# Oregon Council for Behavioral Health
# Round 3, Sustainability Survey Results

This 3rd OCBH survey was collected during the end of May through the second week of June 2021. This report along with the 2 prior surveys, captures roughly one-year of COVID 19 impacts for OCBH members, as a statewide continuum of Behavioral Healthcare (SUD and MH). The update builds on the original surveys and data from June 2020 and November of 2020. The bulk of the questionnaire was focused on sustainability of access, workforce, and system capacity.

As the longstanding workforce crisis experienced in BH buckles under the added stressors of the pandemic, OCBH added a handful of new workforce related questions to this current iteration of the report. The impacts of Covid and a longstanding under-operationalized system leave our membership in a workforce exodus. Left unaddressed this catastrophe will impact access and population health outcomes for years to come.

It is of importance to note when considering the survey results, our sector was already experiencing a workforce crisis and striving to address longstanding insufficiencies for racially diverse, culturally responsive/specific provider and consumer resources pre-pandemic.

For over 20 years Oregon has continuously ranked in the bottom quarter of states in our SUD and MH access based on a variety of reports, while also ranking in the top quarter for systemic need. If we continue using historically informed and biased system structures, we will not create new outcomes. This would be tragic and unnecessary as BH practice and unprecedented opportunities are at hand to implement a modern system.

OCBH continues to urge leadership in Oregon to heed dire warnings of projected increased need for all Behavioral Healthcare services due to the pandemic and its ancillary impacts for years to come.

Tragically trends of increased overdose, BH acuity and more individuals reporting increased BH needs are manifesting from the pandemic. The statewide system to address them remains fragile and **has lost capacity,** in addition to losses reported in November 2020.

Current capacity of OCBH members has reduced significantly anywhere from 20% to 75% across various agencies and programs. This is stark compared to the averaged loss across the state in our November report of 12%. Covid stress, non-competitive wages/benefits and growing competitive wage market outside of our sector have caused our previous workforce crisis to move into a catastrophic exodus. (See section survey answers for specifics on workforce and reductions in specific types of programing SUD has a higher rate of loss compared to MH).

Workforce is more burdened than ever. Positions remain open without application. Wages are stagnated and operations cost have significantly escalated with the pandemic economy. What is being experienced at the Oregon State Hospital in many regards is reflective across the sector.

*"*OCBH members pre COVID-19 employed over 8,000 essential Oregon Healthcare workers and served tens of thousands of Oregonians on the journey to healthier lives. In the last eight months as a statewide group, we have seen reported 10-30% workforce reduction* through layoff, exodus and program attrition, as programs have been impacted due to COVID related pressures. *(Individual *agency's* percent vary widely)

Members report current applications for positions at all levels, peers to doctors, being posted for weeks to months without being filled.

Turnover so significant that positions are perpetually posted.

Rural providers have had accepted applicants who rescind acceptance due to an inability to achieve housing.*"*

Two specific issues are at hand for the BH sector.

- Urgent crisis, the immediate need to fill open positions to deliver care across the state.
- Longer term modernization over the next decade to modernize our system allowing it to implement current and promising best practice, hire quality staff, increase equitable access and come into parity both in operations, resources and cultural acceptance in all aspects with our physical health peers.

The decisions made to address these issues will have lasting impacts far into our future. We implore leadership and payors to work collaboratively with providers and communities ensuring we create a strategic and effective system of care. Today the threats and opportunities are at historic proportions, it is a unique moment in time to make positive change for equitable Behavioral Health in Oregon.

## COVID-19 impact BH system

The rapid and sudden change in consumer engagement and service delivery due to Covid-19 placed significant financial burdens on a longstanding fragile statewide Behavioral Health (substance use disorder and mental health) system infrastructure. Though the BH system is often thought of by payors as regional, many components of the system are truly statewide. The majority of OCBH members hold contracts with multiple CCO's, commercial insurance plans and government contracts. These multiple funding streams in traditional times, improves revenue diversification for providers and support consumer access to BH care not always locally available.

**The most evident impacts continue at elevated levels one year in:**

- Service delivery has been radically altered in most BH service settings.
- Service access has been radically altered by lack of required staff to operate services.
- Referral pathways have been extremely disrupted.
- Staff stressors and workload have been dramatically increased across the sector.
- Operations costs have dramatically inflated. 10 to 20% on average in the reported 6 months.
- The level of severity of BH symptoms experienced by consumers being referred to services is elevated.

- Lack of access is putting pressure on intake and referral partners increasing pressures across the BH system and other social service partners.
- Program access has been reduced by social distancing, workforce shortages and program total and partial closure due to unviable revenues.
- Workforce retention and recruitment has been severely impacted.

## Future Budget Horizon

The survey gives clear data that without new provider relief, new payment approaches that elevate workforce retention and recruitment and match current delivery needs, the statewide BH system of non-profit and private providers will not be able to financially maintain even the currently reduced service access reported here. All respondents reported being at financial risk in pushing forward increased costs for staff retention and recruitment that was unsupported by projected revenues.

Competitive workforce wages, benefits and supports is the primary driver today in our sector. Without the ability to recruit and retain workforce, access to life saving care will decrease.

