Effective System Innovations

COVID-19 Pandemic Effects on Services for Children and Young Adults

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Oregon Department of Human Services
Oregon Health Authority

Background and ODHS Response

The unprecedented COVID-19 pandemic had a significant impact on global organizations, state-operated agencies, local jurisdictions, private businesses, and individuals alike. In March of 2020, social services agencies contracting with and/or operating 24/7 facilities, were instantly faced with the overwhelming challenge of maintaining routine operations while ensuring the safety of staff, children, and young adults in their care in the face of the unknown (e.g., the COVID-19 pandemic). State leaders had to think quickly and generate creative solutions to the challenges they faced.

On February 28, 2020, Oregon confirmed its first case of COVID-19. In response to this information, Governor Kate Brown created the Coronavirus Response Team (CRT) that same day.[1] Based on published reports and information gathered from agency managers and provider/program staff, there is substantial evidence that the State of Oregon Governor, Oregon Department of Human Services (ODHS), and Oregon Health Authority (OHA), responded quickly and effectively to meet system and provider/program needs in response to the pandemic. To supplement the various methods of communication (e.g., frequent memos, emails, reports, public-facing dashboards, etc.) committees were formed and ongoing meetings were immediately established (at the state and agency/ODHS levels). Some of the emergency response activities implemented including those listed below:

- Rapidly transitioning to a remote workforce and deploying technology solutions to ensure continuity of agency operations (i.e., ORCAH (Oregon Reporting Child Abuse Hotline).
- Deploying PPE and COVID-19 testing kits to child care providers. In addition, ODHS established mechanisms for lab testing and contact tracing.
- Creating the COVID Response and Recovery Unit (CRRU). The CRRU represents a joint venture between ODHS and OHA and involved regional coordinators throughout the state. Together CRRU members collaborated and coordinated with lead staff, community members, and counties to manage the state's emergency response to ensure continued access to health and mental health related resources. The CRRU's response included, but was not limited to, creating Incident Management Teams to manage the Delta and Omicron COVID-19 surges; coordinating vaccine events for certain high-risk populations; bringing the National Guard to help address program staffing shortages (e.g., direct care staff, nurses, etc.); helping build an Equity Impact Analysis Tool (co-created by the OHA Office of Equity and Inclusion and the ODHS Office of Equity and

[1] "Post-Incident Review and Improvement Plan" - Oregon Health Authority (OHA); Oregon Department of Human Services (ODHS); Healthcare Surge Unified Command (UC), May 23, 2022

Multicultural Services) to highlight those areas in Oregon that are disproportionately impacted by the pandemic and other diseases; providing food boxes to people at community vaccine events; and providing lodging for those in isolation due to COVID.

- Within two weeks of the Governor's stay at home orders (March 2020), a group of leaders in Behavioral Health Services from various health care organizations (e.g., Oregon Health and Science University (OHSU), Providence, Legacy Health, etc.) and representatives from select OHA contracted residential providers, began meeting every two weeks to problem-solve and provide ongoing support to one another with a focus on the acute care mental health crisis.
- Several other work areas within the child-care continuum also organized regular meetings. For example, in March 2020, ODHS Child Welfare and the Oregon Youth Authority supported weekly meetings led by ODHS Children's Care Licensing Program. These meetings were critical to ensuring ongoing communication, guidance, and strategizing with Child Caring Agencies. These meetings were held until October 2020, then moved to a bi-monthly cadence in mid-2021.
- Increased funds to providers including, but not limited to:
    - Funding for increased rates to staff at Psychiatric Residential Treatment Facilities (PRTFs); funds for childcare for residential care workers; facility enhancements; clinical supervision, and funds to address the workforce shortages.[2]
    - ODHS Child Welfare, Oregon Youth Authority (OYA) and OHA Medicaid (supporting Behavior Rehabilitation Service (BRS) programs were provided COVID supplemental funding from April 2020 through June 30,2021. This COVID supplemental funding was resumed in October 2021 and will be supported through the end of the current biennium (June 2023)
    - Behavioral Rehabilitation Services (BRS) providers also received a 10 percent rate increase for the calendar year 2021. This was followed by a 5 percent increase from January 2022-June 30, 2023.
    - ODHS Child Welfare released more than 16 million dollars[3] in relief funds to support hardships caused by the pandemic, including program staffing shortages (money spent to improve staff recruitment and retention).
    - Implementing a 10 percent rate increase that applied to Psychiatric Residential Treatment Facility (PRTF) providers from July 2020 through June 2021, with an extension approved through December 2021.[4]

[2] Memo dated February 2, 2022 from Steve Allen, Behavioral Health Director and Rebecca Jones Gaston (Child Welfare Director)
[3] "2021 Workforce Stabilization Grant FAQ" (email)
[4] Memo dated February 2, 2022 from Steve Allen, Behavioral Health Director and Rebecca Jones Gaston (Childe Welfare Director)
ca Jones Gaston (Child Welfare Director)

    - Some provider agencies also received financial assistance from the federal government through emergency programs such as the Coronavirus Relief Fund (CRF) and the American Rescue Plan (ARP).
- Augmenting staffing resources to include securing nurses through clinical staffing agencies for both congregate care and hospitals settings.
- Child Caring Agencies were extended certain variances to ease the increased pressures and constraints brought about by COVID-19 such as: allowing preliminary hiring through temporary suspension of the fingerprint-based portion connected to background checks and CPR/First Aid certification for new hires when scheduled with a fully certified staff.
- Organization and distribution of thousands of Personal Protective Equipment (PPE) including reusable masks, N-95 masks, gloves and sanitizer to ODHS contracted Child Caring Agencies.
- ODHS Child Welfare established three quarantine sites to allow for staff and nurse facilitated quarantines as medically necessary when another placement option was not available.
- The Governor required a formal analysis of the state's response to the COVID-19 pandemic, beginning with response activities during January 2020 through May 2020. The Governor's "after-action reviews" provide significant insights into Oregon's overall enterprise response; the impact of actions taken; areas for improvement; and potential solutions to address deficiencies.

Recognizing opportunities to learn from the COVID-19 pandemic experience, ODHS leaders commissioned an independent contractor, Sharon Pette (Owner of ESI LLC – Effective System Innovations, LLC), to conduct a qualitative evaluation. The evaluation was a collaboration between ODHS and the consultant, with experienced researchers from the ODHS research division, ORRAI (Office of Reporting, Research Analytics, and Implementation), leading the quantitative analyses and ESI LLC leading the qualitative portion of the study. This report presents the findings for both the qualitative and quantitative components.

It is important to emphasize that the purpose of the study was to more closely examine the impact of the COVID-19 pandemic on the ODHS child-serving system (agency and provider/program levels). This study did not analyze the decisions made by ODHS, OHA, or contracted children's residential providers nor did it seek to determine whether actions taken were aligned with current best practices. Rather, the intention of this study was to shed light on the impact of the COVID-19 health crisis on Oregon's child-serving system – specifically

agency managers; contracted residential programs and staff; and foster families connected to ODHS Child Welfare (CW), ODHS Office of Developmental Disability Services (ODDS); and the Oregon Health Authority Child and Family Behavioral Health (OCFBH). Results, discussion, and system recommendations are presented in subsequent sections of this detailed report.

Due to the narrow scope of the current study, readers are encouraged to consult Oregon COVID- 19 Response : Resources : State of Oregon for additional information regarding the broader State of Oregon's response to the pandemic.

Methodology: Study Description and Project Scope

The study included quantitative and qualitative approaches aimed to gain a complete picture of the impact of the pandemic on agency leaders and operations as well on contracted residential providers, programs, and proctor/foster families. Both components of the study (quantitative and qualitative) focused on three areas (called "divisions" for the purpose of this study): ODHS Child Welfare (CW); ODHS Office of Developmental Disabilities (ODDS); and OHA Child and Family Behavioral Health (OCFBH). Components of the study also focused on two levels: Agency (Level 1) and Provider/Program (Level 2). Any contracted residential program, group home, or BRS program operated or contracted by OHA Child and Family Behavioral Health (OCFBH); ODHS Child Welfare; or ODHS Office of Developmental Disabilities Services (ODDS) to provide services to children, young adults, and their families were considered "in scope." The table below provides more detailed information regarding programs considered in scope and out of scope.

