. A data dictionary sample is included within the *additional resources* section. For best results, providing initial and ongoing training on data elements and records submission to hospital staff responsible for compiling records is critical. Staff need this training, as data elements might be updated, or staff turnover occurs within hospitals. States might also find it useful to share with hospitals what happens after they submit records, what is the "rest of the story" in terms of connecting individual to services. Communication might serve as a reminder of the importance of collecting complete and accurate records.

There are several factors to consider in terms of **data analysis** that can impact reporting. Several states optimize data collection with extensive analysis through a department or independent epidemiologist, someone skilled in observing patterns of frequency, cause, and effect, and recommending strategies for improvement in healthcare outcomes. This depth of analysis might be beneficial for indicating areas of need for additional funding or changes in legislation.

Additional Sources of Data

Although a traditional system of surveillance and linkage has been obtained and maintained by several states, there are other sources of data that could potentially enhance a state system related to TBI incidence, prevalence, and linkage. Due to the nature of TBI, individuals can exist within any other system at any other time with a diagnosed or undiagnosed injury, receiving services that might or might not be optimal for them. It is important to know about other sources in place that states ultimately could connect with to maximize analysis and reporting. This could lead to stronger infrastructure development and enhancement of services. Here are just a few:

Established in 1984, the **Behavioral Risk Factor Surveillance System (BRFSS)** is a national system of health-related telephone surveys collecting state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS now collects data in all 50 states, the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. CDC continues to work with state and territorial partners to ensure that the BRFSS continues to provide data useful for public health research and practice and for state and local health policy decisions.[7]

Developed in 1990, the **Youth Risk Behavior Surveillance System (YRBSS**) monitors health behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. Six categories of health-related behaviors are included: behavior contributing to unintentional injuries and violence: sexual behavior related to unintended pregnancy and sexually transmitted diseases; alcohol and drug use; tobacco use; dietary behavior; and physical activity. YRBSS is a system of surveys conducted by conducted by the CDC and state, territorial, tribal, and local education and health agencies.[8]

The **VA Traumatic Brain Injury (TBI) Veterans Health Registry** contains information about Veterans who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND); showed symptoms associated with TBI; and sought care or benefits from VA. The construction of the registry and its maintenance is mandated by Congress. Veterans in the registry meet any one or a combination of these conditions:

- Screened positive on the VA health care administered screen when Veterans seek care.
- Had a TBI related diagnostic code in their electronic medical record.
- Applied for benefits for TBI as shown in the VA disability benefit file.[9]

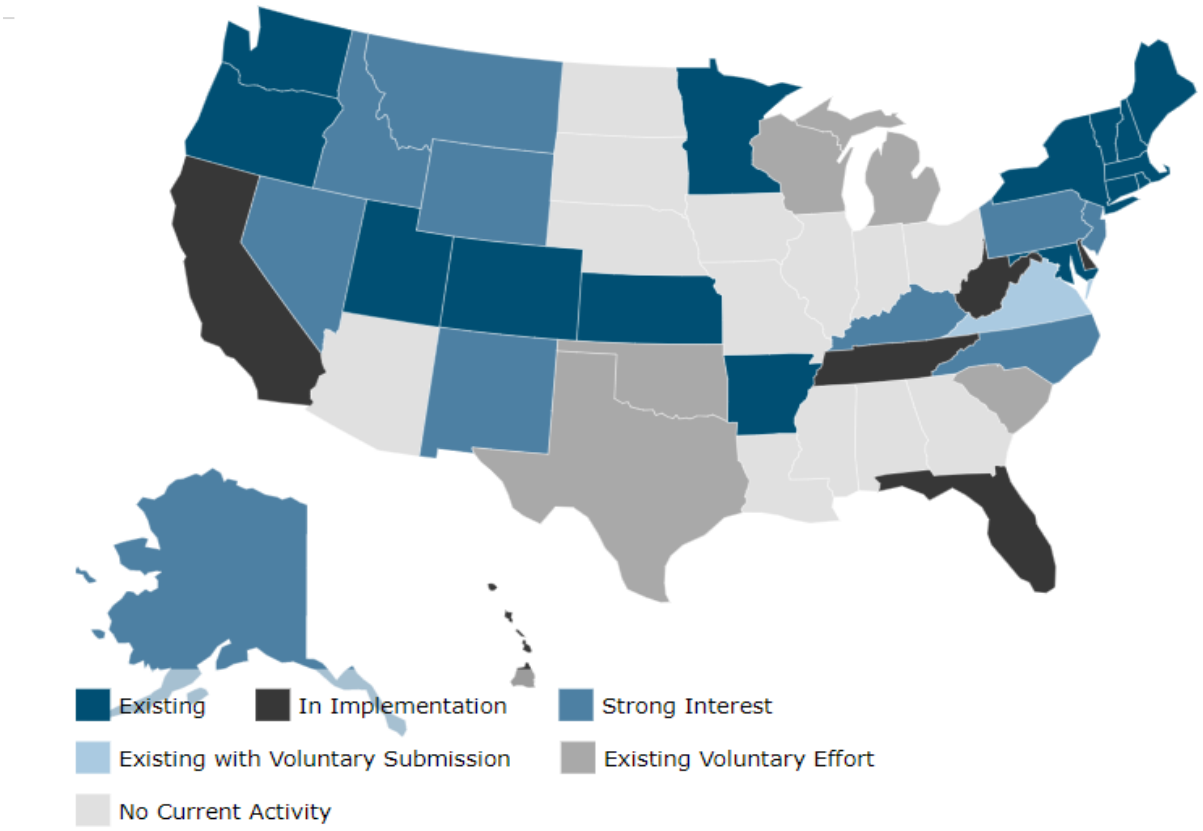
National Core Indicators (NCI) is used across states to assess the quality and outcomes of Developmental Disability (DD) and Aging and Disability (AD) services provided to individuals and their families. NCI offers valid, reliable, person-centered measures that states use to demonstrate how publicly funded supports (State Medicaid, aging, and disability agencies) are impacting people's lives and to determine where quality of those supports can be improved.

Over 46 states participate in NCI for DD and 22 states participate in NCI AD. Participating states use the data to measure and improved important elements of person-centered planning, services, outcomes, satisfaction, and policy.[10]

The CDC estimates that current data sources only capture one in nine concussions annually across the US. To capture a much more accurate picture of concussion, the **National Concussion Surveillance System (NCSS),** enacted in 2018 but still unfunded, will accurately determine how many children and adults sustain a concussion each year and determine the cause. In addition, the results of a national system would inform and equip leaders within communities and states across the U.S. by:

- Creating national estimates of the number of people living with a TBI
- Providing the first national estimates of sports-related concussions among youth that occur both in and outside of organized sports
- Providing information about the most common causes of concussion injury, including motor vehicle crashes, falls, and self-harm
- Monitoring trends to understand whether the number of concussions is increasing or decreasing, and assessing whether prevention efforts are working
- Giving insight to healthcare providers and hospitals about where patients seek care for concussion and their recovery needs.[11]

Insurance factors into the level and type of healthcare received for all US residents. The **All-payer claims database (APCD) systems** are large State databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers. APCD data are reported directly by insurers to States, usually as part of a State mandate. APCD data includes: information on private insurance; data from most or all insurance companies operating in any State; and information on care for patients across care sites, rather than just hospitalizations and emergency department visits maintained by most states. They also include large sample sizes, geographic representation, and capture of longitudinal information on a wide range of individual patients.



There is national and local momentum to establish and implement APCDs. To date, 18 States have legislation mandating the creation and use of APCDs or are actively establishing APCDs, and more than 30 States maintain, are developing, or have a strong interest in developing an APCD.[12]

Conclusions

States seeking to establish a registry must be diligent, organized and collaborative to draft legislation, secure strong partners, and write protocols. States must manage records and connect people to the services they need while ensuring sufficient capacity to support services. Registries require hard work, staff effort, significant analysis, multiple partners, and funding sources to be optimally successful.

Issues arise with data collection, changes in regulations regarding coding, and shifts in technology systems. States must be prepared to solve these issues and accurately report on collection, demographics, causes, areas, and individuals most highly impacted. However, given all these efforts, when successful, registries can "make data sing" (Kinde & Roesler, 2021) by painting an accurate picture of the nature and prevalence of a chronic condition with lifelong challenges and support needs. States can also support residents with TBI that require these supports to be successful. Collectively, states can contribute to the national picture of TBI, and help to better determine trends and best practices in data collection, service delivery and prevention.

Connecting People to Services: A Personal Story

At the age of 21, Ann Smith sustained a TBI in a car crash, and was unconscious when EMT staff arrived. She was taken by ambulance to a local emergency department and then admitted to the hospital due to significant injuries. Ann remained unconscious for several days, and once awake remained in the hospital receiving acute, post-acute and rehabilitative care. While in the hospital, Ann and her family were told she had a moderate TBI and would need some cognitive and community supports when she returned home. She was given information about her injury, possible challenges and a factsheet outlining services she could access. She was discharged after a five- week length of stay to live temporarily with her parents. Once at home, Ann received a letter describing the same services shared at the hospital and after considering it, she and her family contacted the number given in the letter to ask about services and to describe her challenges and needs. TBI staff listened to her describe her current situation and discussed some possible options for home care coordination, assessment and cognitive remediation, and assistance with daily living skills building. Ann contacted the services shared with her and received further feedback, education and services. With extensive guidance and planning, she was then able to continue to recover, strengthen her physical and cognitive deficits and eventually return to college. From there, she secured a job with the help of staff skilled in supporting her job search, interviewing process and employment. She continued to receive encouragement and support while working as was able to maintain employment and live independently.

Summary of State Approaches

The Data workgroup conducted a survey to better understand and compile information regarding TBI Registries. Responses from this survey are shared below. As a reminder, the Data group has defined a TBI Registry as "any mechanism used by a Lead State Agency (or representative) to collect data on individuals living with brain injury for the purpose of surveillance or to 'connect people to services'." This could have included data collected from a state trauma registry or hospital association.