Even in strong economic times Oregon's BH system revenue streams, unlike many other forms of health care, run on a flat to negative cost to operations ratio. This has left organizations for years with limited reserves or ability to expand capacity without facing unsurmountable shortfalls. This becomes more pressing in crisis periods. The independent agencies that comprise the Behavioral Healthcare system have limited strength to meet the projected long-term need of this unprecedented emergency or to have the workforce stability to leverage potential opportunities.

As the world prepares for an unknown period of Behavioral Health Care need, our membership would recommend Oregon take time to create a new approach to supporting the operations and workforce of the sector to ensure a robust behavioral healthcare capacity.

## Survey and results

OCBH members were asked to respond to the following questions to ascertain the workforce needs, sustainability and financial resilience of our statewide continuum.

Workforce Impacts (new questions this survey)

- Are you using overtime to keep programs operating, due to staffing shortages? If yes how many hours per week?
- Have you had to increase wages to obtain applications and or retain staff? Can you support the new wage structures with projected revenues?
- What is your turnover rate? How does this compare to pre-covid?
- Ability to Hire impacts, general?
- Average time positions are posted before qualified applications arrive? (Please identify any trends for different positions/profession types.)
- Average time for position to achieve a person is hired? (Please identify any trends for different positions/profession types.)
- Report exit interview data on where employees are going. (No job? new sector? higher paying competitor?)

- Is acuity /violence/ vicarious trauma/ safety/ staff burnout compounding your ability to keep a program open?
- Is acuity, diagnosis of referrals, workforce constraints or other needs of consumers and or workforce causing you to develop new services or change your services? Please describe.
- What tools/strategies do you need or are using to plan for these COVID impacts to support workforce and serve consumers arriving with increased acuity and different needs, please discuss.

Sustainability questions (all three surveys)

- How long could you maintain full operations using your current reserves?
- Have you had to lay off/furlough employees? What percent of your workforce to date?
- When will you need to enact first or next round of layoffs?
- Have you had to reduce access/close programming, why?
    - Such as due to lack of staff, revenues other?
- If so, what percent of your programming?
- Are you facing a full or partial closure (aka shut down of select programs) if billable utilization levels, relief payments, staffing do not change the scenario? Please report compounding issues
- When do you project the above occurring? Timeline and percent of capacity?
- Did you receive PPP?
- How did your PPP loan impact your operations? (postponed layoffs? Kept program open, avoided using reserves etc.….)
- How long did PPP allow you to avoid negative actions of layoff, reductions and or closures?
- What did other one time or limited duration relief funds support? (CCO payment, Medicare, or Medicaid 2 % payment?)

The responses from the membership created a snapshot of supports, activities and threats for our Statewide continuum. OCBH hopes this information supports advocacy and action to approach sustaining the BH sector in a new way, preserving access to critical lifesaving BH services. For ease of understanding we have interpreted through a SWOT lens.

## Survey SWOT

<u>Strengths</u>:

New delivery methods, membership has blended telehealth and audio services with face to face in all setting outpatient and congregate.

Covid protocols; (MH and SUD) facilities have overall done well with COVID safe environments keeping outbreaks to a minimum in these settings with strong protocols onsite.

Willing; the sector is willing and able to take risks to serve consumers and provide essential life-saving services to communities.

Creative; internal operations of provider agencies are creative, and solution focused. Compared to other health, legal and child welfare systems, community based BH services even at fully loaded cost are effective and responsive.

Weaknesses:

- Historical challenges to sustainability and workforce.
- Limited access, and inconsistent access statewide.
- Hope and moral; workforce are **extremely** burdened and strained. The stressors of COVID on employees' home and work synergistic. Employees report stressors of family needs, financial constraints, cost of living and life quality. Employee's report Covid has made them pause and reevaluate their career path, finances and work life balance.
- Under operationalized, there are numerous reports and studies in Oregon and nationwide documenting historical weaknesses of the BH system in access, funding, operational structures and workforce. We will reserve to reiterate here for brevity. For recent Oregon meta-analysis OCBH recommends both the recent CJC report on the BH system and the ADPC recommendations and report.

Opportunities:

- Newly flexible funding opportunities: Rethinking support and revenue vehicles for BH system during a Health Care Crisis that is projected to increase population need for BH services.
- Relief and stimulus funds; Federal funds and a strong economic forecast provide unprecedented opportunity to impact threats and weaknesses in the system. Continue maturation of Tele-Behavioral health. The time is opportune to create flexible payment, operations, and compliance systems that are responsive to both typical and emergency states.
- Equitable, modern, parity driven forces are more conducive today to create a service delivery that are trauma informed, racially and culturally inclusive and integrated as part of a health care lens with no wrong door.

Threats:

An improving economy coupled with a workforce shortage is the predominate threat to our sector. The BH sector and its creation under historical stigma, race and charity care bias has left the sector without capacity to compete for new hires and retain current employees.

*"*A Cascade of threats, new costs and supports of provider relief to sustain access, programs and essential workforce.*"*

The 3 survey results have made evident that five threat areas are present when considering sustainability from the emergency. These impacts are interwoven and apply compounding pressures to the system.