In-Scope	
Description	**Programs**
A children's residential program, group home, or BRS program administered, operated, or contracted by OHA Child and Family Behavioral Health (CFBH); ODHS Child Welfare; or ODHS Office of Developmental Disabilities Services (ODDS) to provide services to children and young adults, and families.	**ODHS CW** • BRS Basic Residential • BRS Intensive Behavioral Services • BRS Proctor Umbrella Home • BRS Proctor Enhanced Services • BRS Shelter Evaluation Assessment • BRS Therapeutic Foster Care Umbrella Home • BRS Short-term stabilization Program

In-Scope	
Description	**Programs**
	• BRS Community Step Down Proctor **ODHS ODDS** • DD Group Home – SPD Paid • Family Shelter Care Non-Related • Care Kith/Kin 0 (kinship care) **OCFBH** • Residential Treatment • Child Placed in Mental Health Facility • Family Foster Care Non-Related
Out-of-Scope	
Description	**Programs**
ODHS Child Welfare certified resource (family foster) Care; Substance Use Disorder (SUD) programs; residential settings whose primary focus is to serve children and young adults with severe mental health issues such as an acute inpatient hospital setting; "Non-BRS Shelter" programs; programs serving juvenile justice children and young adults (Oregon Youth Authority); programs that closed prior to the COVID-19 pandemic; etc.	**ODHS CW** • Resource Care (Family Foster Care) • BRS Independent Living Program (ILP) • BRS Enhanced Structure Independent Living Program • Non-BRS programs (i.e., Transitional Living) **ODHS DDS** • Programs serving adult clients • Community-based programs (non-residential) **OCFBH** • Programs serving adult clients • Acute inpatient programs (i.e., hospital settings) • Substance Use Disorder programs

For the purpose of this study, March 2020 was considered the start of the pandemic since Oregon's first presumptive positive COVID case was announced on February 28, 2020 (Oregon Health Authority: Oregon announces first, presumptive case of novel coronavirus : External Relations Division: State of Oregon). Additionally, while COVID-19 is still considered a pandemic, both vaccination and natural exposure push the virus toward endemic stability.[5] For the purpose of this study, points in time prior to March 1, 2020, were considered "pre-pandemic" while points in time two years later (March 2022) were considered "post-pandemic." This provided researchers specific points in time for analysis, comparisons, and trend interpretation.

[5] https://www.cdc.gov/coronavirus/2019-ncov/science/science-agenda-covid19.html

Quantitative Study Description

The quantitative portion of the study examined several variables at the agency and provider/program levels. Data used for the quantitative analyses were obtained from several statewide databases (e.g., OR-KIDS, Workday, etc.). The entire population was included in the analyses and therefore no sampling was required.

Level 1 quantitative data were gathered from specific ODHS work areas using various ODHS electronic data systems. Specific variables examined for ODHS Child Welfare, ODDS, and OHA Child and Family Behavioral Health (CFBH), included: (a) Vacancy rates by job classification or work area; (b) Overtime costs and hours; (c) COVID leave issued, workers compensation claims, FMLA, etc. (by position/title and select demographics); (d) New foster home certifications and recertifications; (e) Rate of children entering/exiting the system; (f) Length of stay in programs.

Level 2 quantitative information was gathered from contracted providers to determine the impact of the pandemic (pre/post) on these settings using a seven-question electronic survey. Data collected from individual provider agencies included: number of direct care staff; overtime hours; and the providers' perception of the long-standing effects of the pandemic, to name a few. Specific variables examined at the provider/program level (CW, ODDS, and OHA Child and Family Behavioral Health (OCFBH) funded residential and foster programs) included: (a) Vacancy rates by job classification or work area; (b) Overtime hours; (c) Average time to fill vacancies and (d) Average length of stay pre-COVID vs. during pandemic. The full survey can be found in Appendix A Quantitative Survey (Child Care Agency (CCA) Providers.

Qualitative Study Description

The qualitative portion of the study examined several variables at the two defined levels: 1) Agency and 2) Provider/Program levels. The qualitative portion of the study included conducting 47 structured interviews/focus groups (each between one and two hours of length) with randomly selected "department leaders" (level 1) and provider/program leaders and staff (level 2). More details are provided in the table below.

The consultant obtained lists of child-serving residential agencies and programs from the ODHS ORRAI unit. The list included programs from all three divisions - ODHS CW, ODHS DDS, and OCFBH. The number of children and young adults pre-COVID pandemic ("start" of the pandemic defined as March 2020) as well as the number of children and young adults in the system as of November 23, 2021, was used to guide the selection process.

Role	Area/ Division	Number of Focus Groups and Interviews	Total Participants
Agency Level Leaders	ODHS Executive Team Members (HR and ORRAI)	2	3
	CW	17	18
	ODDS	1	2
	OCFBH	3	3
Provider Program Level	CW (BRS Residential and Proctor Parents)	14	38
	ODDS (Group Homes and Foster Parents)	8	17
	OCFBH (Residential Programs)	2	7
	TOTAL	**47**	**88**

Independent samples were pulled for each of the three divisions (CW, ODDS, and OCFBH). Using these lists, 30 percent of all agencies were selected to participate in the qualitative study. Three providers were selected from each of the agencies within the specific program area. Since the intent of the study was to determine the impact of COVID-19 on the ODHS system, it was determined that when selecting the sample for each identified agency, the provider with the highest population pre-COVID would be invited to participate in study interviews. The remaining two programs were selected using a computerized random sampling procedure.

It is important to note that if other providers expressed interest in the study, an interview was scheduled (resulting in a larger sample size then expected, as described below). Additionally, if a particular program area had less than 10 agencies (such as OCFBH that had only three child-serving agencies, however, they were deemed as in-scope for this study) they would be offered an opportunity to participate. To increase the voice of and participation from proctor parents, researchers invited proctor parents from the six agencies selected through the random sample process. This approach was used to ensure a minimum of two proctor parents from the selected agency would participate in the study. To ensure data integrity and to gain a clear picture of the agency provider experience, each focus group was agency-specific (e.g., provider representatives from a single agency attended one focus group).

Level 1: A diverse set of individuals from various work areas were identified by ODHS Executive Leaders to participate in the Agency-Level (Level 1) interviews. A total of 23 agency-level interviews were conducted across the three divisions (ODHS CW, ODHS ODDS, and OCFBH). These agency divisions or work units included:

- ODHS Human Resources
- ODHS ORRAI
- ODHS Executive Team
- CW District Managers
- Child Welfare managers (Permanency; Child Fatality Prevention and Review
- Resource Home and Well Being – Foster Care
- CW Treatment Services
- Strategy and Innovation
- Program Practice
- CW and Self-Sufficiency
- Equity, Training, and CW Workforce Development
- CW Child Safety
- CW DHS Health and Wellness
- Resource Management/Temporary Lodging
- ORCAH Child Abuse Hotline
- ODDS Leadership Team (ODDS Director)

- OHA Child and Family Behavioral Health (OCFBH), Treatment Services (Intensive Treatment Services Specialist)
- OHA Children and Family Behavioral Health (Director of Children and Family Behavioral Health)
- OHA Director of the COVID Response Recovery Unit (CRRU)

Level 2: Using a random sampling process, 30 percent of provider agencies were selected to participate in the study. A total of 24 interviews and focus groups were conducted with ODHS and OHA Child and Family Behavioral Health (OCFBH) contracted residential providers and foster families, which included a total of 62 individuals participating in the Level 2 portion. Programs not selected in the random sample were also provided the opportunity to participate in the study. **The final sample included 64 percent of CW BRS contracted provider agencies (n=14); 67 percent of OCFBH contracted provider agencies (n=2); and 44 percent of DDS contracted provider agencies (n=8).**

Interviews lasted between one and two hours and were conducted in both one-on-one format as well as focus group style. Interview questions were designed to gather information regarding staff experiences during the pandemic; new practice and policy changes; communication with various groups (e.g., ODHS, OHA, Tribes, families, etc.); challenges faced; key takeaways/lessons learned; recommendations for improvement; and remaining needs. Interview questions are provided in "Appendix C: Qualitative Interview - Focus Group Questions" of this report.

A total number of 88 individuals participated in one of 47 interviews or focus groups. Once data collection was completed (agency and provider/program interviews concluded), thematic analyses were conducted and themes were drawn. Detailed results and a summary of common themes across ODHS CW, ODHS ODDS, and OHA Child and Family Behavioral Health (CFBH) are provided in the "Findings/Results" section of this findings report.

Findings/Results

Quantitative

The quantitative analyses found that ODHS Child Welfare operations were moderately to significantly impacted by the COVID-19 pandemic. Some of the key findings are provided below. Graphs associated with some of the data elements can be viewed in Appendix B – Quantitative Graphs.

Screening Referrals - The overall volume of reports of abuse/neglect initially decreased in 2020 then increased in 2021 back to baseline levels. The largest decrease in referrals were from school-related sources. The report volume has been steadily increasing and 2022 H1 (first half of the year) was similar to 2019 H1.

Referral Sub-Types - In 2020 and 2021, there was a slight increase in Threat of Harm allegations and a slight decrease in Neglect and Physical Abuse allegations. This trend has eased in the first half of the year (H1) in 2022.