All states were asked **to respond, even if they did not have an active registry.** The survey included questions around registry history, operations, data, outreach, and reporting. Almost all the ACL TBI grantees responded, and an additional two states not currently funded also responded:

State	Current Grantee	Registry	Link
Alabama	Yes	Yes	https://www.alabamapublichealth.gov/atr/index.html
Alaska	Yes	Yes	http://dhss.alaska.gov/dph/Emergency/Pages/trauma/registry.aspx
Arkansas	Yes	Yes	https://atrp.ar.gov/wp-content/uploads/sites/24/2018/08/TBI-Registry-Referral-Process.pdf
California	Yes	No	
Colorado	Yes	Yes	https://cdphe.colorado.gov/emergency-care/trauma/colorado-trauma-registry
Georgia	Yes	Yes	https://dph.georgia.gov/georgia-central-trauma-registry
Idaho	Yes	Yes	https://idahotseregistry.org/index.php
Indiana	Yes	Yes	https://www.in.gov/isdh/19540.htm
Iowa	Yes	Yes	https://idph.iowa.gov/brain-injuries/surveillance-and-reporting
Kansas	Yes	No	http://www.kstrauma.org/trauma_guidance.htm
Kentucky	Yes	Yes	https://lern.la.gov/trauma/trauma-registry/
Maine	Yes	No	
Maryland	Yes	Yes	https://law.justia.com/codes/maryland/2013/article-ghg/section-20-108/
Massachusetts	Yes	Yes	https://www.mass.gov/service-details/state-trauma-registry-data-submission
Minnesota	Yes	Yes	https://www.health.state.mn.us/facilities/traumasystem/mntrauma/index.html
Missouri	Yes	Yes	https://health.mo.gov/data/headspinalcordinjury/index.php

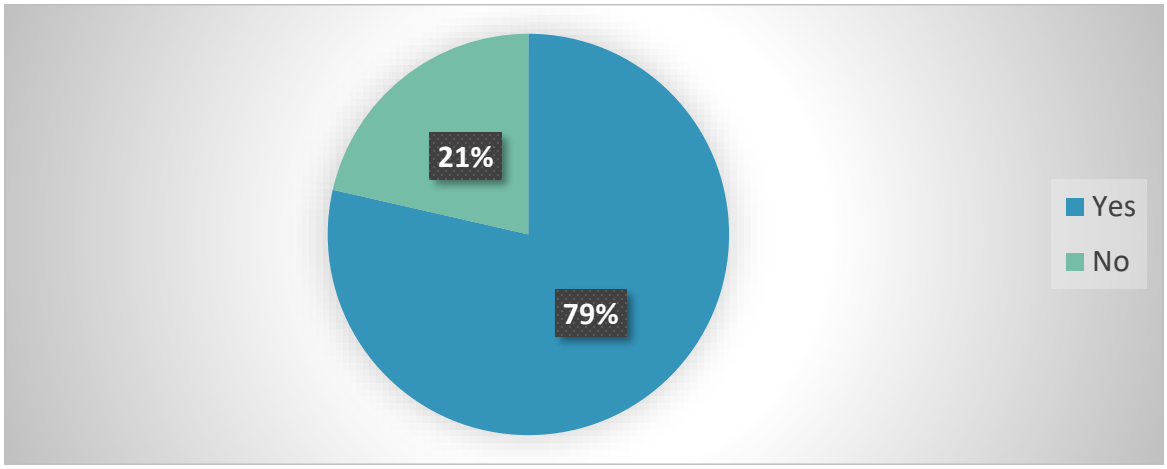
Nebraska	Yes	Yes	https://braininjury.nebraska.gov/resources/brain-injury-data-and-statistics
North Carolina	Yes	Yes	https://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html
Ohio	Yes	No	
Oregon	Yes	Yes	https://www.oregon.gov/oha/PH/ProviderPartnerResources/EMSTraumaSystems/TraumaSystems/Pages/registry.aspx
Pennsylvania	Yes	No	
Rhode Island	Yes	Yes	https://health.ri.gov/programs/detail.php?pgm_id=34
Tennessee	Yes	Yes	https://www.tn.gov/health/health-program-areas/health-professional-boards/ems-board/ems-board/trauma.html
Utah	Yes	Yes	http://www.utahtrauma.org/
Vermont	Yes	No	
Virginia	Yes	Yes	https://www.vdh.virginia.gov/emergency-medical-services/trauma-critical-care/virginia-statewide-trauma-registry/
West Virginia	Yes	Yes	http://www.tbi.cedwvu.org/tbi-at-a-glance/wv-tbi-registry/
Arizona	No	Yes	https://atrp.ar.gov/about/
North Dakota	No	No	

Additionally, there are other states who have registries that did not respond to the survey. Further information can be found in the Literature Review reference within the *additional resources* section.

Questionnaire Responses

A copy of the questionnaire is included in the *additional resources* section. General comments regarding each question are included below the chart.

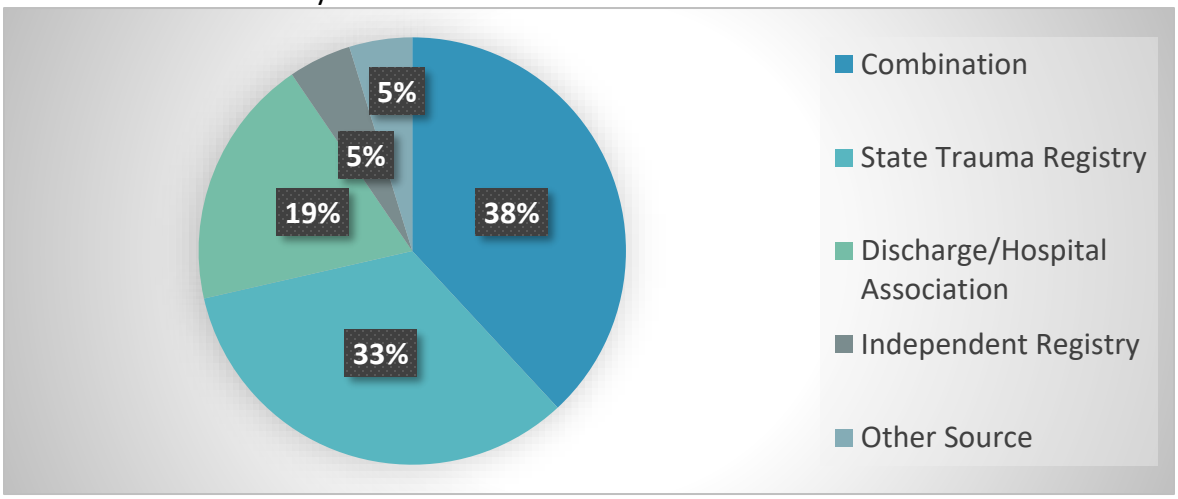
Q1. Does your state have an established process for TBI data collection (e.g., TBI Registry, Trauma Registry, Hospital Association data)?



States with no registries reported a need for data collection to be more cohesive, consistent and integrated across agencies and programs. They also reported denied state attempts to create legislation for surveillance. Some states report adding screening questions to other data mechanisms, such as: Behavioral Risk Factor Surveillance System (BRFSS); Long-Term Care systems; and school system concussion data collection.

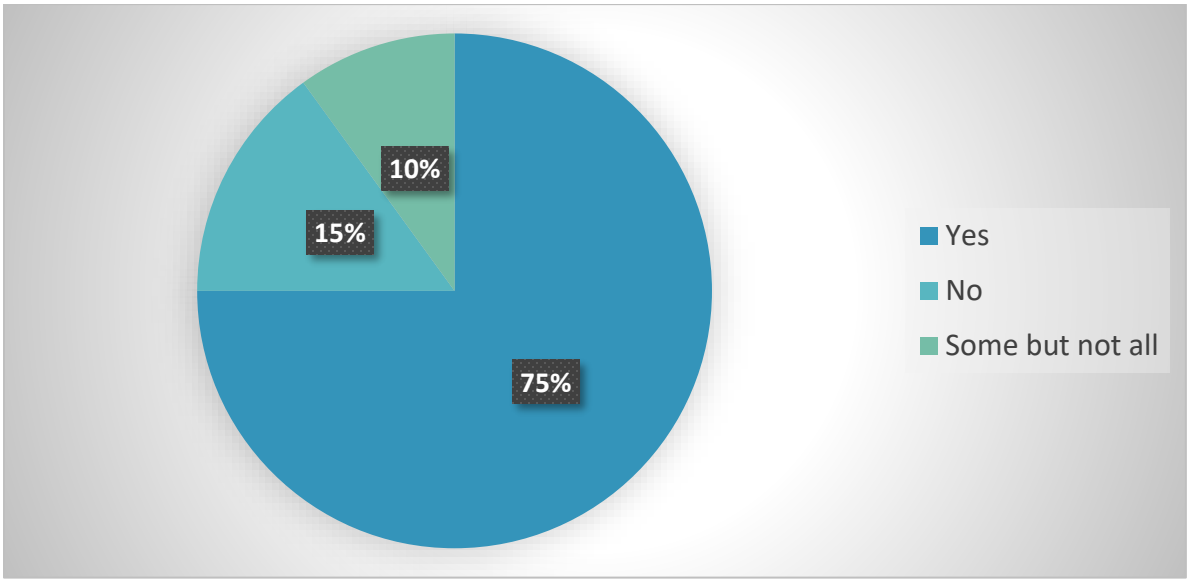
Registry Data

Q2. What is the source for your state TBI data?