- 1st cascade, Covid-19 social distancing reductions.
- 2nd cascade, financial gaps due to Covid-19 and social distancing.
- 3rd cascade, Provider relief vehicles exhausted.
- 4th cascade, Workforce fatigue, vicarious trauma hazards and exodus from the system.
- 5th cascade, Inability to compete for workforce.

**Top identified financial costs in June 2020 through June 2021**

**Below we will include the previous report and the current report.**

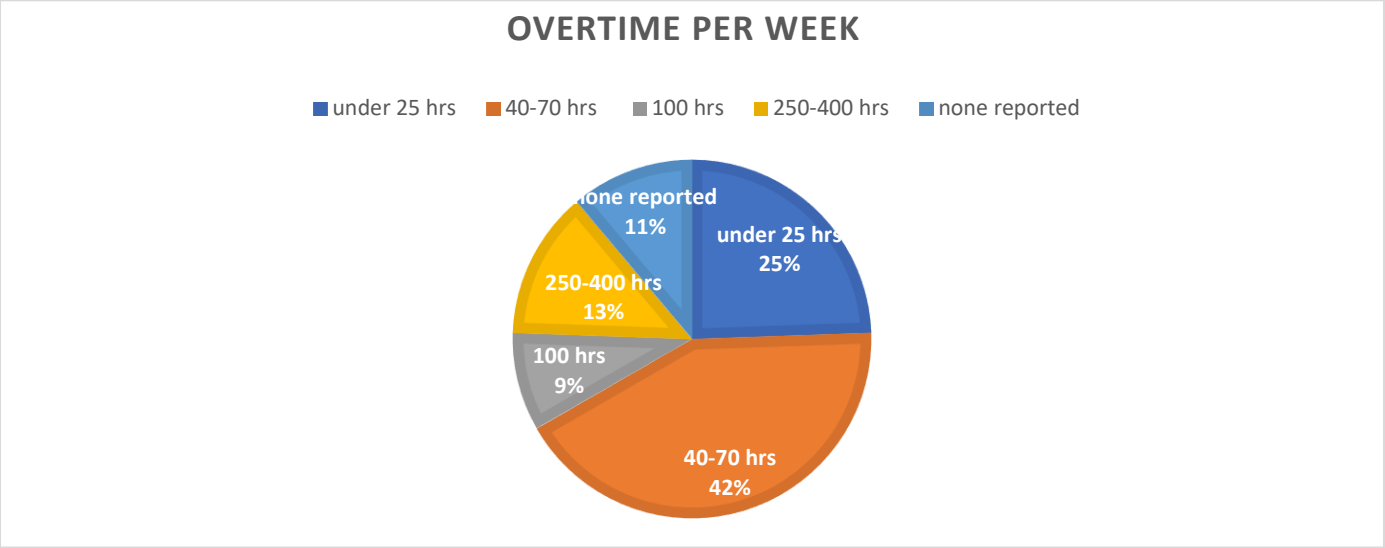
| March to June | June to November | November to June 2021 |
|---|---|---|
| NA | Workforce costs stabilized by provider relief. | Work force recruitment and retention costs |
| Lifting telehealth | Operating 2 service delivery systems with independent costs. Telehealth and face to face services. Increased outreach and engagement costs. | Telehealth and face to face services. Operating 2 service delivery systems with independent costs and staffing needs. Increased outreach and engagement costs. |
| COVID-19 hygiene, PPE, cleaning supplies, etc... | COVID-19 hygiene | COVID-19 hygiene |
| Policy and procedure and other admin costs, audits, compliance etc. | Continues with constant additions and retraining. | Continues with constant additions and retraining. |
| Consultant costs (legal, HR etc. related to COVID regulations) | Continues | Continues |
| Lost revenue due to dramatic shifts in delivery and stay at home safely | Continues, though a slight increase in face to face nominally offset a slight reduction in telehealth for outpatient from earlier in pandemic. Telehealth for most providers has never matched the attendance of previous face to face services. SUD outpatient attendance has been more highly impacted than MH outpatient. SUD residential is on average 30% less incapacity due to social distancing facility needs. MH residential is closer to 1% reduced. | Remains similar to last report period. |
| Employee training and support infrastructures | Continues | Continues |
| NA | Infrastructure costs to run agency in building services and at home workforce. | Infrastructure costs to run agency in person services and at home workforce. |
| NA | Facilities restructuring design and construction costs to support COVID distancing for in person and supported telehealth services | Continues |