CPS Investigations - The median days to complete a disposition somewhat declined at the beginning of the COVID-19 Pandemic, allowing for a temporary increase in productivity.

Service Placements - The total number of children with a service placement during a given half-year time frame decreased substantially during the COVID-19 Pandemic. The number of service placement changes (i.e., transfers to a new substitute care placement setting) also decreased. It was not the case that this decrease was countered with an influx of in-home services, as the in-home service population decreased in parallel. The term "in-home services" is defined as a child who is currently placed with their parents in a home setting, and the family (child or parents) is receiving one or more DHS-related services. Although the number of youth/families exiting and entering placements decreased, there were sufficiently fewer entries than exits to result in a net decrease in substitute care population, with the largest contributing factor being a net decrease in Family Foster Care placements. In addition, the placement setting type that experienced the largest proportional decrease were group and congregate settings.

Length of Stay - The decrease in the number of service placement changes coincided with an increase in the length of stay for a child's current placement. During the COVID-19 pandemic, the length of stay within a placement increased at the child-level.

Race/Ethnicity Composition - There was no meaningful change in the Race/Ethnicity composition of the children who entered (first entry) or remained in substitute care in Oregon during the COVID-19 pandemic.

Certifications - The total number of active certified Foster Homes decreased by 992 (16 percent). The number of new certifications decreased at a relatively higher proportion (30 percent) when compared with certifications that ended and did not restart (a decrease of 10 percent). Note that Child Specific certifications denote potential Resource Parents seeking certification to care for an individual child in their familial or social network, whereas General certification denotes Foster Parents seeking certification in order to provide care for children from the general population seeking a foster care setting. Data show that more Child Specific foster care certifications ended compared with the number of Child Specific certifications opened. General certifications had increased closures and fewer new certifications starting. Overall, more General settings experienced an ending certification relative to the other types. There were 32 percent fewer Child Specific certifications Post-COVID-19 versus Pre-COVID-19. BRS Proctor Foster Care also experienced a 44 percent reduction in brand new certifications, while new General certifications remained steady. The largest increase in certification ending reason was in the "No Longer Interested" and "Child(ren) Adopted" categories. The largest decrease was in "Other" and "Foster Child Left Foster Home," which reflects the decrease in placement setting changes.

Foster Parents Satisfaction (Exit Survey) – The Oregon Resource Family Retention/Recruitment Services (ORFRRS) provides exiting foster parents the opportunity to respond to an optional survey based on a 5-item Likert Scale (response range from Strongly Disagree through Strongly Agree). Response rates remained stable before and after the pandemic (25 percent), although the completed survey volume differed (Pre-COVID-19 N=82, Post-COVID-19 N=261). Results show there was an increase in positive agreement from Pre- (survey results available from September 2019 to February 2020) to Post-COVID-19 (survey results available from March 2020 to August 2022), with the largest increases regarding ODHS' communication, timeliness, and support (e.g., accessing respite care, helping problem solve, etc.). Statements regarding case planning had a slightly lower positive agreement.

Vacancies - It was not possible to draw a meaningful comparison between vacancy rates before and after the pandemic because there are too many factors unrelated to the pandemic that impacted vacancy rates during the established study timeframes (e.g., requirement to complete classification reviews, changes in the background check process, and changes in the number of staff available to process applications). The largest increase in vacancies in October 2019 (see Appendix B – Quantitative Graphs, Figure 1) can be explained by the surge of new positions Child Welfare received from the legislature at that time. Child Welfare was still working on filling these positions at the start of the pandemic.

Overtime costs and hours - Total overtime cost[6] decreased by about 10 percent in the two years following March 2020 relative to the two years prior to March 2020 (Appendix B – Quantitative Graphs, Figure 2). Total overtime hours decreased by about 21percent in the two years following March 2020 relative to the total overtime hours in the two years prior to March 2020 (see Appendix B – Quantitative Graphs, Figure 3). Overtime costs and hours varied from district to district, but a decrease in overtime hours after March 2020 was observed in most districts. A decrease in overtime costs was observed in about half of all districts. A consultation with regional district managers provided possible reasons for the decrease in overtime hours during the pandemic. Many of the explanations centered on moving to remote platforms to conduct daily business activities. For example, during the pandemic staff conducted virtual Protective Services assessments; attended court virtually; and conducted parent visits remotely. This temporary shift away from in-person sessions decreased the time needed to transport youth and travel time to physical locations.

[6] Overtime costs and hours include both exempt and non-exempt employees. The following overtime types are included in the count of overtime hours and total cost of overtime:
a. For non-exempt employees: CTA (compensatory leave time accrued at time and one half in lieu of overtime pay for FLSA and non-exempt employees), OT (overtime rate of pay for non-exempt employees for hours worked in excess of 40 hours per work week and/or scheduled hours in the day), and OTM (mandated overtime work-cash, which includes time worked that offsets SL hours in the same period)
b. For exempt employees: STA (straight-time leave accrued for FLSA exempt employees as hour-for-hour for time worked over 40 hours per week/eight hours per day), CTO (mandated compensatory time leave accrued for overtime work, which includes time worked that offsets SL hours in the same period)

COVID leave issued, workers compensation claims, FMLA - Though the overall percentage of time off for the CW workforce and for select positions (e.g., Social Service Specialist 1, Social Service Assistant, Office Specialist 2, and CW supervisors) was similar in 2020 as in other years, there were differences in the type of leave taken after the Families First Coronavirus Response Act was passed on April 1, 2021. This act expanded the reasons that someone could take FMLA/OFLA and offered employees additional paid sick leave that didn't require workers to use their stored banks of time. After taking COVID leave became an option, employees were less likely to take regular sick leave and FMLA, instead of taking COVID leave. Employees were also less likely to take time off for vacation in 2020. Child welfare supervisors had a lower percentage of total time off taken in 2020, especially in quarter 2. This was largely driven by the fact that they took less vacation time in 2020, but they also tended to take less COVID leave than non-supervisors.

Qualitative

Results from the qualitative portion of the study verified that the COVID-19 pandemic had a significant impact on the child-serving system (i.e., ODHS and OCFBH agencies; provider agencies/programs; and on children, young adults, and families). Some of the key themes as it relates to the study's questions regarding policy changes; communication; challenges faced; key takeaways/lessons learned; suggestions for improvement; and remaining needs, are provided below. For the purposes of brevity, only themes that were reported by representatives in each of the three divisions (ODHS CW, ODDS, and OCFBH managers and provider/programs) are provided below. A summary chart of overarching themes can be found in Appendix D – Qualitative Themes of this report.

General Experience and Challenges – Data revealed the most common challenges reported by agency leaders and provider/program staff were/are staffing issues (e.g., recruiting and retaining staff) and the significant decrease in the availability of services provided to children, young adults, and families (resulting in decreased skill development; increased in acting out behaviors; etc.). Both agency managers (level 1) and provider/program staff (level 2) in all three divisions reported these to be among the greatest challenges during the pandemic. **Participants were asked to rate each of the following areas using a three-point scale with a score of 1 defined as "no impact"; a score of 2 defined as "some impact"; and a score of 3 defined as "significant impact."** The common themes about the general experience and challenges faced among all three divisions at each level are provided below.

- **Staffing issues**– i.e., Challenges recruiting and retaining staff; overtimes costs; staff burnout and exhaustion; turnover rates; needed additional staff to do remote schooling; running lower staff to children/young adults ratios because of quarantining (reported by agency managers and providers/programs). When agency and program staff, including resource parents, were asked to rate the impact of the COVID-19 pandemic using a scale of 1 to 3, interviewees responded with an average score of 2.9 regarding the impact of the on Staffing (n=17 unique programs; all three divisions were represented).

- **Impact to services to children and young adults and families** – i.e., Decreased service provision and or less effective methods for service delivery; implemented virtual visits from case workers, mental health providers, medical; limited opportunities for skills practice; family visitation impacted; and home schooling was difficult, etc. (reported by agency managers and provider/programs). When agency and program staff, including resource parents, were asked to rate the impact of the COVID-19 pandemic on Family Engagement using a scale of 1 to 3, individuals responded with an average score of 2.4 regarding the impact to Family Engagement (n=13 unique programs; all three divisions were represented). Using the same scale of 1 to 3, providers also rated the impact of the pandemic on Daily Operations. The average impact score for Daily Operations was 2.8 (n=19 unique programs; all three divisions were represented).