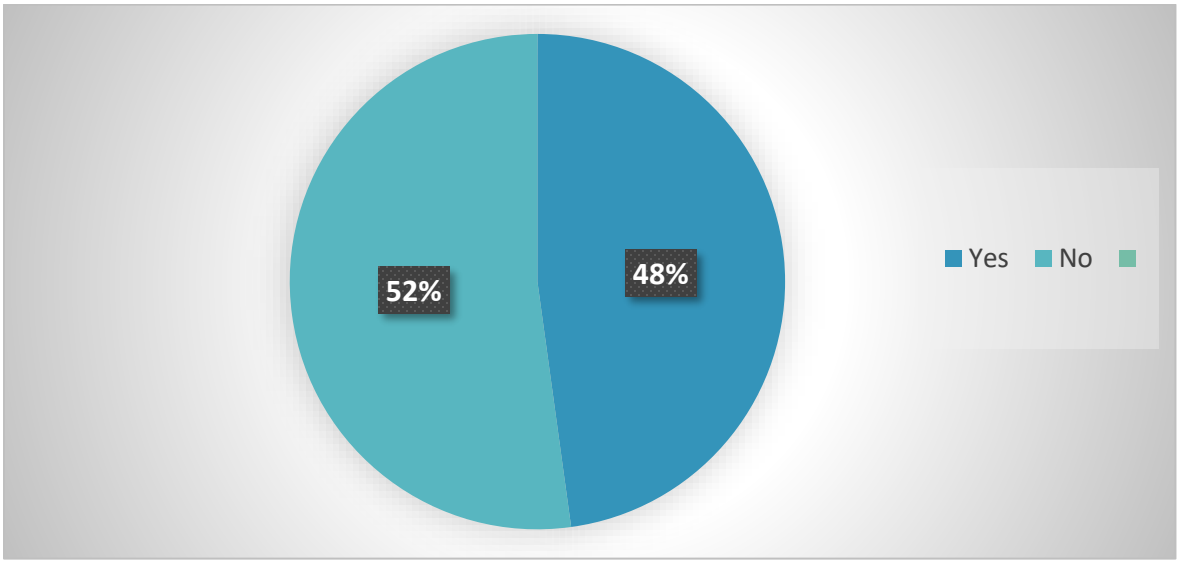
Other data sets states utilize included: Office of Highway Safety; EMS records; Vital Records; mortality data; and TBI Model Systems Prevalence data.

Q3. Do you have an agreement in place to access the TBI data source(s) selected above?



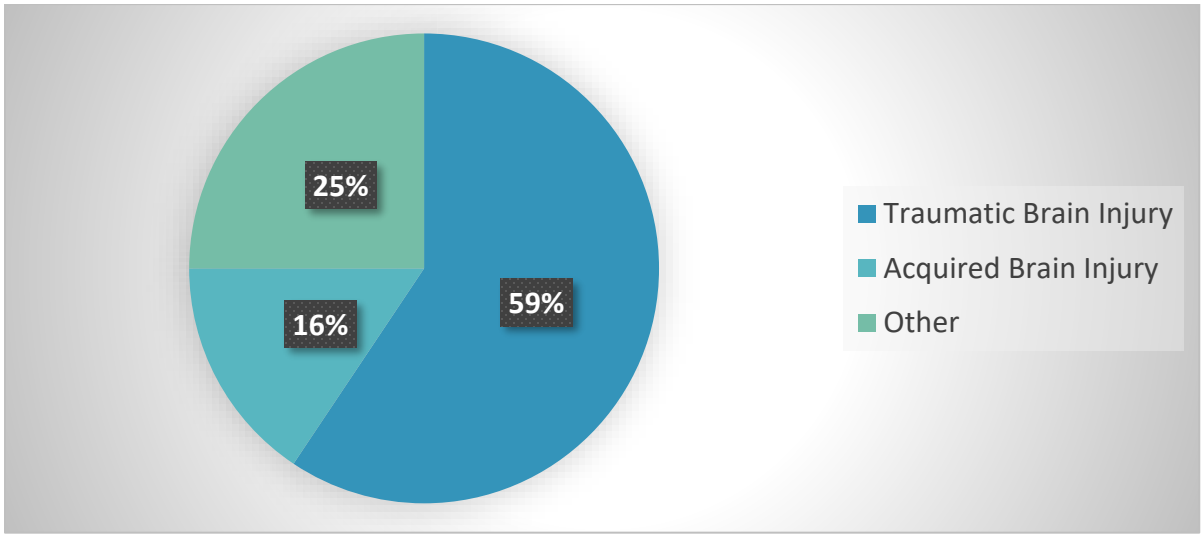
States have a variety of agreement types. Most states work through departments of health and several involve the state hospital association and have some level of legislation securing access.

Q4. Does your state TBI registry use data to link people to services?



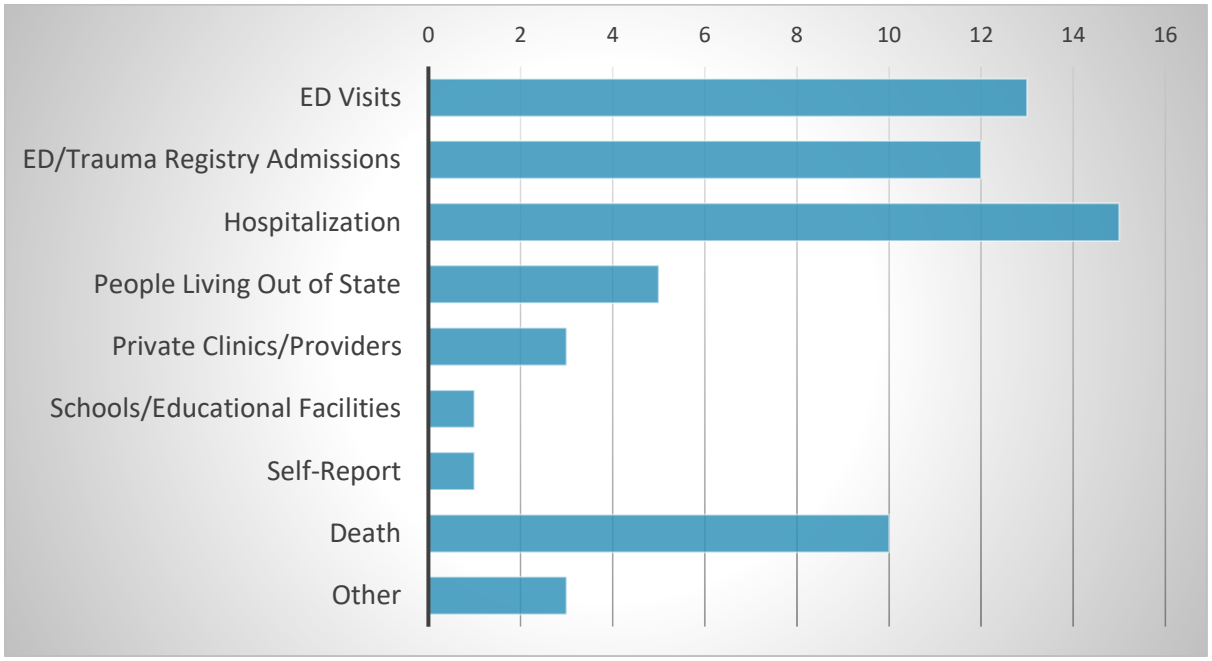
Some states are in the process of enhancing registry surveillance to also include connection to services. Other states have other measures in place for outreach.

Q5. What is the focus of data collection for your registry?



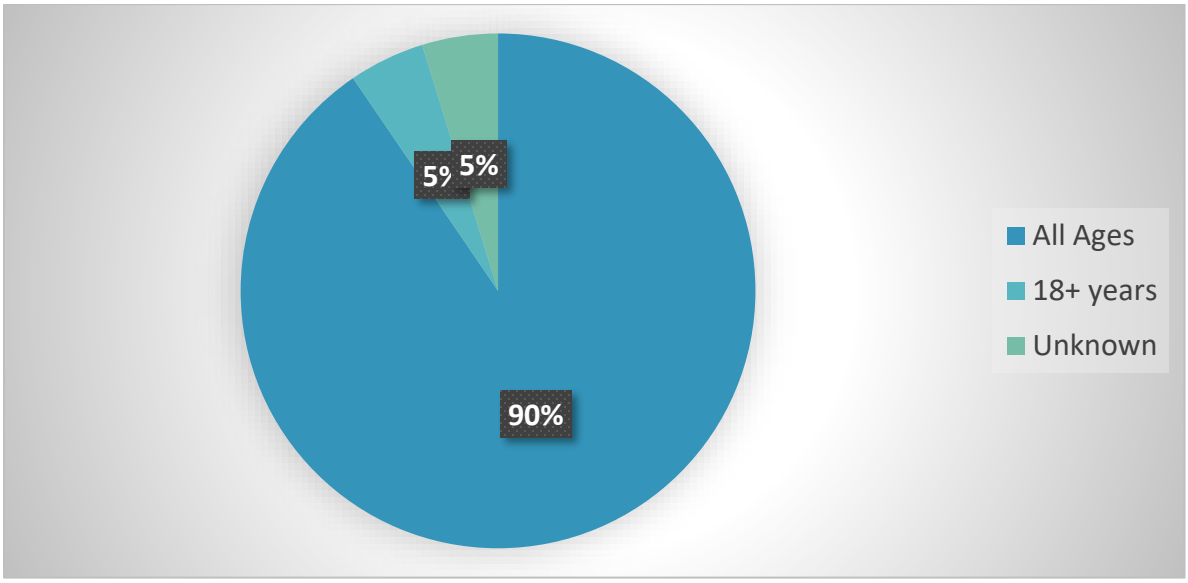
States selecting "other" reported gathering data on spinal cord injury, heart disease, and general trauma.

Q6. Which of the following are included in your TBI Registry data set?