## Survey question results,

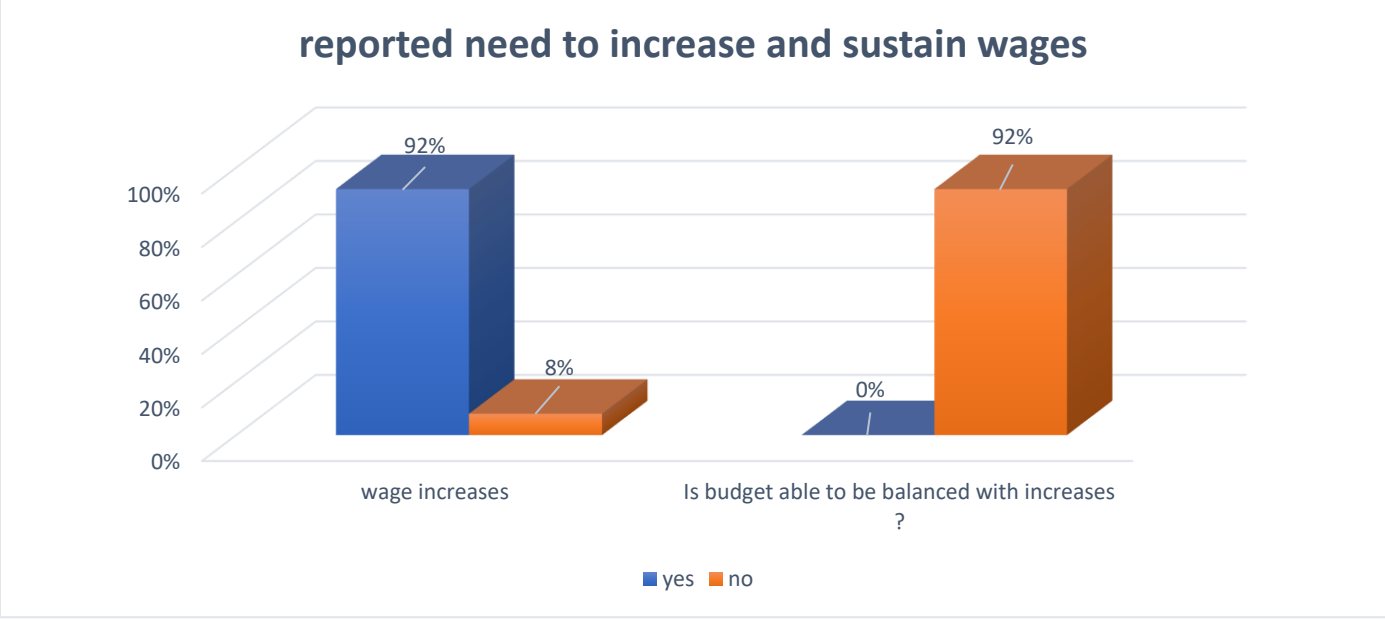
As the largest reported threat to the sector and access is workforce, we will present the new workforce survey results first and provide the comparison over time standing question results next.

**Workforce questions, June 2021**

- **Are you using overtime to keep programs operating, due to staffing shortages? If yes how many hours per week**




- **Have you had to increase wages to obtain applications and/or retain staff? Can you project supporting the new wage structures with a balanced budget in next cycle?**



**Narrative comments on hiring and retention.**

Members reported using a wide variety of strategies to retain and attract BH employees in conjunction with raising wages. In fact, most members have performed a combination of these practices for years and now must also increase wages at an expansive and unprecedented rate due to the current economies threats.

The top practices to recruit included hiring bonuses, relocation costs, imbedding loan forgiveness information and assistance in onboarding, helping locate housing, Increased benefits, training, continuing ed, credentialling and licensing reimbursement. Top practices for retention, raises, bonuses, tuition, training and CEU's, flexible scheduling, snacks if onsite, supervision, EAP, morale specific activities and supports.

Increases reported across all BH professions used to stimulate application range from 5% to 20%.

- **What is your turnover rate? How does this compare to pre-covid?**
    - Turn over rates prior to covid ranged from 1% to 32% across the membership pre-covid.
    - Turn over rates have elevated to 3% to 64% across member agencies in 2021.
    - Over 52% of members report turnover between 35% to 64%
    - About 12% of members report elevation in turn over, standing in the 3% to10% range.
    - About 30% responded no significant increase without a number.
    - 5% did not respond.