Impact Scaling Category	Average Score (Max Score = 3)
Daily Operations (n=19 provider programs)	2.8
Staff Ratios (n=17 provider programs; all divisions represented)	2.9
Parent/Caregiver Morale (n=8 provider programs; all divisions represented)	2.5
Children and Young Adults' Morale (n=19 provider programs); all divisions represented)	2.7
Staff Morale (n=16 provider programs); all divisions represented)	2.9
Family Engagement (n=13 provider programs); all divisions represented)	2.42
Agency/Program Resources (n=19 provider programs); all divisions represented)	2.7

- **Impact to children and young adults' morale, health, and well-being** – i.e., increased children and young adults' frustration and aggressive behaviors; regression in basic living skills; increased mental health issues; prolonged mental health struggles; children and young adults' feelings of isolation (reported by providers/programs). When agency and program staff, including resource parents, were asked to rate the impact of the COVID-19 pandemic on Children and Young Adults' Morale using a scale of 1 to 3 providers responded with an average score of 2.7 regarding the impact on Children and Young Adults' Morale (n=19 unique programs; all three divisions were represented).

- **Impact on finances/revenue** - Increased financial costs; decreased revenue (resulting from lack of referrals and inadequate number of staff); delayed funding at times. When residential provider agencies and resource parents were asked to rate the impact of the COVID-19 pandemic on their Agency and Program Resources using a scale of 1 to 3 individuals responded with an average score of 2.7 regarding the impact on Agency and Program Resources (n=19 unique programs; all three divisions were represented).

- **Impact on work team members** - Staff morale and/or sense of teamwork negatively impacted – e.g., staff stress; burnout; etc. *(*reported by providers/programs*).* When agencies and resource parents were asked to rate the impact of the COVID-19 pandemic on Staff Morale using a scale of 1 to 3, individuals responded with an average score of 2.9 regarding the impact on Staff Morale (n=16 unique programs; all three divisions were represented). It is important to note that there were several representatives from all three divisions that also reported an increase in teamwork and cohesion among staff members throughout the pandemic.

- **Impact on transition services** - Children and young adults served in residential treatment were not able to participate in transitional visits leading up to successful completion of a treatment stay. Consequently, children and young adults stayed longer in programs (reported by providers/programs).

- **Decreased access to resources** – mental health and medical providers; limited access to respite care; difficulty finding cleaning supplies and COVID tests (reported by providers/programs).

- **Decreased bed capacity and/or program closures due to lack of referrals or not enough staff to staff program** (reported by providers/programs).

- **Challenges with virtual/remote education and adopting a virtual mental health format** – Approximately 68 percent of providers (n=15) who mentioned virtual/remote learning specifically stated that remote learning was difficult and presented numerous challenges -e.g., staff and foster parents serving as a teacher and trying to supervise; needed extra staff to sit with children and young adults; etc. (reported by providers/programs).

- **Community activities halted** and consequently, adopted different recreational activities – e.g., hikes, walks, river, etc. (reported by providers/programs).

- **Additional funding and resources provided** – i.e., ODHS and OHA provided emergency fund dollars to further support children and young adults and families; temporary rate increases for providers; etc. (reported by providers/programs). Some provider agencies also received financial assistance from the federal government (i.e., Coronavirus Relief Fund (CRF); American Rescue Plan (ARP); etc.).

- **Increased communication** from CW, DDS, and OCFBH (reported by providers/programs).

Practices to Retain – Study participants in all three divisions (ODHS CW, ODDS, and OCFBH) reported they will be retaining three main practices post-pandemic.

- **Retain some remote working/hybrid model** (reported by agency managers)

- **Retain the use of technology for trainings, meetings, telehealth for children and young adults, family therapy sessions, etc.** (reported by providers/programs)
- **Retain emergency procedures and sanitation practices** - i.e., individualized boxes with thermometer, gowns, masks, sanitizer etc. in case children and young adults get sick. (reported by providers/programs).

Lessons Learned – There were many lessons learned identified by study participants regarding their experience during the COVID-19 pandemic. However, five main themes emerged (as reported by representatives from all three divisions). These were:

- **Allowed us to shift and prioritize projects** – i.e., explored equity and race more deeply; increased understanding of anti-racist values; drew attention to mental health and suicide prevention (reported by agency managers)
- **Changed the way we view staff** - i.e., learned the value of being more flexible and trying to meet staff needs; need to listen to staff; show greater appreciation for staff; importance of work life balance (reported by providers/programs)
- **Negative impact on children and young adults** – i.e., increased mental health issues; decreased social skills practice; etc. (reported by providers/programs)
- **Improved teamwork, morale, and team cohesion** (reported by providers/programs)
- **Highlighted/exposed deficiencies** - i.e., staffing issues; no advertising/recruitment budget; communication barriers; long-term solutions, etc. (reported by providers/programs)

Remaining Needs – Agency managers and provider/program level staff across all three divisions highlighted two main needs remaining:

- **Funds to address staff recruitment and retention challenges**
- **Additional services, providers, beds, and/or resources for families** - e.g., Psychiatric residential care primarily as well as proctor foster homes, etc. (reported by agency managers and providers/programs).

In addition, a common theme among providers/programs across all three divisions was a need to improve communication and coordination across divisions and with counties and increasing communication needed between programs and case workers.

Discussion and Conclusion

This study illuminated the impact of COVID-19 on child serving agencies and their contracted placement providers in the Oregon Department of Human Services (ODHS) system. Data supports that the State of Oregon, OHA and ODHS responded swiftly and effectively to the unknown and frequently changing health crisis. Despite the rapid response, the impacts of the pandemic on residential and foster programs were significant and far reaching. Some of the most salient impacts are discussed below. It is important to note that the study scope and subsequent evaluation report addresses the impact of the COVID-19 pandemic and does not include the compounding effects felt by the ODHS system as a result of new federal and state regulations enacted during the study period, such as the implementation of Qualified Residential Treatment

Program (QRTP) and other enhanced standards related to Child Caring Agencies. Therefore, it is essential that readers understand that the impacts highlighted in this report, although significant, represent only the baseline of the overall impact to the ODHS system.

Study data provides evidence that the pandemic increased stress on the overall ODHS system, most notably access to care and the number of beds available in the system. Data showed that the pandemic impacted the number of foster home placements available. The study revealed a 16 percent reduction in the number of active certified foster homes and a 30 percent reduction in the number of new certifications issued during the pandemic. In addition, there was a 44 percent reduction in the number of new certifications for Professional Foster Care homes. In addition, study participants reported significant wait times to access outpatient mental health services (e.g., psychiatry, mental health therapy, etc.). While it is expected that ODHS will work to increase their foster care recruitment and retention efforts, these efforts may not be enough to fully close the existing gap that exists in the wake of pandemic, as the workforce challenges remain a driving factor. OHA and ODHS will need to generate innovative strategies to address the foster home resource issue and barriers to accessing outpatient mental health care in a timely manner. This will require leadership and commitment from individuals at the highest levels – i.e., Governor's Office, legislature, etc.) as well as collaboration across state agencies.

There is no doubt that social service programs (i.e., child welfare, juvenile justice, etc.) across the nation are experiencing devastating impacts stemming from staffing shortages. During the pandemic these struggles were elevated with staffing shortages impacting the number of available beds in the OHA, ODDS, and CW system. Study participants were asked a series of questions using a scale of one to three to gauge the degree of impact the pandemic had on a specific area. **A response of 1 corresponded to "no impact;" a response of 2 represented "some impact;" and a 3 corresponded with a response of a "significant impact."** Program providers participating in the study reported an average of 2.9 out of 3 when asked the degree to which the pandemic impacted staffing. Many providers explained that they were not able to operate at full capacity (i.e., unable to fill all client beds) because they lacked enough staff to supervise youth. Quantitative findings verified this fact – demonstrating that group and congregate settings saw a significant decrease in the net population. The inability to staff programs has not only created a backlog of youth awaiting placement in the overall ODHS/OHA system but has also negatively impacted overall revenue for provider agencies since providers are paid based on the number of youth physically in the program. It may be valuable for ODHS and OHA leaders to connect with leaders from other states to generate additional strategies for addressing the staffing shortages.

This study highlighted the impacts from the pandemic, ranging from operational issues (e.g., where to obtain hand sanitizer and masks; how to staff programs in the face of a mounting number of "call outs;" etc.) to increased emotional and behavioral issues exhibited by children and young adults. Study participants rated the impact of the pandemic on youth morale/well-being as 2.7 out of a total possible score of 3. The pandemic not only brought decreased revenue to residential programs (due to a decrease in the net population and significant staffing shortages) but also an increase in program expenses. Residential program participants

consistently reported a dramatic increase in the use of overtime during the pandemic to pay for quarantine coverage, staff members calling in sick, etc. Other examples of expenses include purchasing plexi-glass for the reception desk, upgrading the ventilation system, and purchasing hand sanitizer, etc.