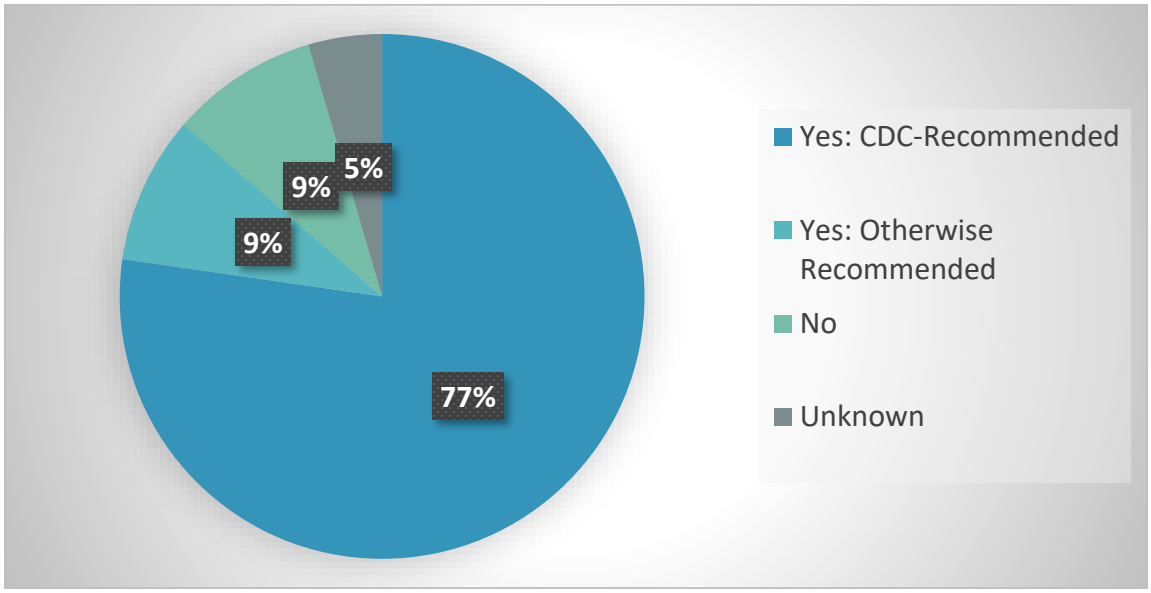
States with registries include several types of records, with the majority focused on hospital admissions.

Q7. Which age groups are included in your TBI Registry?



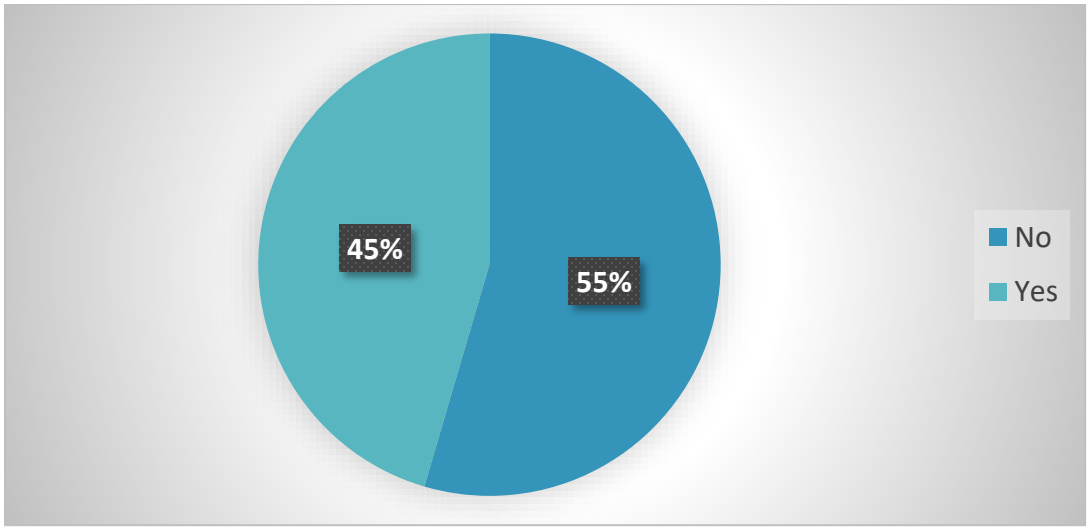
While many states collect data related to children and youth, few are linked to services. There has been much discussion about the need for pediatric registries within and across states.

Q8. Does your state use ICD-10 codes for inclusion criteria to collect TBI or Trauma registry data?



A few states do not have any specifications in legislation and use data that is accessible.

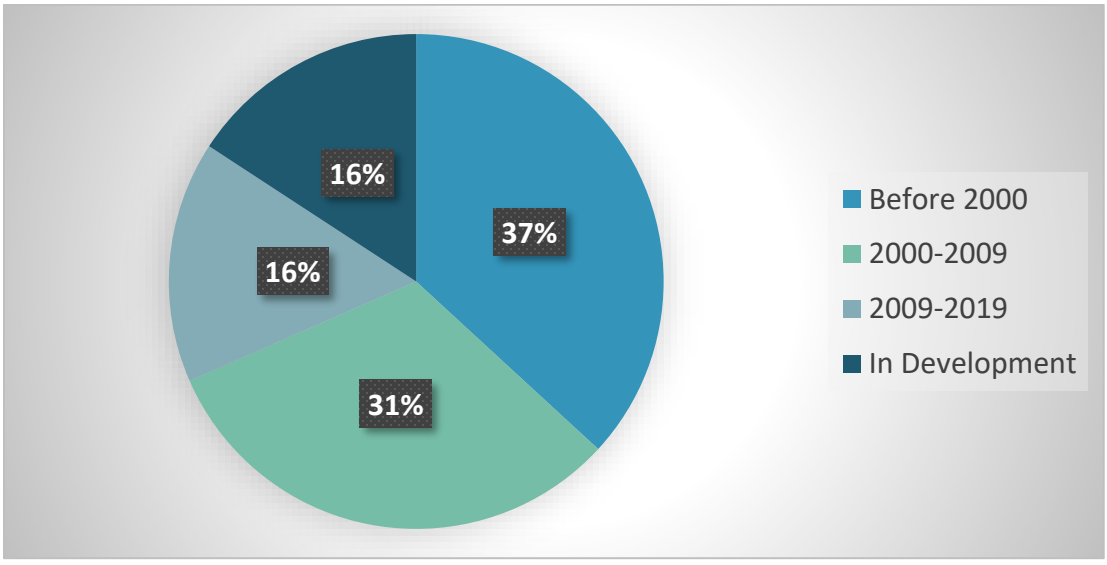
Q9. Do you include/download the unspecified head-injury ICD-10 Code: S.09?



States who do not include this code due to billing and/or reimbursement stipulations, Lack in specificity for head injury, and the possibility that this code might not include brain injury (more likely to be used for superficial injury).

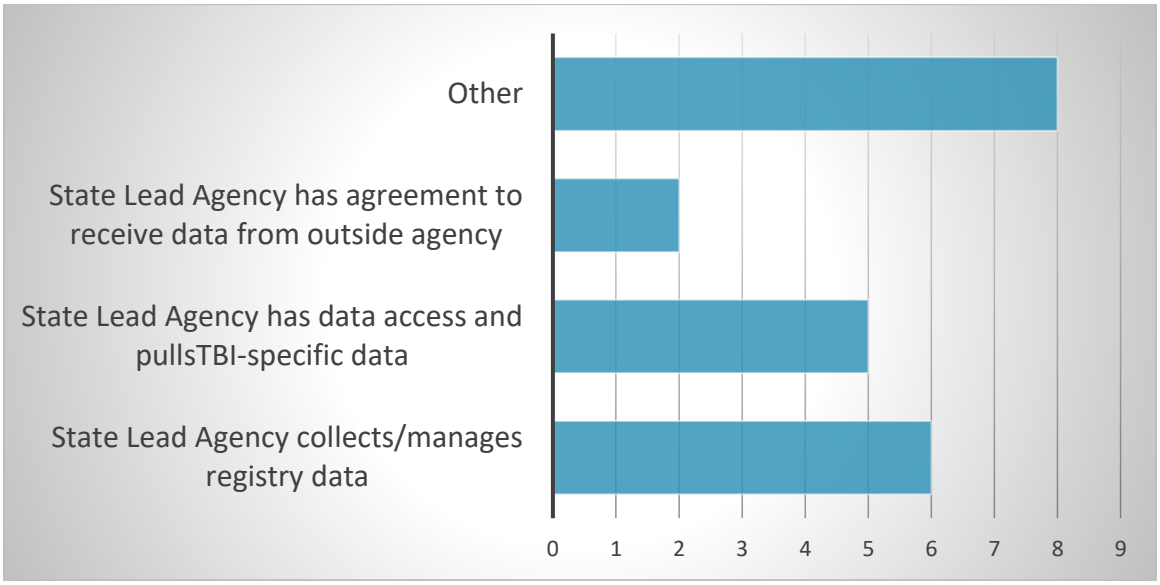
Registry History

Q10. What year was your TBI registry established?



With two exceptions, states who reported having established registries reported accomplishing this effort through legislation.

Q11. What is your state's relationship to the TBI Registry?

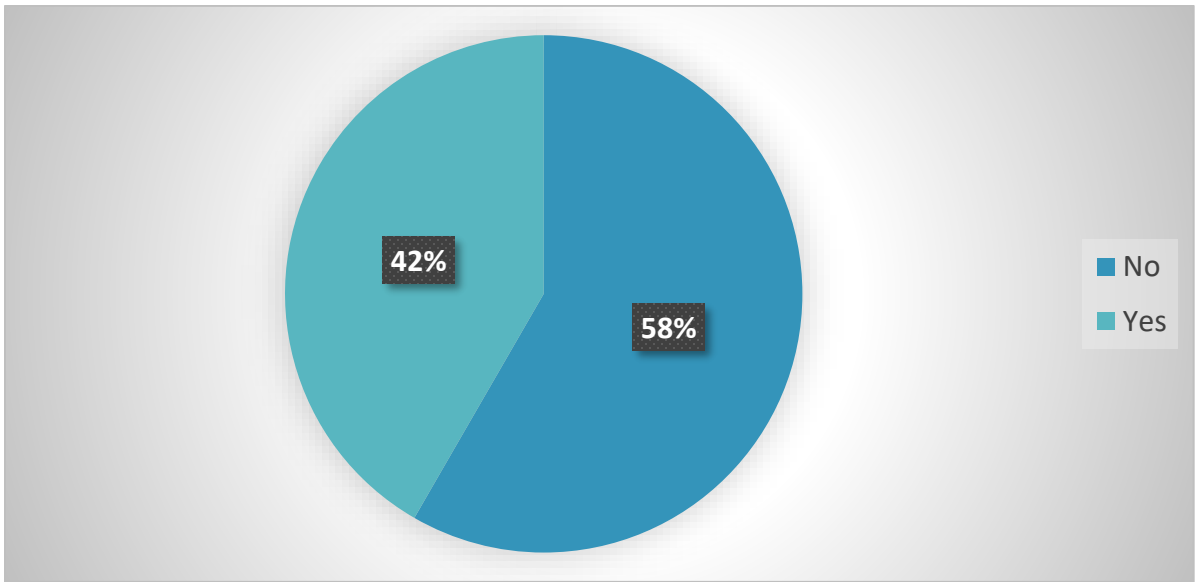


For states answering "other", the majority did not have a registry in place.

