

CHRT

at University
of Michigan



SUPPORTING INDIVIDUALS WITH LONG-TERM PHYSICAL DISABILITIES

**A National Institute on Disability, Independent Living, and
Rehabilitation Research (NIDILRR) funded survey of organizations**

The Center for Health and Research Transformation (CHRT) at the University of Michigan is conducting a survey to collect information about services and programs that support individuals with physical disabilities, as well as information about the organizations providing these services and programs. The survey is part of a larger research initiative through the IDEAL Rehabilitation Research and Training Center (IDEAL RRTC), which aims to promote the successful aging of adults with long-term physical impairments and disabilities. IDEAL RRTC Community Grants are supported with funding from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant number 90RTHF0001).

To thank you for your participation:

As part of the survey, you will be asked questions about your organization and the populations you serve. To thank you for your participation, those who complete these questions will be eligible to receive an Amazon gift card of up to \$25. At the end of the survey, you will have the option to choose whether you would like to claim or to decline your gift card. Those who would like to claim their gift card will be directed to another survey that asks for an email address where the electronic gift card should be sent. The email address that you provide will not be connected to your survey responses.

About the survey:

As part of the survey, we will be asking about the services that your organization provides. Only one survey may be submitted per organization; however, feel free to complete the survey in consultation with others at your organization.

The survey has a mixture of multiple-choice questions and questions that will ask you to respond by typing in a few words. The data will be collected through the online survey platform Qualtrics.

We greatly appreciate your participation!

ABOUT YOUR ORGANIZATION

First, we'd like to know some basics about your organization.

1. What is the name of your organization? _____

2. What is your primary role at your organization?

- a. Administrative
- b. Clinical Staff
- c. Non-Clinical Staff
- d. Executive/Leadership
- e. Researcher
- f. Other, please specify:

3. During a typical year, how many people are regularly employed or volunteer at your organization?

- a. 1-10
- b. 11-25
- c. 26-50
- d. 51-100
- e. 100+

4. Is your organization equipped with high-speed internet in locations where consumers are served?

- a. Yes
- b. No
- c. Not Sure

5. For how many years has your organization been in existence?

- a. 2 years or fewer
- b. 3-10 years
- c. More than 10 years

6. What are the sources of funding for your organization? **Please select all that apply.**

- Federal allocation/mandates
- State allocation/mandates
- Medicare or Medicaid reimbursement
- Private insurance reimbursement
- Federal or State Grants
- Foundation or Philanthropic Grants
- Private donations or fundraising
- Other sources, please specify:

7. Which of the following describe your organization? **Please check all that apply.**

- | | |
|--|--|
| <input type="checkbox"/> Health or healthcare agency
(including hospitals, nursing homes,
home health, etc.) | <input type="checkbox"/> Community Center or Senior Center |
| <input type="checkbox"/> Government agency (local, state, or
national) | <input type="checkbox"/> Advocacy/Policy Organization |
| <input type="checkbox"/> Educational/University setting | <input type="checkbox"/> Grass-roots Organization |
| <input type="checkbox"/> Social Services Organization | <input type="checkbox"/> Non-profit |
| | <input type="checkbox"/> Other, please specify:
_____ |

If you selected "Health or healthcare agency" in question 7, what best describes your organization?

- Hospital or health system
 - Community-based health
 - Home health care
 - Nursing home or assisted living
 - Other
- _____

8. In what state is your organization primarily housed or operating out of?

9. What geographic region does your organization serve? **Please check all that apply.**

- Local/Municipal
- County
- Region within a state
- State-wide
- Multiple States/ Region
- Nation-wide
- International
- Other, please specify:

POPULATIONS YOU SERVE

In the following questions, you will be asked for information regarding the intended populations you serve.

10. Please indicate which of the following are intended recipients of the services that your organization provides. **Please check all that apply:**

- | | |
|--|---|
| <input type="checkbox"/> Those with a physical disability | <input type="checkbox"/> Our services are intended for anyone with a disability |
| <input type="checkbox"/> Those with a developmental disability | <input type="checkbox"/> Our services are not specifically intended for individuals with a disability, but they may be eligible to receive our services |
| <input type="checkbox"/> Those with cognitive impairment (e.g. Alzheimer's Disease) | <input type="checkbox"/> Other, please specify:
_____ |
| <input type="checkbox"/> Those with sensory impairment (e.g. vision impairment, hearing impairment) | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Those with mental and behavioral health needs (e.g. anxiety and depressive disorders) | |

In the following questions, you will be asked specifically about your organization's experience serving individuals with long-term physical disabilities.

By long-term physical disability, we are referring to physical disabilities lasting longer than 5 years (such as multiple sclerosis, spinal cord injury, spina bifida, cerebral palsy, amputation, among others).

11. Does your organization serve individuals with long-term physical disabilities?

- Yes
- No (If no, please skip to Question 31 on page 11)
- Don't know (If don't know, please skip to Question 31 on page 11)

12. Does your organization have a specific focus on serving those with any of the following conditions?

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Spinal cord injury | <input type="checkbox"/> Amputation |
| <input type="checkbox"/> Spina bifida | <input type="checkbox"/> None of the above |

13. Please indicate the extent to which the following represent challenges to your organization’s ability to serve those with a long-term physical disability.

Lack of or insufficient...	Not a challenge	A small challenge	A moderate challenge	A significant challenge
Staffing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amount of physical space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accessibility of the physical space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outreach/ Marketing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information technology resources/ expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Web-presence/ Website functionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training or technical assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partnerships with other service providers/ other organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telehealth capability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-home services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support and/or resources for data collection and evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support and/or resources for data translation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local policy changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State or federal policy changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Are there any other challenges that limit your organization’s ability to serve those with a long-term physical disability?