Many program providers stated that if it were not for the emergency funds issued by ODHS and OHA, their programs would have closed. It is important to note that while residential program providers consistently reported a significant increase in the use of overtime during the pandemic, ODHS and OHA agency-level data showed a decrease of about 10 percent in total overtime costs and a 21percent decrease in the total overtime hours in the two years following 2022 when compared with the two years prior to March 2022. ODHS regional district managers provided reasons for this decrease as moving to remote platforms to conduct daily business activities (e.g., virtual court appointments; virtual Protective Services assessments; remote family visits; etc.) which reduced the amount of transportation time needed for in-person sessions.

As mentioned, data show that programs experienced an increase in expenses (i.e., overtime costs) and a decrease in revenue caused by insufficient staffing. It is important to note that although emergency funds from ODHS and OHA allowed programs to stay open during the COVID-19 pandemic, there is growing concern that these programs will not be able to successfully operate once the emergency funds expire. Additional resources are needed to address the significant staffing issues faced by programs and to address the lack of overall beds and services that are needed to effectively serve youth in the Oregon system (i.e., CW and ODDS foster care, ODDS group homes, OHA acute care beds, etc.). These two critical issues must be addressed in order for all Oregon children and young adults to be served based on eligibility and need. The Children's Continuum Rate Study connected to HB 4012 of the 2022 Legislative Session is one of the state's approaches to ensure adequate resourcing is supported. Additionally, related needs are being highlighted in the 2023 Policy Option Packages (POP) proposed by ODHS to the Legislature: POP 118 enhances workforce in the initial child safety assessment response. POP 122 which expands service array for children and young adults with specialized needs in communities where they reside and POP 123 which proposes to raise the reimbursement rate to certified Resource Parents.

In addition to the significant impacts to the overall system, the pandemic also impacted program clients. Individuals of all ages were faced with increased isolation; grief from losing family and staff members; increased mental health symptoms; decrease in the ability to regulate emotions; and a decrease in opportunities to practice social skills. With this knowledge, ODHS and OHA providers must devote the resources necessary to conduct post-pandemic academic and clinical assessments (i.e., mental health symptoms, social and daily living skill level, etc.) of clients in their programs. This will allow providers to gain an accurate picture of client functioning. Revising case plans and treatment plans using these data will ensure goals address the individual's current needs/deficiencies.

Impact of the Pandemic: Comments Regarding Finances and Staffing for Proctor Foster and Residential Providers

"We don't have enough staff so can't run programs at capacity. We had to close some homes as a direct result of staffing."

"In November 2022 we had 11 staff that quit in eight-week period…. had staff who accepted the position and then never showed up…had six or seven of these happen during pandemic. Staffing was tight before the pandemic. We're down staff so we didn't admit youth July 2021 to 2022. We even increased the salary in July 2021 by 6 percent and did this again in July 2022. We are going to do another 6 percent increase in 2023 and we're still not keeping up with inflation or the competition."

"Pre-COVID had 500 homes with 600 staff. Now we're actively serving 300 youth and have 300 staff now."

"Our capacity was 105. At our low point we were down to high 50s or 60 youth."

"Difficult to recruit staff - we spent $30,000 trying to recruit staff."

"We had significantly more overtime. Our staffing needs doubled because youth were home all day, so we needed 15 shifts. Veteran staff pulled us through. They worked overtime…we tried to keep it under 100 hours for overtime, but it wound up being 500 or 700 overtime hours."

"We quickly were overbudget. We had to purchase additional supplies and pay hazard pay if there was a breakout. We still had to fill shifts when someone was out with COVID so paid overtime to fill vacancies."

"Cost of rental facilities was $10,000 to $12,000 just for the nurses when we had to [quarantine] one youth for 10-14 days."

Study data also showed an increase in the length of time children remained in their current placements. Particularly in the early months, the pandemic temporarily paralyzed the court system as they transitioned to remote platforms. During the shut-down period, many hearings, including those related to permanency were halted causing increased length of stay for many foster care youth. Many children also remained "stuck" in their current treatment placements because of new safety protocols – i.e., youth not able to complete their transitional home visits that are required as part of the transition process. The delay in children returning home gave way to additional issues for providers, including managing increased negative youth behaviors.

Although the study found some significant challenges and an adverse impact on system resources (i.e., lack of acute mental health care beds, decrease in number of certified foster homes, etc.), data has also illuminated some unintended positive effects surfacing from the pandemic experience. Based on qualitative interviews and the Foster Parents Satisfaction (Exit Survey) implemented by the Oregon Resource Family Retention/Recruitment Services (ORFRRS), results showed providers reported a large increase in ODHS' communication, timeliness, and support (e.g., accessing respite care, helping problem solve, etc.). Overall, qualitative interviews supported these findings, with the majority of provider agencies stating they felt ODHS responded to their needs during the health crisis (i.e., providing additional funds; providing guidance/support through regular communication; etc.). Other positive impacts identified by study respondents include: Changing the way managers view staff (increased appreciation and value for the work staff do); a recognition of the long-term impact on youth skills and treatment progress; the benefit of using technology (i.e., for trainings, family engagement, mental health appointments, etc.); and highlighting system and agency areas for improvement. All three divisions also reported improved teamwork during much of the pandemic, as team members banded together to address the crisis at hand.

Impact of the Pandemic on Proctor Foster and Residential Providers

"Youth weren't able to practice their skills in the community."

"Couldn't get youth into mental health services and medical services. It took months to get an appointment because there was a lack of providers."

"We need to examine the impact of the pandemic given all of the challenges they [youth] already have. Now they are even further behind in school; people have died in their families; their social skills are less because of the limited peer interactions for two years; etc. What investment is the state going to make for tutors to get them up to speed? They [youth] need to graduate. They don't only need mental health services. When youth come into foster care they are required to have a mental health assessment in first 90 days but we don't do this for education."

"Pandemic has magnified the problem. Our staff are essential workers … .they need to be compensated. We need leaders to raise awareness and appreciation for our essential workers at a national level."

Quantitative data also showed a decrease in the number of the median days to complete a disposition for CPS investigations pre versus post pandemic. Although this is likely due to a decrease in the overall CPS investigation volume, this phenomenon provided a temporary increase in productivity. Additionally, data showed that while the overall percentage of time off for the Child Welfare workforce and for select positions (i.e., Social Service Specialist 1, Social Service Assistant, Office Specialist 2, and CW supervisors) was similar in 2020 as in other years, there were differences in the type of leave taken after the Families First Coronavirus Response

Act was passed on April 1, 2021. After taking COVID leave became an option, employees were less likely to take regular sick leave and FMLA, instead taking COVID leave. Employees were also less likely to take time off for vacation in 2020.

This study has highlighted the impact the pandemic has had on the ODHS/OHA provider system. The most salient impacts have been on access to care (i.e., not enough beds to serve youth needs; delayed placements; etc.) and severe staffing shortages. Program closures and a decrease in the number of foster home certifications caused additional negative impacts to the Oregon system. Addressing these issues is paramount if the ODHS system is going to fully achieve its mission: *"*To help Oregonians in their own communities achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity.*"* Resolving these serious issues will require a significant investment on behalf of the state and much collaboration at all levels (i.e., between providers, across divisions, with stakeholders, etc.). Additional recommendations for future consideration have been put forth in the Future Considerations section of this findings report.

Responding Effectively: Proctor and Residential Partners

"The DHS agency leaders did a great job communicating and supporting us as much as possible."

"During COVID DDS really considered our feedback; feel like we have more say - if you want to help with policy development then can attend and have a voice."

"DHS set up weekly meetings with providers to answer questions and discuss changes. They did this very quickly. Sometimes they didn't have answers which was frustrating, but it wasn't their fault because the rules were always changing."

"DHS managers were very attentive and responsive (licensing folks) to our questions. They tried to find answers for us (program analysts and program coordinator) …they did a great job. They communicated a little bit more, but they are always good about communicating with us. They are always responsive."

"Communication was great with the state. They had weekly calls to provide info and share…. feel there is more sympathy from ODDS about what we do. And increased transparency from the state."