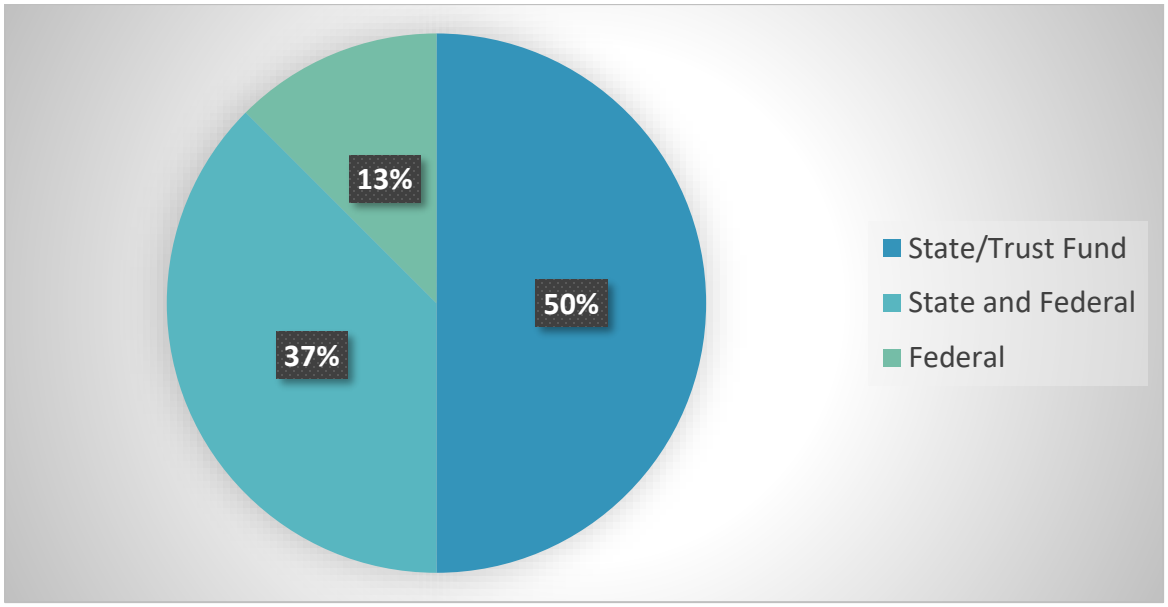
Q12. How many staff are required to manage your registry?

Although the number of staff varied across states, from 0 to more than 6, none of the states reported requiring the equivalent of more than 1 FTE.

Q13. Is your registry funded?

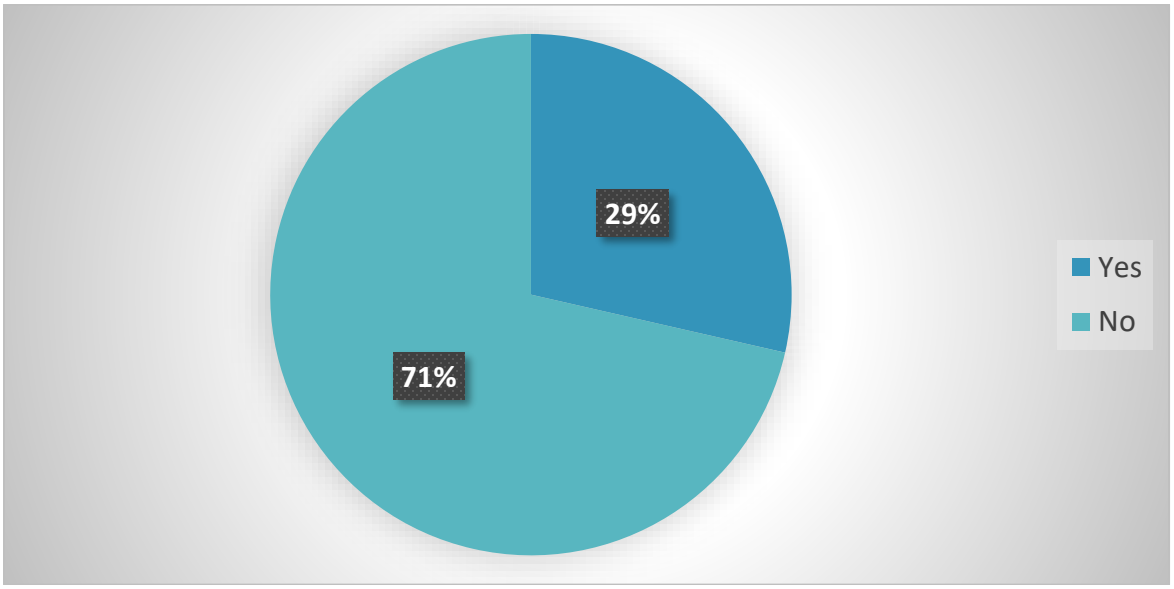


Q14. If funded, what is the source of funding?

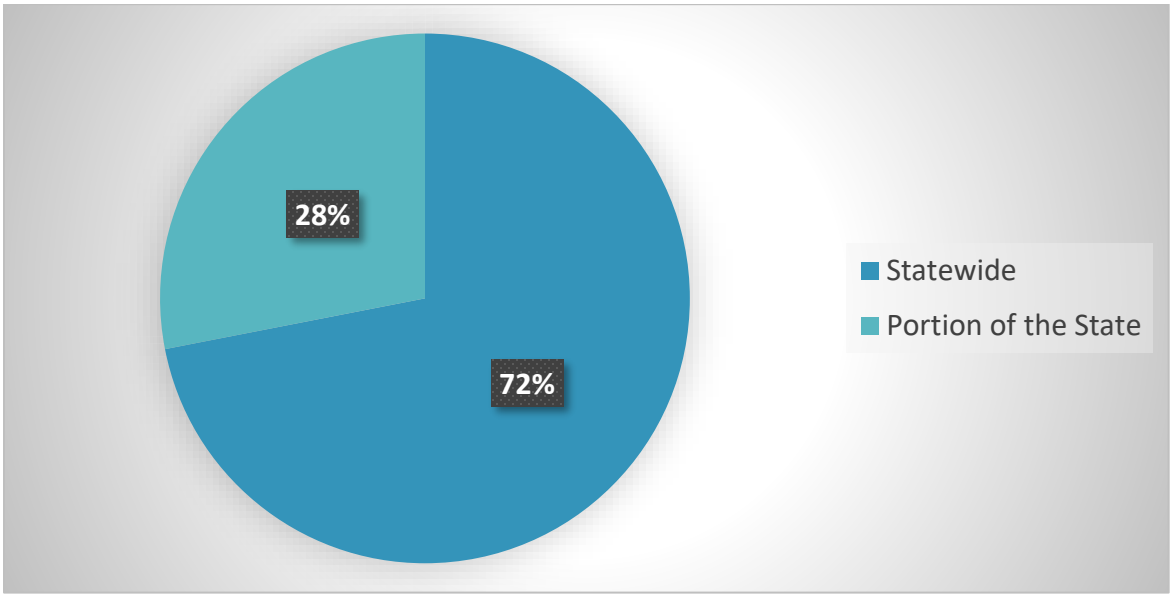


Unfortunately, the amount of funding is largely unknown.

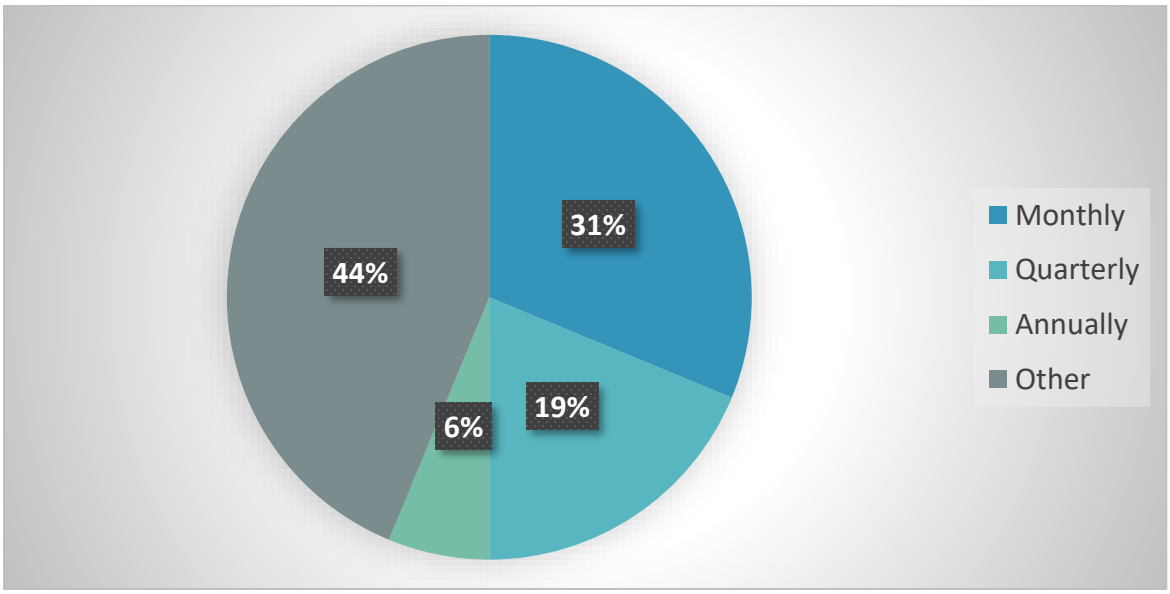
Q15. Does your state receive funding from the Centers for Disease Control (CDC) to systematically collect data on TBI incidence?