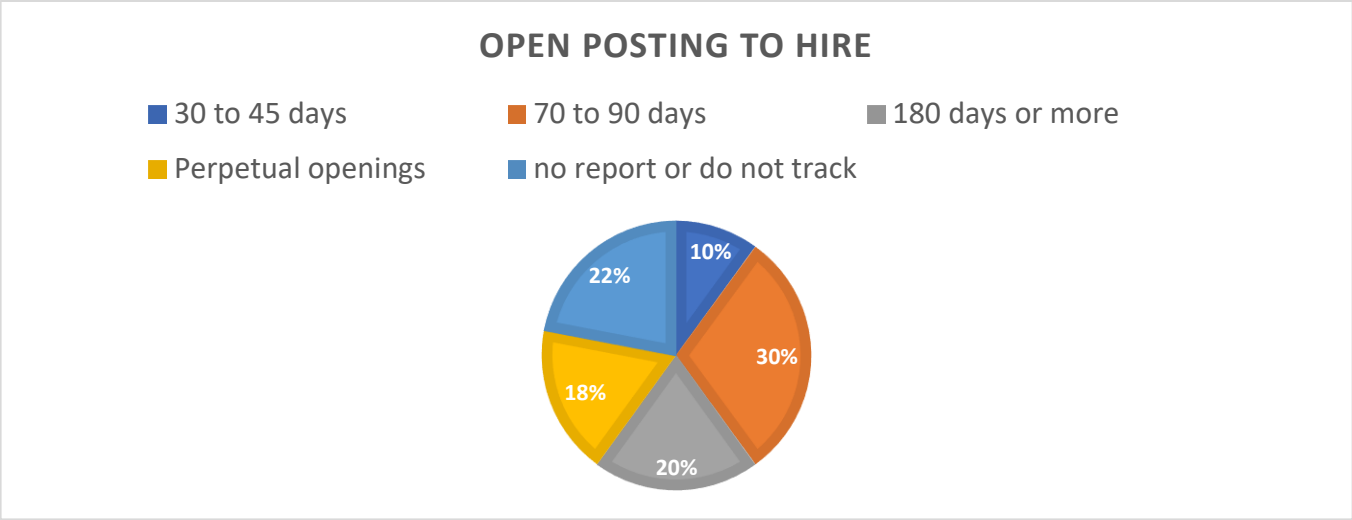
**Ability to Hire impacts, general?**

It was reported by survey participants that all Behavioral Health position types from direct service at congregate settings, administration staff, peers, clinical associates through licensed staff and medical staff such as nurses, physician's assistance and doctoral level staff suffer from ability to hire issues in our sector. The problem is catastrophic, it is persistent and universally prevalent statewide. Some specifics will be reported below.

- **Average time positions are posted before qualified applications arrive?**

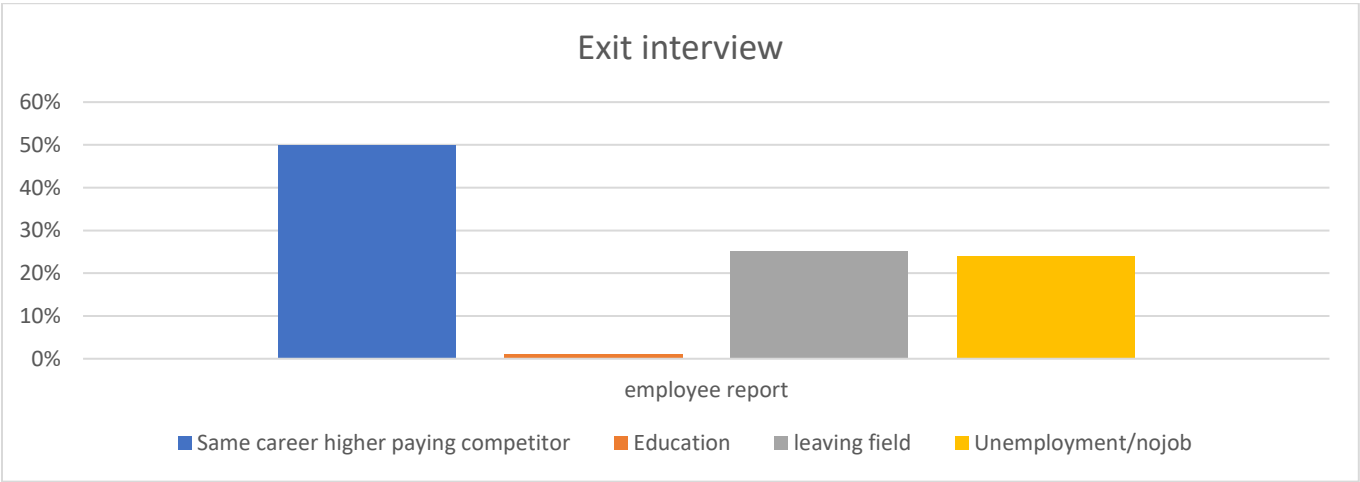
The majority of respondents did not have a reasonable internal capacity generally a lack modern HR platform or equivalent staff that could easily track this specific data. Larger members with economy of scale tend to have more robust HR analytics and could pull but was not representative, as this is a limited number of respondents.

- **And/or average time for position to achieve a person is hired?** (Please identify any trends for different positions/profession types.)




Typically, across members the most difficult positions to hire included Direct Care staff for congregate care settings, CADC, all BH Supervisors, RN's and specialty psychiatry/medical. All reported this categorization was irrelevant as all critical staff were becoming difficult to hire.

- **Report exit interview data on where employees are going. (No job? new sector? higher paying competitor?)**




Within the higher paying competitor, Hospitals, Private Telehealth companies, Government ranked as typically sited. The number of persons reporting no plan or leaving field is of grave concern to the membership. Typical feedback from employees included life review of financial impacts of working in the sector and stress of the field including caseloads, administrative burden burnout, safety, lack of resources at a system level to serve consumers with the right support at the right time.

- **Is population acuity /violence/ vicarious trauma/ safety/ staff burnout compounding your ability to keep a program open?**

51% of members report increased consumer acuity and the lack of resources to serve clients across all sectors is a driving factor in employee burnout.

- **Is population acuity, diagnosis of referrals, workforce constraints or other needs of consumers and or workforce causing you to develop new services or change your services? Please describe.**

50% yes

50% no

As our members provide a wide array of services a percent of which is designed to serve consumers with high needs, this section must be interpreted with some additional context. The majority of respondents who state “no” tended to provide a high rate of programing working with SMI and crisis, detox and other high need stabilizing services.

Within the narrative report it becomes clear that all members are increasing staff training for crisis services, de-escalation training, have increased employee clinical and moral supporting supervision activities, co-occurring training and inter-agencies partnerships to assist in care coordination of complex cases.