Future Considerations

Based on the quantitative and qualitative study findings, the following items are put forth for consideration by the ODHS Executive Team and system partners. It will be necessary for agency leaders to use a formal process to prioritize based on key factors (e.g., impact on the agency's mission if implemented; level of risk to the agency if not implemented; resources available, etc.) Additionally, once priorities are identified the agency is encouraged to incorporate the projects/initiatives into the existing three to five-year strategic workplan to better ensure priorities are implemented. It is also important that agency leaders review previous evaluation

and "after-action" reports (such as those listed in the references section, among others) that detail specific points for improving overall system response. That said, the takeaways below were created based on data obtained throughout the study (both quantitative and qualitative results). ODHS and system partners are encouraged to consider the following:

1) **Leaders across the System of Care throughout Oregon are encouraged to conduct further analyses to determine the specific populations that the system is currently unable to serve because of access to care issues. It is critical to identify the populations most affected to include those individuals with the highest needs. Proper identification will allow leaders to accurately allocate resources to these areas. Part of the solution also includes state agencies maintaining the commitment to helping programs resolve staffing challenges.**
   The study data provided evidence that the COVID-19 pandemic has greatly stressed the ODHS system in terms of available programming and access to services. Because of negative impacts from the COVID-19 pandemic, ODHS requires additional resources to provide for the number of dependent children and young adults needing services. This is particularly true for specialized client populations such as developmentally disabled young adults and clients who have acute psychiatric symptoms. In particular, residential programs serving youth with acute mental health challenges; Developmental Disability homes (foster and group home settings); proctor and foster care homes/beds; and access to outpatient services (i.e., psychiatry, mental health, etc.) require additional resources to reduce the negative impacts each of these programs has experienced as a result of the COVID-19 pandemic. ODHS and OHA are encouraged to continue to support providers in their efforts to address the workforce and staffing shortages and should engage leaders at the highest levels– i.e., Governor's Office, legislature, etc.) as well as collaborate across state agencies to identify common challenges and effective system-wide solutions. Addressing these issues will help decrease health disparities and the long-term impacts the COVID-19 pandemic has had on the ODHS system and its clients.

2) **ODHS staff and providers/programs must re-assess children and young adults' skill levels in a variety of areas (e.g., treatment, education, social skills, etc.) post pandemic.**
   Respondents consistently reported a significant decline in children and young adults' skills and progress in treatment throughout the two-year pandemic. It is critical that ODHS staff and providers/programs use assessment information to adjust child-related plans e.g., case plans, treatment plans, safety crisis plans, transition plans, etc.). It is expected that children and young adults will need additional supports in the coming months or years to compensate for the lack of in-person services over the course of the pandemic. Since youth and families are core to the ODHS and OCFBH missions, additional resources should be seriously considered among the agency's priorities.

3) **Evaluate the ODHS and partner response to the pandemic and develop a more robust emergency response plan at the State system and agency/provider levels.**

Interviews revealed that ODHS (CW and ODDS) and OCFBH responded swiftly to the health crisis. Most contracted providers/programs reported ODHS responded well to their needs by supplying additional funds to support children, young adults, and families and through frequent communication. That said, interviews also highlighted a need to fine-tune communications and implement a more coordinated response across divisions (CW, ODDS, and OCFBH). This will help prevent "information overload" and confusion resulting from inconsistencies in messaging. In addition, the agency is encouraged to consult national resources on emergency preparedness to ensure all areas are addressed in the system's emergency response plan. Some activities to consider when fine-tuning the system's existing emergency response plan may include, but not be limited to:

a) Creating a short-term workgroup to include ODHS representatives, OHA, Oregon Youth Authority, agency providers, county representatives, and other partners to conduct a deeper dive into the overall system's response to the pandemic. It is important that readers understand that the qualitative analyses showed the vast majority of providers/programs reported the divisions communicated effectively during the pandemic and responded as quickly as possible to their needs. However, a short-term workgroup with a structured facilitator would allow the overall system to solidify roles and emergency response activities.

b) Conducting a detailed review of policies and procedures implemented in response to the health crisis (i.e., system and provider/program levels).

c) Mapping out a clear process for communicating new information that impacts all divisions (e.g., format of communication, how often, who will serve as the lead messenger, etc.). This will limit the number of duplicate emails and prevent providers from becoming overwhelmed by information. This will also better ensure consistency in messaging and prevent confusion as a result of slight differences in directives/guidance.

d) Providing an emergency response template for providers/programs to use when developing their detailed response plans. In addition, ODHS should make the system's overarching emergency response plan readily available to providers/programs.

e) Formally reviewing provider/program emergency response plans to ensure key components and expectations outlined in the ODHS system-wide plan are reflected in these local plans. ODHS may also consider having providers share key elements of their plans and/or creative solutions to pandemic-related challenges in small group discussions. This "cross-pollination" will allow programs to build robust emergency response plans and better prepare staff for future emergency health crises.

f) Providing resources and clearer guidance (including responsibilities and expectations) to county public health entities for developing robust emergency response plans that closely align with the overall system-wide emergency response plan.

g) Examining the process for dispersing emergency funds to providers/programs. It may be of value for ODHS and OHA to identify bottlenecks in the disbursement process. Decreasing the amount of time in which providers/programs receive these monies will ensure that programs have the financial supports necessary to continue operating their programs throughout a state of emergency.

h) Developing a system-wide plan to ensure respite care is available during future health crises. ODHS is encouraged to determine creative solutions to ensure foster and proctor parents can access respite care while minimizing risk of exposure – e.g., developing a cohort approach; pairing respite providers with designated proctor/foster homes; etc.).

i) Ensure the revised emergency response plan supports effective transitions for children and young adults returning home. It is recommended that ODHS and OCFBH determine ways to continue provisional home visits between residential and familial settings during a health crisis and/or provide alternative methods and transition activities. This planning will better ensure all parties are adequately prepared and ultimately, increase the chance of successful reunification.

j) Identifying post-pandemic activities that will foster a smooth return to pre-pandemic base line (e.g., guidance regarding steps to return to "normal" facility operations, programming, etc.)

4) Increase collaboration in advocacy efforts to secure long-term funding for supports and additional resources needed to sustain the ODHS system over time.

It is understood that the pandemic greatly impacted public service agencies and private providers, not only in Oregon but across the nation. Programs reported experiencing staffing shortages and significant cost increases – e.g., purchasing PPE, sanitizer, air filters, safety shields, etc.; rising food and gas prices; and overtime expenses. With the shrinking economy and limited financial resources, ODHS is encouraged to seek out opportunities for collaboration and additional shared resource models. The ODHS/OHA ORRAI team (Office of Reporting, Research, Analytics and Implementation) team is currently a shared resource between OHA and ODHS. ODHS is encouraged to look to this model to determine what allows it to be successful and what considerations they might incorporate into future shared resource models. In addition, ODHS may consider initiating formal Memorandum Of Understandings (MOUs) with partner agencies outlining the roles and responsibilities of involved parties; shared set of values; and actions as it relates to agreed upon priorities. At the time this report was drafted, ODHS and OHA were in the process of finalizing such an MOU.

In addition, ODHS and system leaders are strongly encouraged to increase advocacy efforts at the state and national levels for subsequent funding. The COVID pandemic

impacted ODHS and provider agency budgets as a result of a multitude of factors (i.e., labor market dynamics, state legislation, and other factors mentioned in this report). Additional funds are needed to achieve system stability and ultimately, to more effectively serve clients in the care of ODHS and OCFBH. Executive leaders from various divisions (and/or states throughout the country) may choose to band together to advocate to state legislative bodies and political affiliates for additional funds or rate increases. Armed with accurate data to "tell the story," a cohesive front will likely produce more positive results than providers acting alone in their advocacy efforts. This joint approach may also take the form of Oregon state agencies jointly seeking federal funding packages. ODHS should also continue to explore grant opportunities from the federal and Oregon state governments.

5) **Create additional data points/measures to gather information regarding system health and functioning. This may also include conducting a formal system gap analysis and identifying system/provider needs at regular intervals. This also involves securing sufficient funds to address prioritized system needs.**

Since June 2020, the ODHS has held quarterly target reviews in which key performance measures are reviewed and discussed across programs. In addition, the agency has created and implemented a statewide continuous quality improvement program to track federal performance measures. This routine review allows the agency to identify when business processes are not functioning optimally and/or the agency is falling short of achieving its desired outcomes. This process also provides the foundation for identifying key change initiatives that align with the agency mission and desired outcomes. It may be beneficial to identify additional measures that will provide regular data as it relates to system gaps, needs, and overall functioning (e.g., new programs and services; supports to sustain existing programs; etc.).

ODHS may also consider conducting a formal system gap analysis at regular intervals to help better identify bottlenecks, and other issues. Devoting resources to bridging system gaps having the greatest influence on ODHS and OCFBH successfully achieving the mission statements. Implementing this recommendation may involve periodically surveying providers/programs and/or holding focus groups to determine immediate and longer-term needs. This information can be useful in helping ODHS executive team members prioritize agency initiatives based on the degree of risk to the agency/system if the system gap is not fixed. It can also be valuable information to help inform the agency budget requests during legislative cycles. Additionally, creating a formal list of priorities allows the agency to methodically estimate the resources needed to support those projects that will have the greatest impact on outcomes (i.e., fulfilling the agency mission and decreasing overall risk to the agency).