Q16. Is the registry statewide, only a portion of the state, or only a portion of the hospitals across the state?

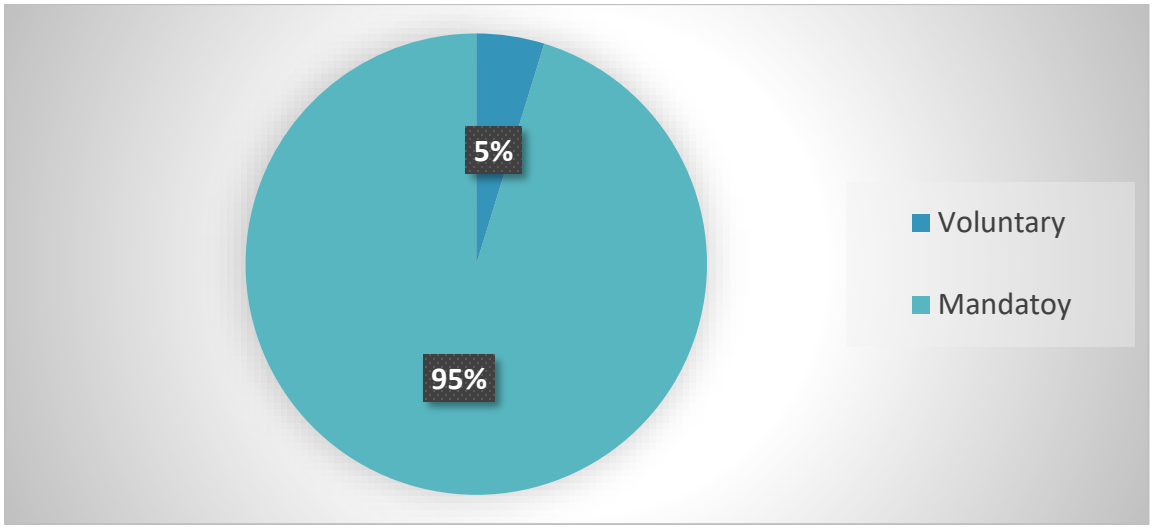


Q17. How often is data downloaded?



For states who responded 'other', most states responded that data was downloaded more frequently, even daily, or that the consistency of the download varied.

Q18. Are hospitals or other units required to submit data or do they contribute voluntarily?

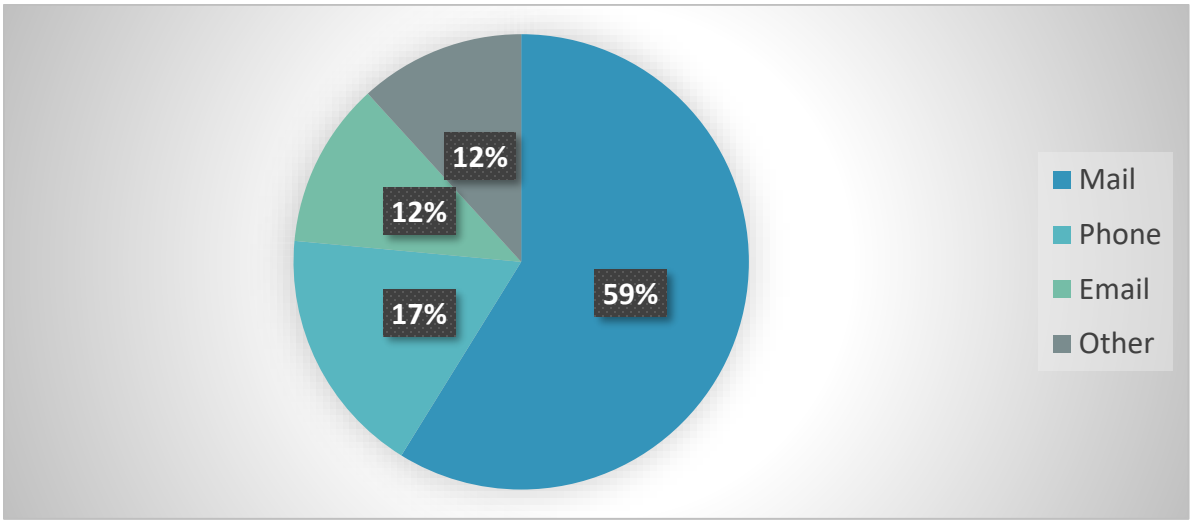


Even with mandatory data submission, states report it challenging to maintain consistency with receipt of data if coming from an outside agency. Data is shared but not regularly or is delayed in transfer. This may be due to several reasons: hospital staff turnover; changes/issues with reporting mechanisms; a lack of program or financial consequence for non-compliance.

Registry Outreach

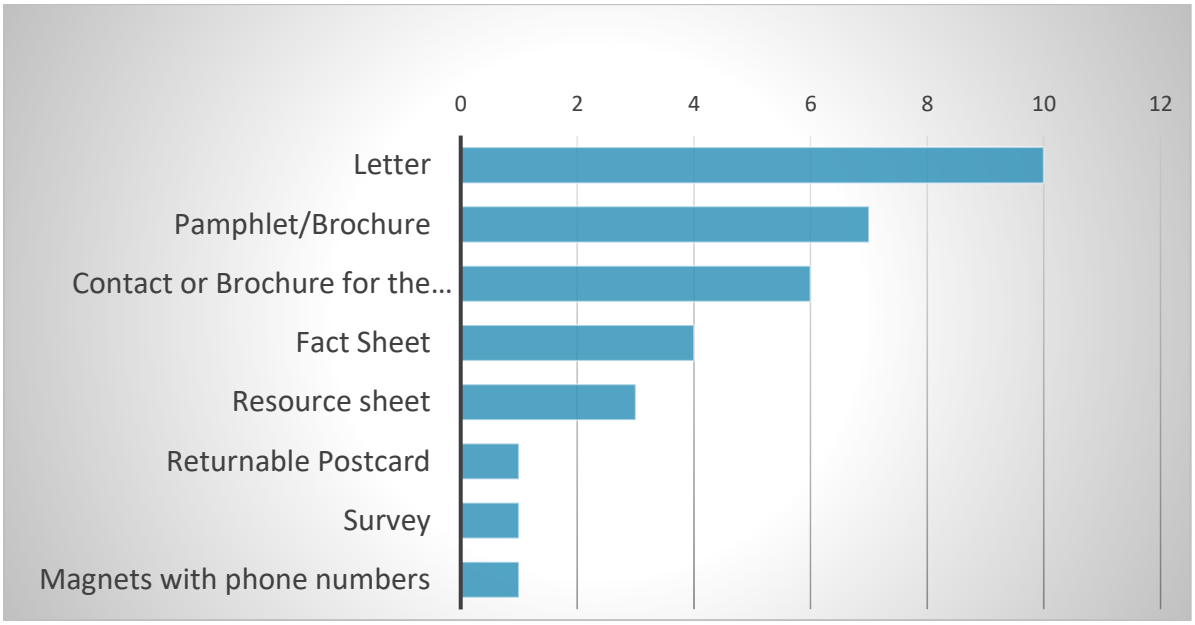
For this questionnaire and Guide, outreach is defined as any mechanism used by state Lead Agencies to use TBI Registry data to connect people living with TBI to services and/or supports.

Q19. How is the TBI Registry outreach conducted?

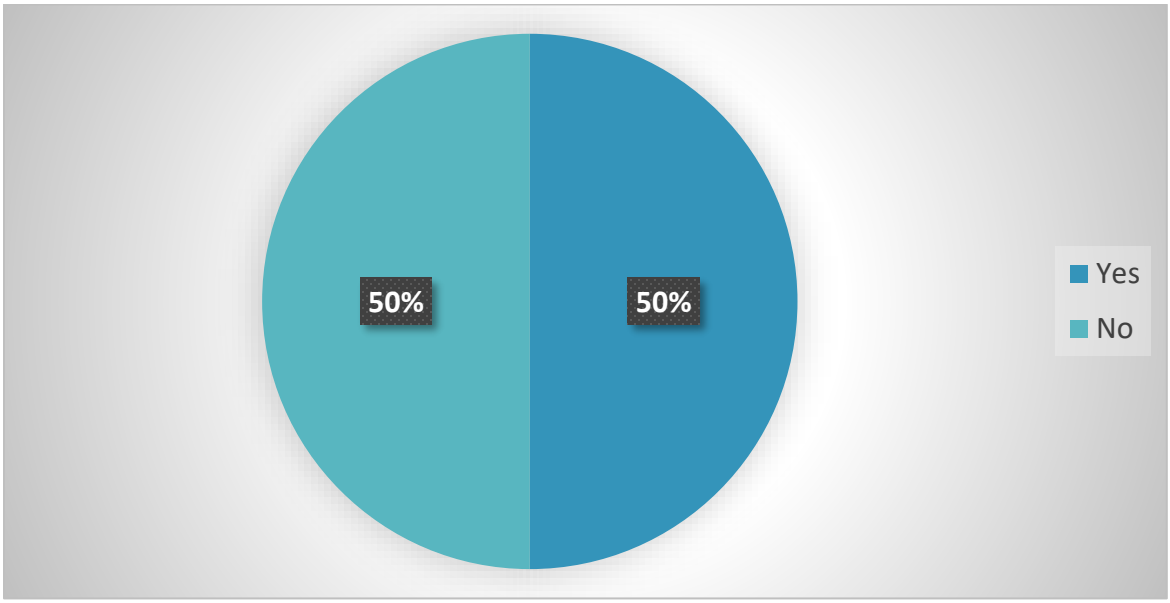


States selecting 'other' report utilizing the lead agency or other website, or public events for outreach. It is interesting to note whether any states use a combination of these methods, and if it proves to increase efforts.