New services implemented or being worked most included outreach and early engagement, telehealth, co-occurring, and crisis. Most desired housing with services.

- **What tools/strategies do you need or are using to plan for these COVID impacts to support workforce and serve consumers arriving with increased acuity and different needs, please discuss.**

Members reported a broad array of initiatives that were in planning to full action. These activities focused on streamlining services for consumers, supporting staff with a mix of financial appreciation, kudos, reducing burnout stimulators such as administrative burden, case load pressures and increased training, skills and supervision to support confidence. Agencies are heavily relying on, leveraging and stewarding partnerships and resources.

Two critical themes presented are outside the control of providers and require support from system payors and leaders; Creating Covid safe environments remains a significant pressure and the need for ongoing state guidance and vaccination still exists as does a deep need for payment strategies and administrative burdens overhaul that release the system from structural burdens created under a history of stigma, racism and charity care/poverty bias.

**Top reports.**

**In use and would use more**

- Sign-on bonuses, $1,000 to $5,000. Used widely.
- Relocation assistance resources. Used widely.

- Employee housing and or “voucher” funds. Desired
- COVID Incentive pay. Used widely.
- Staff recognition and appreciation resources. Used widely.
- Organizational crisis planning and strategic planning for chaotic/high change environments. Members report robust resources to no time or skill to perform.
- Co-occurring training, Crisis and other training reimbursement at the whole program level. Used widely.

**Need support payor and leadership support.**

- Payment methodologies and rates that support competitive wages, reasonable caseloads and robust employment packages. Desired.
- State level Covid Guidance for staff and employees. Desired.
- Support to be able to require vaccine for staff, particularly co-occurring or fragile consumer contact. Desired.

**Standard survey question; performed in all 3 surveys.**

Below the results from all three surveys are presented for convenience.

1. **How long could you maintain full operations using just your current reserves (assuming no outside revenue, aid, and current utilization?** (Note June 2021 report is impacted by reduction of overall costs due to shrinking programs and staff costs, not apples an apples comparison to previous reports.)

| June report | November report | June 2021 |
|---|---|---|
| • 42% reported 60 days **or less** of full operational reserves.<br>• 20% reported 90 days of full operational reserves.<br>• 19% reported 180 days (6 months) of full operational reserves.<br>• 19% reported approximately 12 months of full operational reserves | • 68% report less than 3 months of operating reserves<br>• 20% report 4-6 months of operating reserves.<br>• 12% reported approximately 9-12 months of operating reserves | • 50% have less than 3 months of operating reserves.<br>• 35% have between 4- and 6-months operating reserves.<br>• The remaining 15% have between 7- and 12-months operating reserves. |

2. **Have you had to lay off employees?**

| June Report | November Report | June 2021 |
|---|---|---|
| • Yes 35% enacted layoffs in the first two months of the emergency. | • Yes 50% enacted layoffs in the first two months of the emergency. (an increase of 15% since last report in June) | • No significant layoffs reported since last report. Staff exodus has |

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|---|---|---|
| • No 65% no layoff reported. stable | • No 50% no layoff reported. (attrition is occurring) | become the operations burden. |

3. **If so, what percent of your workforce to date?**

| June Report | November Report | June 2021 |
|---|---|---|
| • Half reported less than 2% of workforce.<br>• Half reported a range 10-20% of workforce | • Half reported less than 5% of workforce<br>• Half reported a range 20-35% of workforce | • No change from November |

4. **When will you enact first or next round of layoffs, without a change in payment or relief?**

| June report | November report | June 2021 |
|---|---|---|
| • 20% 30 days<br>• 20% 60 days<br>• 20% 120-180 days<br>• 40% unsure, unable to predict currently. | • 70% highly likely in 45 days (January)<br>• 30% Unsure or did not answer | • No new layoffs since November report.<br>• **Concern** as employees exits cause program closure it will require reassignment or layoff of remaining staff. |

5. **Have you had to reduce access/close programming (**responses could be due to staffing, revenue, covid census issues)?

| June report | November report | June 2021 |
|---|---|---|
| • Yes 67%<br>• No 33% | • All members reported either program downsizing or program specific closure. | • All members report no capacity growth.<br>• 50% of members report new additional capacity reductions since November.<br>• Over 90% of capacity reductions originating cause is related to inability to staff. (No specific staffing type trends independently, this includes DR/nurses through direct care floor staff) |

6. **If so, what percent of your programming?**

Based on member report we have aggregated data by reported trends to improve clarity.