15. In recent years, there has been a growing interest in what it means to age “successfully.”

How would your organization define “successful aging” for those living with a long-term physical disability?

16. Does your organization partner or have strong relationships, formal or informal, with organizations providing services for seniors or older adults?

a. Yes, please describe:

b. No

17. Please indicate which of the following best describes the ages of those your organization serves.

- We serve individuals of all ages
- We serve specific age groups (check all that apply below):
 - Children (12 years and younger)
 - Adolescents (13-17 years)
 - Young Adults (18-24 years)
 - Adults (25-44 years)
 - Middle-Aged Adults (45-64 years)
 - Seniors/ Older Adults (65+ years)

18. Does your organization have a focus for providing services for any of the following populations?

Please check all that apply:

- Specific disability/condition, please specify:

- Veterans
- Those living in rural areas
- Racial/ethnic Minorities
- N/A – no focus on any specific population
- Women
- Men
- Low-Income
- Immigrants or Non-native English speakers
- LGBTQ+
- Other _____

19. Is there anything else that you would like to share about the population that your organization serves?

SERVICES YOU PROVIDE

In the following questions, you will be asked about services that your organization provides and how you track outcomes and successes/challenges.

20. What metrics, if any, does your organization track related to the services that you provide?

Please check all that apply:

- Number of consumers served
- Consumer demographics
- Consumer satisfaction
- Initial baseline needs assessment/ screening results
- Follow-up/ outcome assessment
- Some other method of evaluation:

- Do not track
- Not sure

21. Does your organization screen clients for any of the following social determinants of health?

Please check all that apply:

- Food insecurity
- Transportation needs
- Utility needs
- Health literacy/illiteracy
- Housing Instability
- Family care, including child and elder care, needs
- Educational/vocational training
- Technology support or accessibility
- Social Isolation/Loneliness
- Financial need
- Mental Health/ Substance use
- Other, please specify:

- No Screening

22. Please indicate which of the following services your agency provides to meet the social determinants of health needs of your clients.

	Does your organization provide this service?				Please specify the program/service name when possible. Otherwise, please leave blank. Name of program/ service:
	Yes, we provide	We provide referrals	No	Don't know	
Legal Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housing Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financial Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation or Mobility Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family Care and Respite Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Health Literacy Assistance (including translation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental and Behavioral Health Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Use Treatment/ Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social Support/ Socialization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

23. Does your organization provide any of the following on behalf of your clients?

	Does your organization provide this service?			Please specify the program/service name when possible. Otherwise, please leave blank. Name of program/ service:
	Yes	No	Don't know	
Advocacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Policy Development/ Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Provider Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

24. Please indicate which of the following services your agency provides to meet the needs of your clients.

	Does your organization provide this service?				Please specify the program/service name when possible. Otherwise, please leave blank. Name of program/ service:
	Yes, we provide	We provide referrals	No	Don't know	
Physical Therapy/Occupational Therapy Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Primary Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Long Term or Skilled Nursing Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Senior Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Life Transitions/ Adaptation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Independent Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication or Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nutrition Planning or Meal Delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

25. Please indicate your organization's level of familiarity with the follow programs:

	Have never heard of this program or resource	Have heard of but haven't used this program or resource	Have used but am not currently using this program or resource	Currently using this program or resource
Enhance Wellness/ Project Enhance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tai Chi Quan: Moving for Better Balance (TJCMBB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Free from Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stay Active and Independent for Life (SAIL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IMPACT OF THE COVID-19 PANDEMIC

We know that these are unprecedented times. In the following questions, you will be asked about how the COVID-19 pandemic has impacted your organization.

26. Please describe how funding for your organization has changed as a result of the COVID-19 Pandemic. **Please check all that apply:**

- Decreased funding amount
- New or more funders than in the past (irrespective of the amount of funding)
- Fewer funders than in the past (irrespective of the amount of funding)
- Increased funding amount
- New or more funding specifically for Covid-19 related response
- No change/funding has stayed about the same

27. Has your organization added any new services as a direct result of the COVID-19 pandemic?

a. Yes

If yes, please describe: _____

b. No

c. Not Sure

28. Has your organization changed or cut any existing services as a direct result of the COVID-19 pandemic?

a. Yes

If yes, please describe: _____

b. No

c. Not Sure

29. What has been the biggest challenge to your organization during the COVID-19 pandemic? Please consider challenges to both the organization itself/staff, and to clients served.

30. What, if any, would you consider to be organizational successes during the COVID-19 pandemic? Please consider successes for both the organization itself/staff, and to clients served.

**ANY ADDITIONAL
COMMENTS?**

31. Please provide any additional comments you'd like to share in the space below:

**TO THANK YOU FOR
YOUR
PARTICIPATION**

Thank you for taking our survey!

To thank you for your participation, we would like to offer you a (\$10 / \$25) Amazon gift card. To receive your gift card, please select "Yes" below. If you would like to decline your gift card, please select "No."

If you select "Yes," you will be redirected to another survey where you will be asked to provide an email address; your electronic gift card will be sent to the email address that you provide. The email address that you provide will be kept confidential, and it will not be connected to your survey responses.

Would you like to receive a (\$10 / \$25) Amazon gift card for your participation?

- a. Yes
- b. No

(If selected that they would like to accept their gift card, they were directed to another survey where they were shown the following question.)

Thank you for taking our survey!

To thank you for your participation, we would like to offer you an Amazon gift card. If you would like to accept the gift card, please provide the email address where you would like the electronic gift card to be sent. The email address that you provide will be kept confidential.

To what email address would you like the electronic gift card to be sent?