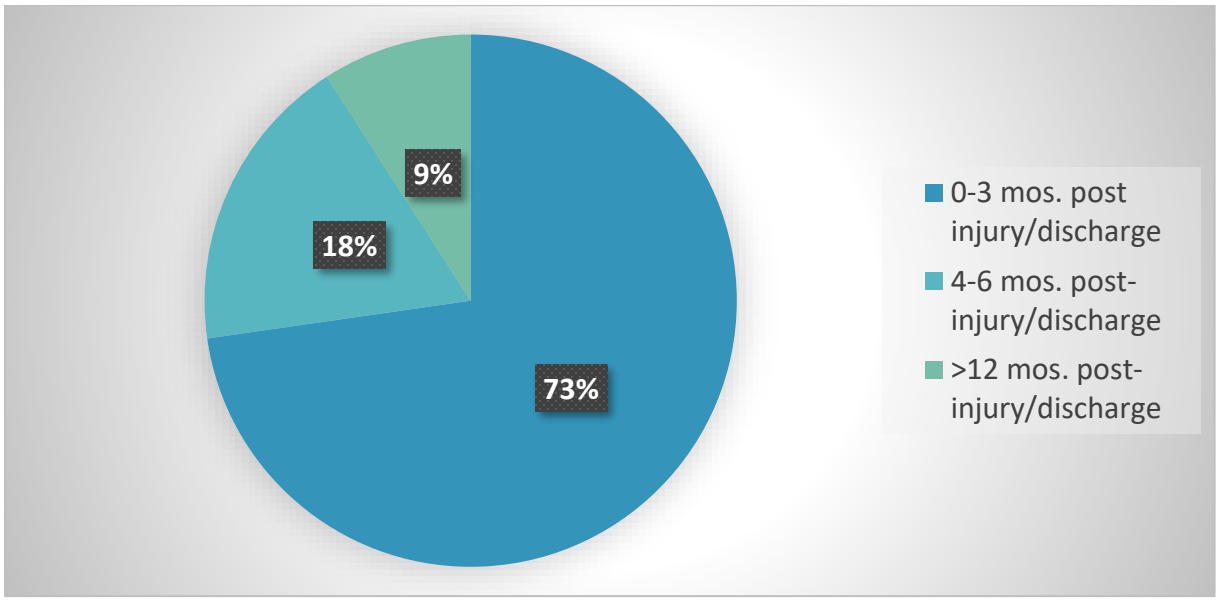
Q20. What information is provided during outreach?



Q21. Is a case manager or resource facilitator assigned?

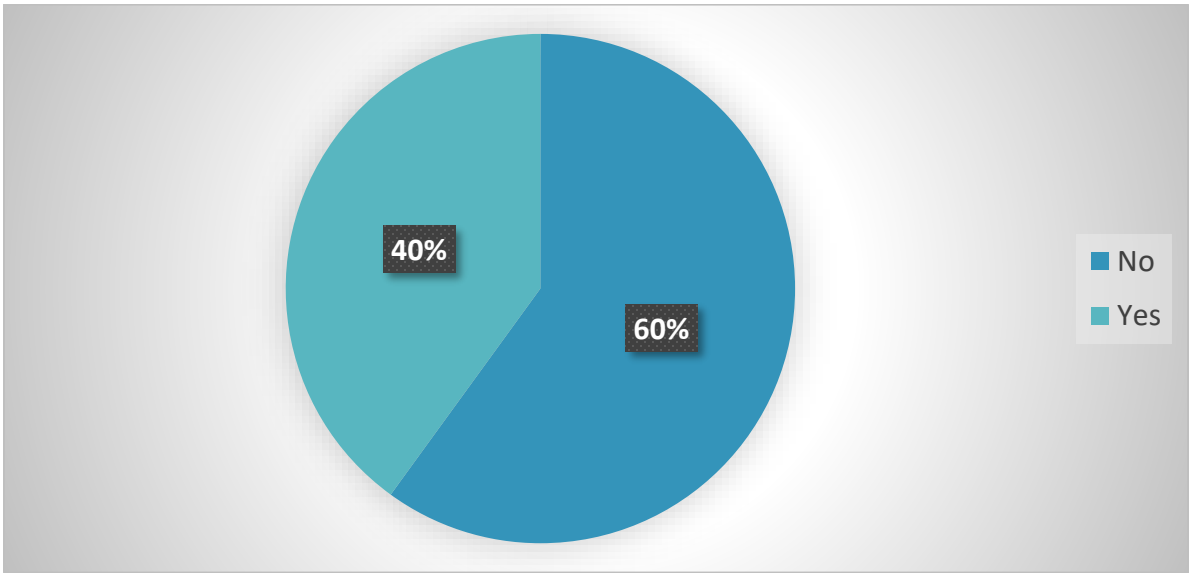


Q22. What is the expected time frame for contacting the person living with brain injury for purposes of connecting them to services?



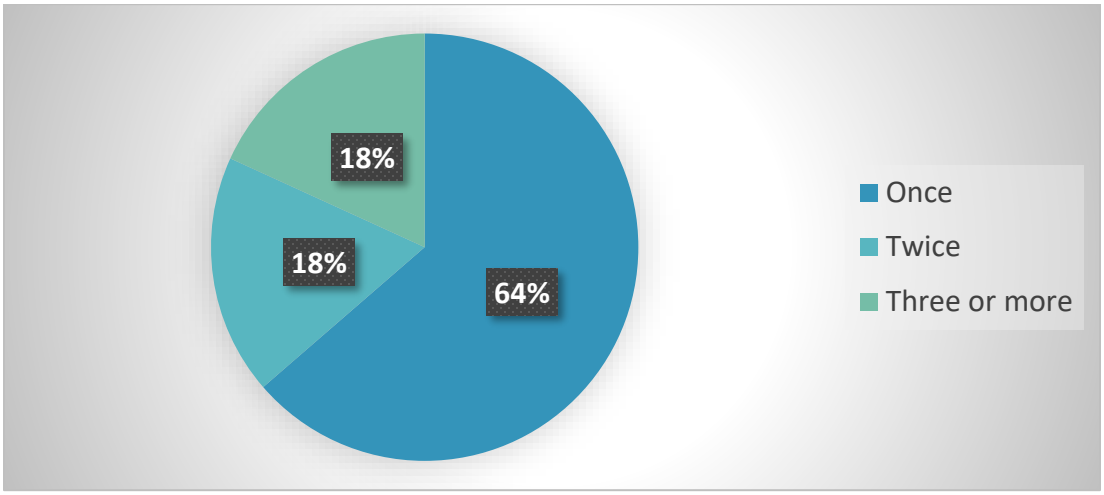
Is there an optimal time for contact? Should multiple points of outreach be the standard?

Q23. Is everyone in the registry eligible to be contacted?

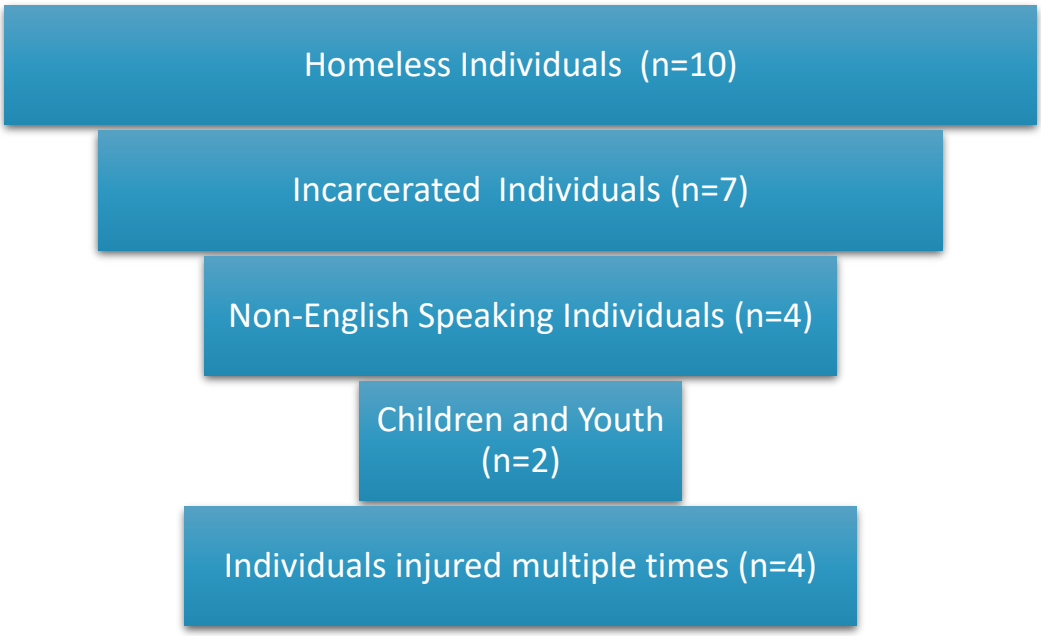


States responding with 'no' reported eliminating from contact those who are deceased, homeless, incarcerated, out-of-state residents, or those with mild TBI. Records are still reported in terms of incidence, however.

Q24. How frequently is the person living with brain injury contacted for purposes of linking them to services?