| June report | November report | June 2021 |
|---|---|---|
| As a statewide delivery setting adult outpatient for both SUD and MH are down by 50-60% reduction across the group. Individual responses ranged more widely between 30% and 72%. | As a statewide delivery setting adult outpatient for SUD is down 30 to 60%.<br><br>MH outpatient is down by 20 to 30% reduction across the group.<br><br>Individual agencies responses ranged more widely between 30% and 72%. | No change in SUD outpatient<br><br>Slight reduction in MH outpatient due to in ability to staff issues 25 to 40% loss in capacity.<br><br>Individual agencies responses ranged more widely between 30% and 72%.<br><br>All agencies report increases capacity loss, caused by staffing or referral/census. |
| As a statewide delivery setting Residential SUD settings 20-35% to comply with social distancing | Continued at similar rate | Capacity reduced based on constraints of social distancing and inability to staff. **37% and 75% under pre-covid capacity.** Referral pressures are significant as capacity is reduced. Increased referral of SMI into sector. See possible pressure in MH res sector, or perhaps Covid acuity reason? No clear answer at this time. |
| Youth SUD res and outpatient (Residential beds under 100 operational, not licensed) Disruptions to referral streams appear to have a steep impact and are highly vulnerable today as they were pre-COVID. | Severely impacted without COVID vacancy payments this service area would be in severe jeopardy.<br><br>Outpatient is also struggling as referrals and other youth systems and families are strained. | Youth SUD residential Severely impacted. One full closure of youth SUD residential, without COVID vacancy payments this service area would be gone. Even with vacancy payment between inability to staff and Covid impacts this sector is collapsing. OCBH membership is about 87% of the providers of this service and as a group they have less than 40 beds. |

| | | |
|---|---|---|
| | | Outpatient is also struggling as referrals and other youth systems and families are strained. |
| The remaining 51% responded within 4 to 6 months without relief closures would need to ensue to preserve other programs. Or if a smaller organization would lead to a Board scope of service question. | Various relief buckets sustained programs generally at June report levels. | Rolling, partial and full closures have begun to be experienced across sector. Mix of staffing and solvency in determinations. |
| MH residential reports little to no reduction in capacity, but an increase in referrals and a slight slowing of moving residents to different levels of care. This is not significantly different from pre-COVID-19 longstanding system capacity and access issues. Primary issues for this sector relate to keeping residents safe from COVID-19___0 19, PPE, and the cost burden of safety operations for COVID 19. Also stress to workforce due to COVID-19 and increased pressures of waitlists and system capacity. | Continues | Continues all members providing this service report program operations and capacity being impacted by inability to hire. Long standing lack of access impacting population health and access outcomes as need for services increase across the state. Referrals becoming increasing erratic in appropriateness as system pressures mount. |

**7. What percent of your overall program has been impacted?**

| June report | November report | June 2021 |
|---|---|---|
| • 44% of respondents report 10% or less.<br>• 24% of respondents report 20%<br>• 8% of respondents report 35%<br>• 24% of respondents report N/A | Members responded with detailed narrative that did not lend to gather a commiserate to June response.<br><br>Please see the responses to question 6 where data from both questions was | Members responded with detailed narrative that did not lend to gather a commiserate to June 2020 response. |

| | | |
|---|---|---|
| It appears from data that programs with larger numbers of SUD programing tend to be impacted at a higher percent. This result likely is due to historic factors that weaken the SUD sector and COVID-19 impacts. | combined to paint a clearer picture. | |

8. **Are you facing a full or program specific closures if hiring, billable service levels or relief payments do not change the scenario? Please report compounding issues.**

| June Report | November report | June 2021 |
|---|---|---|
| • Yes 70%<br>• No 20%<br>• Blank 10%<br>Compounding factors narrative: Reportable trending reflects significant sustainability concerns within the SUD sector and child, youth, and family services. The larger part of this questions report was highly individual related to how agencies with a multiple program structure braid resources to sustain operations therefore causing complexities that are less predictable related to sustainability as programs begin to unravel. | These answers do not include any future 2021 state budget reduction calculations<br><br>Yes 45%<br>No 50%<br>Blank 5%<br><br>Note on change between the two reports there was a 15% increase in actionable program reduction, so it appears the response was similar for this question across periods. | Yes 60%<br>No 37%<br>Blank 3%<br><br>Note on change between the two reports there was an increase in actionable program reduction. All programs reporting inability to hire as primary impact. SUD residential reports both hiring and a catastrophic closure if empty bed rate is removed during covid impacts. |

9. **Programs most at risk for closure?**

The results from both June 2020, November and June of 2021 reporting periods are the same for risk but all systems have degraded in sustainability, due to inability to hire and covid census and referral issues.

- Youth SUD residential and outpatient collapsing
- Adult SUD residential high risk
- Adult SUD and MH Outpatient services and associated peer services

**10. Timeline for reduction/closures of high-risk programs due to COVID 19 concerns or related financial sustainability. Answers do not include any state budget cut impacts, based on today's environment.**

| June report | November report | June report |
|---|---|---|
| This was a complicated question for members. As demonstrated by response to the question.<br><br>• 49% of respondents did not respond | Members reported on this number more robustly, factors could have improved response rate include comfort with questionnaire, increased internal tracking, higher level of anxiety of pending threat.<br><br>18% Weekly watch/ December<br>15% January<br>15% March<br>18% July<br>17% Using a target reduction (layoff and attrition) across multiple programs to preserve a broad scope of service. Banking that this strategy will preserve and hold until improved circumstances occur.<br>17% BLANK | Member reports were highly narrative and variable. Respondents independently reported that their ability to predict based on typical strategies of projecting with referral trends, capacity and revenues was inadequate. The operation threat of workforce inability to hire has become the unpredictable driver in program closure and reductions. |