As part of this COVID-19 Impact Study, interviewees (agency and provider/program levels) were asked to identify their outstanding needs. A list of the most common remaining needs is provided below for Executive Team member consideration.

a) Increase in-home behavioral health services to prevent out of home placements.
b) Additional mental health services for children and young adults (e.g., acute mental health needs; in-home behavioral support services; educational support; etc.)
c) Respite and crisis options to prevent hospitalizations.
d) Classify all direct care staff as "essential workers" to set clear expectations and to allow them to experience the benefits of being classified as such (e.g., accolades and appreciation for their work; hazard pay for working on the front line during a pandemic or emergency situations; etc.)
e) Funds to address the provider workforce shortages.
f) Increase rates and provide quality benefits (e.g., health insurance, Personal Time Off (PTO), etc.) to entice potential employees.
g) Streamline key agency processes related to staff recruitment and retention using lean management tools. Offer support to contracted agencies who are interested in streamlining these processes at the provider/program level.
h) Improve or adopt screening tools to better determine whether staff are qualified for the position.
i) Provide sufficient funding for alternative work schedules.
j) Additional funds for staff health and wellness - Provide additional resources to help create an environment where people want to work. If one doesn't already exist, the ODHS and OCFBH system may consider creating a system-wide staff health and wellness committee as a way of sharing/discussing strategies to effectively address the workforce challenges and promote staff health and wellness.
k) Increase system bed capacity. Specifically, increase the number of respite beds, BRS proctor homes, acute mental health beds, and DDS group homes, to name a few.
l) Increase rates for foster/proctor parents.
m) Increase funds incentives and recreational/therapeutic activities for children and young adults in order to reinforce social skill development.
n) Increase opportunities for coordination and collaboration at the systems level across divisions as well as among providers/programs.
o) Organize a peer-to-peer support group for proctor and foster parents as a forum for these individuals to openly share their fears, frustrations, concerns, and ideas.
p) Provide childcare for proctor families.
q) In a health crisis situation, create pods of social groups that will allow children and young adults to continue social interactions – i.e., pair up families based on social dynamics and allow them to visit outdoors to minimize risk of exposure.

6) Identify key business processes to streamline using lean management tools.

ODHS executive team members and other agency leaders are encouraged to formally evaluate and identify which processes are causing the biggest resource drain and which processes, when underperforming, are causing the greatest threat to agency success. In

addition to producing a cost savings, streamlining critical functions reduces overall risk to the agency (e.g., lawsuits; not meeting the ODHS mission; etc.) and can improve staff morale. The agency may consider the following areas when determining which processes to streamline. Areas identified by providers/programs include:

- Accessing and tracking funds for county children and young adults. Interviewees explained that OHA oversees the Community Care Organizations (CCOs), but every county manages and monitors the Medicaid funds. As such, the county of the children's origin and the receiving county have specific authorizations. When children and young adults move to a different county there are often gaps in services and lapses in insurance coverage.
- Process for allocating funds during a pandemic (i.e., reduce the time to allocate monies to providers/programs). This will allow contracted providers to use the financial assistance needed to immediately address the crisis state.
- Referral process. Interviewees mentioned that at times they are unable to open the referral emails. The question was raised, "Is there an alternative method for receiving this information? Can we have a meeting once a week with providers to discuss referrals?" ODHS should consider remedying any technological challenges preventing providers from accessing referrals and/or identify ways to increase efficiency and effectiveness of the existing referral process.
- Process for working with people with co-occurring disorders. Results from this study illuminated the need to develop a clear process and expectations for working with people with co-occurring disorders. Interviewees stated that existing processes and practices involves ODDS and OHA stating "s/he is yours."
- Develop and/or adopt a standardized response protocol from CDC and public health department for all providers.
- Program reporting requirements. Interviewees explained that some reporting requirements were paused during the pandemic. This has raised the question, "Is there a 'value-add' in reinstating these requirements?"
- Documentation requirements for foster and proctor parents. Study participants (mainly proctor and foster parents) reported they are required to document 10 hours of notes per week. The question was posed, "Can we reduce the documentation requirements and/or allow these notes to be submitted electronically?" ODHS and partners will need to consider this recommendation in the context of formal OHA and Medicaid documentation requirements.
- Streamline state audits. Interviewees suggested that the timing of audits be coordinated at the system level (i.e., licensing audits and contract audits to occur at the same time) to decrease the disruption at the program level.

7) **Identify and pursue opportunities to promote well-being of staff, caregivers, and providers, including additional avenues to provide support and highlighting the good work staff do (at both the systems and provider/program levels).**

Responses demonstrated thematic agreement that the pandemic had a negative impact on staff morale. Generally, research shows that providing acknowledgement and appreciation and making a concerted effort to support a work/life balance are key elements influencing staff morale. Study participants explained that the pandemic pushed provider/program managers to gain a greater appreciation for listening to staff concerns and staff solutions to issues. Managers also expressed the positive impact increased efforts of appreciation and acknowledgment have had on staff morale. Additionally, several managers reported gaining a deeper understanding of the importance of being flexible with (i.e., supporting the work/life balance). ODHS is encouraged to continue to support existing efforts and expand its current strategies for improving team cohesion and bridging the gap between agency managers and direct care staff. These efforts to create an atmosphere of compassion and support will positively influence staff morale and ideally, improve staff retention.

Appendix A: Quantitative Survey (Child Care Agency (CCA) Providers)

COVID Impact Study Survey

This short survey is designed to help the Oregon Department of Human Services gather quantitative data about the impact of the COVID-19 pandemic on Oregon's residential and foster care settings that serve children. Particularly, it's focus is to gain information about the pandemic's effect on staffing levels and overtime hours in your facilities.

The survey is secure and should take about 10 minutes or less to complete. Thank you for the work you do and for taking part in this effort, as we gather the information, we need to help Oregonians and our partners who serve them recover from this worldwide medical emergency.

Demographics: Provider Number and Agency Name

Staffing Levels

2) In those residential programs and foster homes who serve children, please tell us the number of full-time staff positions in the specified categories you had **available** at the specific periods noted.

Answering this question will help us understand the impact of the pandemic on available positions at your facility(s).

	February 2020	**March 2020**	**March 2021**	**March 2022**
Mental Health Professionals				
Proctor Foster Parents				
Social Service Professionals (Defined in BRS Rule 410-170-0020(57))				
Other Classified Staff (Direct care or frontline)				

3) In those residential programs and foster homes who serve children, please tell us the number of full-time staff positions in the specified categories filled **at the specific periods noted.**

Answering this question will help us understand the impact of the pandemic on filled positions at your facility(s).

	February 2020	**March 2020**	**March 2021**	**March 2022**
Mental Health Professionals				
Proctor Foster Parents				
Social Service Professionals (Defined in BRS Rule 410-170-0020(57))				
Other Classified Staff (Direct care or frontline)				

4) In those residential programs and foster homes who serve children, what was the average time to fill staffing vacancies at the specific periods noted?

Answering this question will help us understand the impact of the pandemic on filling vacant positions at your facility(s).

	February 2020	**March 2020**	**March 2021**	**March 2022**
Mental Health Professionals				
Proctor Foster Parents				
Social Service Professionals (Defined in BRS Rule 410-170-0020(57))				

Other Classified Staff (Direct care or frontline)				

Overtime Hours

5) In those residential programs and foster homes who serve children, please tell us the total number of overtime hours logged in the specified categories at the specific periods noted below. (If no overtime was logged, enter "0" - Do not include exempt employees)

Answering this question will help us understand the impact of the pandemic on overtime hours logged at your facility(s).

	February 2020	**March 2020**	**March 2021**	**March 2022**
Mental Health Professionals				
Proctor Foster Parents				
Social Service Professionals (Defined in BRS Rule 410-170-0020(57))				
Other Classified Staff (Direct care or frontline)				

In Closing

6) In general, how confident are you about this facility's ability to recover to "normal" pre-COVID operations within the next year?

( ) Very Confident
( ) Somewhat Confident
( ) Neutral
( ) Not very Confident
( ) Not at all Confident

7) Is there anything else you would like to tell us about the impact of the COVID-19 pandemic on your facility's operations or its impact on your staff and consumers?

Appendix B – Quantitative Graphs

Table 1.

Reporter Type	Pre	Post	Change
Household Family	2282	3076	794
Police / Law Enforcement	7067	7511	445
Medical/Psych Professional	7451	7716	265
Lawyer/ Legal Professional	446	652	206
Perp	7	12	6
Extended Family / Friend	2495	2497	2
Anonymous	1103	1044	-59
Government Worker	7612	7463	-148
Victim	726	458	-268
"Other"*	2981	1074	-1907
Community, School Professional	10490	8519	-1971

Reporter Type	Pre	Post	Change	% Change
Non-Mandatory	9938	8650	-1288	-13%
Mandatory	32721	31374	-1347	-4%

**The "Other" category saw a large decrease starting in 2019*

Table 2.