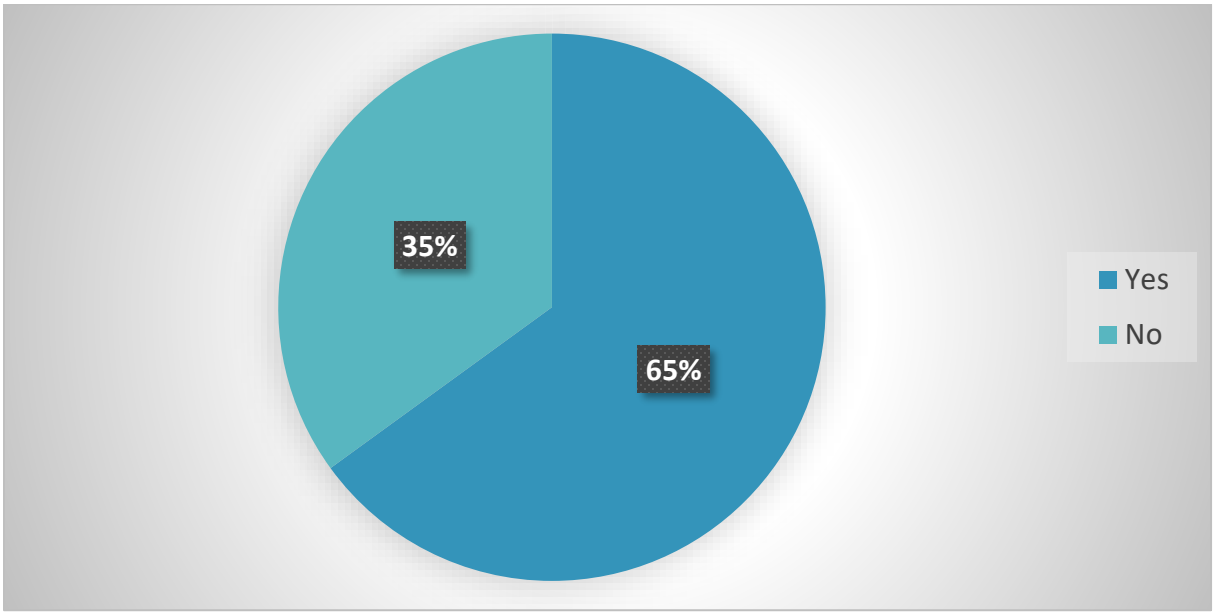
Q25. Does your state have challenges reaching certain populations to do TBI Outreach?



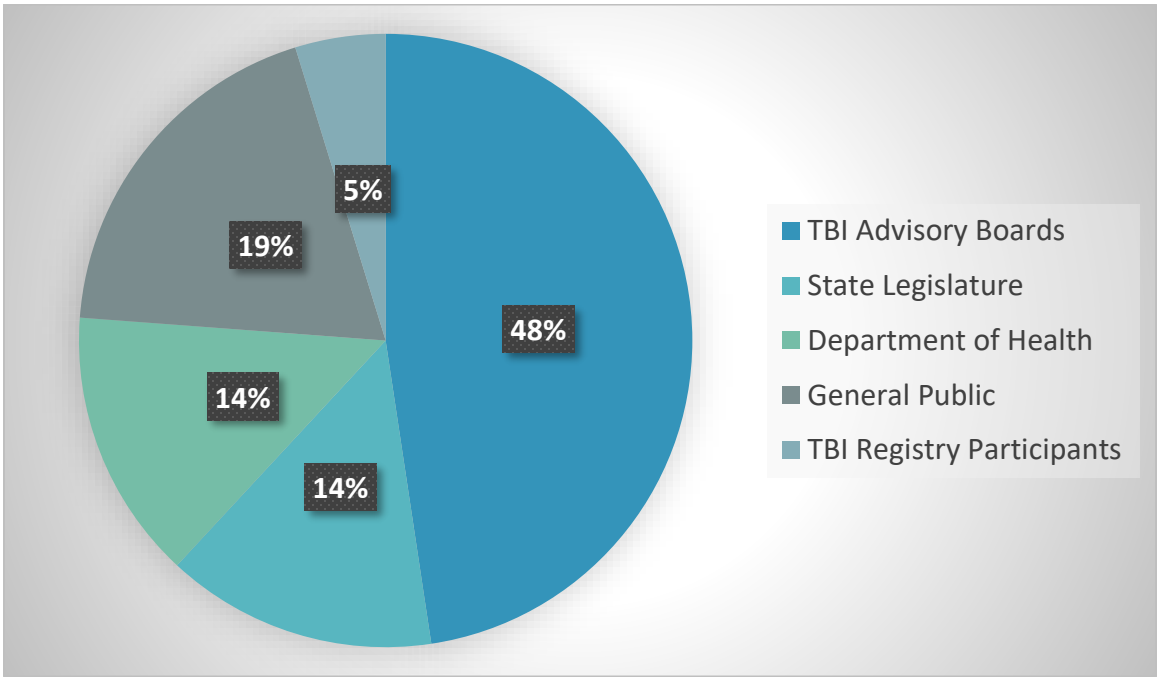
Many states have outreach issues related to registry contact with these populations. Some states work to increase outreach effectiveness by providing age-specific contact information or contact information in alterative formats and languages. Vulnerable populations with the justice system or who experience homelessness without a discharge to home or with a permanent address might be ineligible for contact. Other options for outreach rather than through a traditional registry process are sometimes applied.

Registry/Data Reporting

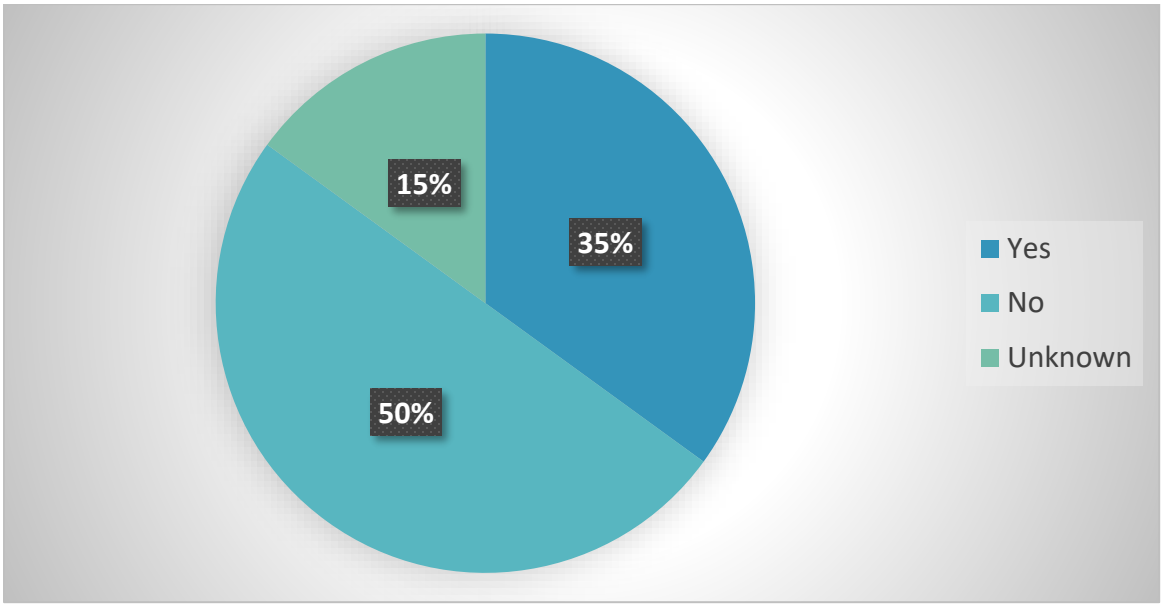
Q26. Is TBI registry data analyzed and aggregated into a report by the Lead Agency?



Q27. Who receives Registry Reports?



Q28. Does your Lead Agency or their partners collect additional data from individuals on the registry?



Additional information collected by states included surveys gathering additional demographics or interest in resources, diagnoses, financial resources, payor source, referrals, requests, assessments, services, conducted after outreach and contact.

References

1. Mayo Clinic Staff; Mayo Foundation for Medical Education and Research: "TBI" *Mayo Clinic Diseases and Conditions,* https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557?utm_source= Google&utm_medium=abstract&utm_content=Traumatic-brain-injury&utm_campaign=Knowledge-panel; 1998-2021.

2. Physiopedia; European General Data Protection Regulation; https://www.physio-pedia.com/Data; 2021.

3. Langlois JA, Rutland-Brown W. Traumatic Brain Injury in the United States: The Future of Registries and Data Systems. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2005.

4. Feinstein AR. Clinical Epidemiology: The Architecture of Clinical Research. Philadelphia: WB Saunders; 1998.
5. Teutsch SM, Thacker SB. Planning a public health surveillance system. *Epidemiological Bulletin: Pan American Health Organization;* 1995.

6. Vaughn, SL: Building Up TBI Systems: Tools for Successful TBI State Programs: Administration for Community Living TBI TARC; 2021.

7. National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health: https://www.cdc.gov/brfss/about/about_brfss.htm; 2014.

8. Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: https://www.cdc.gov/healthyyouth/data/yrbs/overview.htm; August 2020.

9. U.S. Department of Veterans Affairs: https://www.publichealth.va.gov/epidemiology/reports/oefoifond/health-care-utilization/tbi-registry.asp; August 2020.

10. ADvancing States and Human Services Research Institute (HSRI): https://nci-ad.org/about/; 2021.
National Association of State Directors of Developmental Disabilities Services and HSRI: https://www.nationalcoreindicators.org/about/history/; 2021.

11. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control: https://www.cdc.gov/traumaticbraininjury/ncss/index.html; March 2019.

12. Agency for Healthcare Research and Quality: All-Payer Claims Databases: https://www.ahrq.gov/data/apcd/index.html; February 2018.

Additional Resources

These resources can be accessed below or through the workgroup or online at www.nashia.org:

1. Questionnaire: Using Data to Connect People to Service workgroup
2. Data Elements/Dictionary Data Dictionary Sample: Idaho TSE Registry https://www.idahotseregistry.org/dataspecifications.php
3. Sample Data Sharing Agreement: Alabama Department of Rehabilitation Services/Alabama Department of Public Health
4. Sample contact letter: Virginia Department of Aging and Rehabilitative Services/Brain Injury Association of Virginia
5. Literature Review: Human Services Research Institute