**11. How did your PPP loan impact your operations?**

| June report | November report | June 2021 |
|---|---|---|
| • All eligible members reported (OCBH has some members who due to their size were not eligible, creating a layer of vulnerability for larger programs who provide a significant amount of service to communities)<br>• Supported keeping services and workforce whole during the emergency.<br>• Preserved reserves for future use and pending budget reduction planning<br>• Supported COVID PPE, telehealth lift etc. | Same report outcome<br><br>Uses<br>• Supported keeping services and workforce whole during the emergency.<br>• Preserved reserves for future use and pending budget reduction planning<br>• Supported COVID PPE, telehealth lift etc. | 25 % of members were eligible and received 2nd round PPP increasing ability to retain workforce for an average or one quarter (3 months) before the resource was exhausted. |

**12. How long did/will PPP support sustainability?**

| June report | November report | June 2021 |
|---|---|---|
| These answers where projections as PPP was in early stages.<br><br>35% NA or no answer<br>25% one month<br>15% two months<br>25% four to six months | These answers are post PPP results.<br><br>80% of members received a PPP loan. 80% have expended their PPP Loan in less than 5 months.<br><br>The remainder are attempting to evenly spread use until end date.<br><br>The remaining 20% reported ineligible or left blank. | See above in question 11. |

**13. What did other provider relief funds support or projected to support?**

In the June and November 2020 reports this had extremely variable responses causing an inability to average the member responses in consistent statewide system trending. In the June report the primary consistent report was a significant reduction of provider relief resources from January to date. This has made the few relief vehicles extremely significant to the system as options shrink. The OHA empty bed rate is solely responsible for keeping open a significant proportion of SUD residential programing and is the sole small relief support MH residential system. During the reporting period some CCO's have provided one off support to specific agencies but not in a system impact level capacity.

## Provider Relief

Over the last 14 months, OCBH members have accessed a wide variety of small and time limited provider relief that has supported their ability to stave off significant reductions. These various relief funds have been critical. It is reported by respondents at this time relief funds are predominately extinguished meanwhile the needs of sector remain at a crisis and in some programs closure level. New funds will be needed to address the workforce exodus, costs inflation, and payment methodologies which do not match COVID-19 19 environment delivery needs.

Emergency provider relief fulfilled its purpose while available and as a strategy has been proven to work as a temporary time limited crisis support.

These various funds though not rapidly provided, once received by providers have been rapidly expended.

Not all system providers have been eligible or received similar relief funds.

**Federal relief**

**No current application**: US HHS provider relief slightly less than 2% of Medicaid revenues for a specific time limited time frame were made available to the majority of Medicaid, CHIP BH providers. The majority (over 75 %) of OCBH members have exhausted this relief on covid-19 eligible costs. A nominal percent project to attempt to ration out until the required use date of June 30th, 2021. Another small percent did not receive this funding.

**No current application**: **PPP**

A small percent of providers where not eligible for this funding. The majority of OCBH members received a PPP loan, most expended this resource in 3 to six months preserving staff and reserves during this period.

**No current application**: **State CARES for BH provider relief.**

Less than 50% of members have received these funds. Expending has been pressured as the roll out of the funds was less than ideal in relation to the tight federal timeline required.

**Available and essential to state BH system of care; State waiver supports.**

COVID-19 congregate care vacant bed payment. This relief has been critical to preserve SUD residential level of care programing. This relief fund is a simple effective mechanism to ensure access and avoid permanent loss of programs that are extremely expensive to rebuild/implement.

It has also been critical to provide support to MH residential programs as operations costs drastically increase with increases in food, utility, PPE, and other operations essentials.

**Pending; State one time 10% congregate care increase**

**CCO supports.**

Early release of budgeted CCO incentive funds in the first report period. The impact was highly variable for individual BH organizations, there was no significant reportable impact to statewide BH system from this allowance.

In report survey periods from November 2020 and June 2021, across the state the reported CCO provider relief efforts have been highly variable. If funds were received by a provider, it did help with emergency cash flow and lifting of COVID related service.

In this June 2021 report it appears a small number of CCO's are working with individual providers to support capacity within various programs. This has been **critically helpful in the short term**, but not at system impact level for access nor addressing the primary threat of system payment structures at hand in the workforce exodus and inability to recruit with competitive wages into the future in an extremely workforce competitive market.

**Telehealth payment equity**

Statewide and critical impact as a piece of braided funding. Telehealth alone will not preserve pre-COVID system access. Tele-health is imperative during Covid-19, but overall utilization across the system has continued to hover at roughly 50% of pre-COVID service levels.

## Provider relief fund summary

Continued relief funds are essential to preserve and sustain access for Oregonians in their time of need. Timeliness is imperative as members report the majority of these supports are expended. **The lack of meaningful payment reform completely tethers the ability of the sector to weather the workforce competitive market.**

Over a year into the pandemic the sectors traditional payment/funding mechanisms have not been addressed for our new normal. Thus, the workforce crisis has manifested into the most serious threat to deliver care. Relief funds, one time investment, outcomes and lives are at risk if workforce fails to show interest in the sector's opportunities.

**New federal and state resources and flexibilities to address the pandemic, specifically in unprecedented levels tied to the increased BH need, present a historic opportunity to implement equity and modernization for the sector.**