Reporter Source	Composition (Post-COVID)	% Change	Sexual Abuse	Physical Abuse	Neglect	Threat of Harm	Medical Neglect	Mental Injury
Community, School Professional	21%	-2%	0%	-8%	0%	3%	-2%	-1%
Medical/Psych Professional	19%	2%	-1%	0%	-5%	2%	-5%	-1%
Police / Law Enforcement	19%	1%	-2%	-1%	-4%	4%	0%	-1%
Police / Law Enforcement	19%	3%	-1%	-2%	-7%	-3%	-2%	-1%
Household Family	8%	2%	-3%	-2%	-5%	6%	-3%	-2%
Extended Family / Friend	6%	0%	0%	1%	-7%	7%	-2%	-1%
"Other"	3%	-5%	-3%	-2%	-1%	4%	-2%	-1%
Anonymous	3%	-1%	0%	1%	-8%	8%	-2%	-2%
Lawyer/ Legal Professional	2%	1%	3%	0%	7%	-13%	-1%	-2%
Victim	1%	-1%	-6%	0%	2%	4%	-2%	0%

Mandatory Reporter	Composition (Post-COVID)	% Change	Sexual Abuse	Physical Abuse	Neglect	Threat of Harm	Medical Neglect	Mental Injury
TRUE	78%	5%	-1%	-4%	-4%	2%	-2%	-1%
FALSE	22%	-5%	-2%	-1%	-3%	6%	-2%	-1%

Table 3.

Placement Setting	Brand New Entrants Per Day Pre	Post	Change
Regular Family Foster Care-non relative	4.23	2.80	-1.44
Relative Family Foster Care	2.49	1.84	-0.65
Hospitalization	0.53	0.42	-0.10
Residential Treatment - Facility	0.27	0.17	-0.10
Group Home	0.13	0.08	-0.05
Independent Living	0.09	0.02	-0.07
Left Placement without Permission	0.05	0.02	-0.02
Incarceration	0.05	0.04	-0.01
Residential Treatment - Home	0.03	0.02	0.00

Table 4.

Children in Substitute Care or In-Home Settings

Setting Type	*Typical Half-Year Counts* Pre-COVID-19	Post-COVID-19	Change	% Change
Family Foster Care (Non-Relative)	4562	3374	-1189	-26%
Family Foster Care (Relative)	3758	2880	-878	-23%
In-Home Setting	4609	3769	-841	-18%
Trial Reunification Setting	1894	1450	-445	-23%
Residential Treatment Facility	546	396	-149	-27%
Pre-Adoptive Setting	955	835	-120	-13%
Independent Living Setting	365	282	-83	-23%
Group / Congregate Setting	220	147	-73	-33%
Residential Treatment Home	233	170	-62	-27%
Hospital Setting	245	207	-38	-16%
Incarceration Setting	130	93	-37	-28%
Setting Characterized as Missing/Runaway	260	250	-11	-4%

Table 5.

Children in Substitute Care or In-Home Settings

Setting Type	*Typical Half-Year Counts* Pre-COVID-19	Post-COVID-19	Change	% Change
Group / Congregate Setting	220	147	-73	-33%

Incarceration Setting	130	93	-37	-28%
Residential Treatment Facility	546	396	-149	-27%
Residential Treatment Home	233	170	-62	-27%
Family Foster Care (Non-Relative)	4562	3374	-1189	-26%
Trial Reunification Setting	1894	1450	-445	-23%
Family Foster Care (Relative)	3758	2880	-878	-23%
Independent Living Setting	365	282	-83	-23%
In-Home Setting	4609	3769	-841	-18%
Hospital Setting	245	207	-38	-16%
Pre-Adoptive Setting	955	835	-120	-13%
Setting Characterized as Missing/Runaway	260	250	-11	-4%

**Note these numbers are rounded to the nearest integer*

Table 6.

Certified Foster Homes (Resource Homes)

	Typical Half-Year Counts			
	Pre-COVID-19	**Post-COVID-19**	**Change**	**% Change**
Counts During Period				
Active	6304	5312	-992	-16%
Ending	3010	2600	-409	-14%
Never Restarted	*1174*	*1058*	*-116*	*-10%*
Starting	3036	2500	-536	-18%
Brand New	*1100*	*772*	*-328*	*-30%*
Ending - Never Restarted				
Child Specific	915	790	-126	-14%
General	201	214	13	6%
Professional FC	57	54	-3	-5%
Due to Closure	788	675	-113	-14%
Due to Expiration	382	381	-1	0%
Starting - Brand New				
Child Specific	951	645	-306	-32%
General	103	101	-2	-1%
Professional FC	47	26	-20	-44%

Table 7.

Reasons Given for Certifications Closed and Never Restarted

Reason Given	*Typical Half-Year Counts*			
	Pre-COVID-19	Post-COVID-19	Change	% Change
No Longer Interested	102.0	134.0	32.0	31%
Child(ren) adopted	137.8	154.8	17.0	12%
Move from Area	17.0	19.6	2.6	15%
Uncooperative with Child's Case Plan	2.3	2.4	0.1	3%
Duplicate Provider Clean-up	1.2	1.2	0.0	3%
Capacity, Gender or Age Range Change	1.0	1.0	0.0	0%
Activate additional service types	1.0	1.0	0.0	0%
Foster parent request	1.0	1.0	0.0	0%
Child abuse neglect assessment	1.0	1.0	0.0	0%
Compliance Issue	1.0	1.0	0.0	0%
Adoption in progress	1.0	1.0	0.0	0%
Administrative decision	1.0	1.0	0.0	0%
Went to Another Agency	1.8	1.8	0.0	-2%
Training requirements not satisfied	2.0	1.8	-0.2	-10%
Personal requirements not satisfied	1.7	1.2	-0.5	-28%
Child abuse/neglect substantiated	3.0	1.6	-1.4	-47%
Personal requirements not satisfied	3.5	2.0	-1.5	-43%
Child abuse neglect committee recom.	7.0	4.2	-2.8	-40%
No Reason Given	394.7	391.8	-2.9	-1%
Home does not meet standards	8.5	3.4	-5.1	-60%
Other, document on provider note	222.8	163.0	-59.8	-27%
Foster child left foster home	350.8	245.4	-105.4	-30%

Table 8.

Foster Parent Exit Survey

Statement	Category	% Agreed (Pre)	% Agreed (Post)	Difference in % Agreed (Post - Pre)
DHS staff were timely in handling my paperwork :	Timely/Communication	40%	56%	16%
DHS was helpful and assisted me in accessing child care and respite services :	Support/Information	22%	38%	16%
DHS staff were timely in responding to my phone calls, texts or e-mails:	Timely/Communication	44%	59%	15%
Overall, I was satisfied with DHS' services:	Overall	40%	52%	12%
My communication with DHS was positive:	Timely/Communication	47%	59%	12%
DHS staff provided me with the information I needed about children needing placement:	Support/Information	43%	53%	11%
DHS provided the support I needed when I was dealing with difficult problems:	Support/Information	35%	45%	10%
I felt respected by DHS staff:	Respected/Valued	57%	66%	9%
I felt valued and appreciated by DHS staff:	Respected/Valued	56%	63%	7%
DHS staff were helpful when I had questions:	Support/Information	57%	63%	6%
DHS staff were courteous and professional in their interactions with me:	Respected/Valued	66%	71%	5%
I felt like DHS staff considered me part of the team caring for children:	Respected/Valued	54%	56%	2%
DHS staff supported my participation in case planning:	Case Planning	45%	42%	-3%
DHS staff encouraged my participation in case planning:	Case Planning	49%	44%	-5%

Table 9.

	Primary Race / Ethnicity						
COVID-19	**White**	**Hispanic (any race)**	**Black or African American**	**American Indian or Alaskan Native**	**Unknown /Declined / Unable to Det.**	**Native Hawaiian / Other Pacific Islander**	**Asian**
All Placement Changes							
Pre	66.1%	17.4%	6.8%	6.0%	2.2%	0.9%	0.6%
Post	64.0%	17.1%	7.6%	6.3%	3.7%	0.8%	0.5%
Change	-2.1%	-0.3%	0.9%	0.2%	1.5%	-0.1%	-0.1%
First Entry to Substitute Care							
Pre	64.6%	18.2%	5.8%	5.0%	4.6%	1.1%	0.8%
Post	60.4%	16.9%	6.3%	6.5%	8.7%	0.9%	0.4%
Change	-4.2%	-1.3%	0.5%	1.5%	4.1%	-0.2%	-0.3%

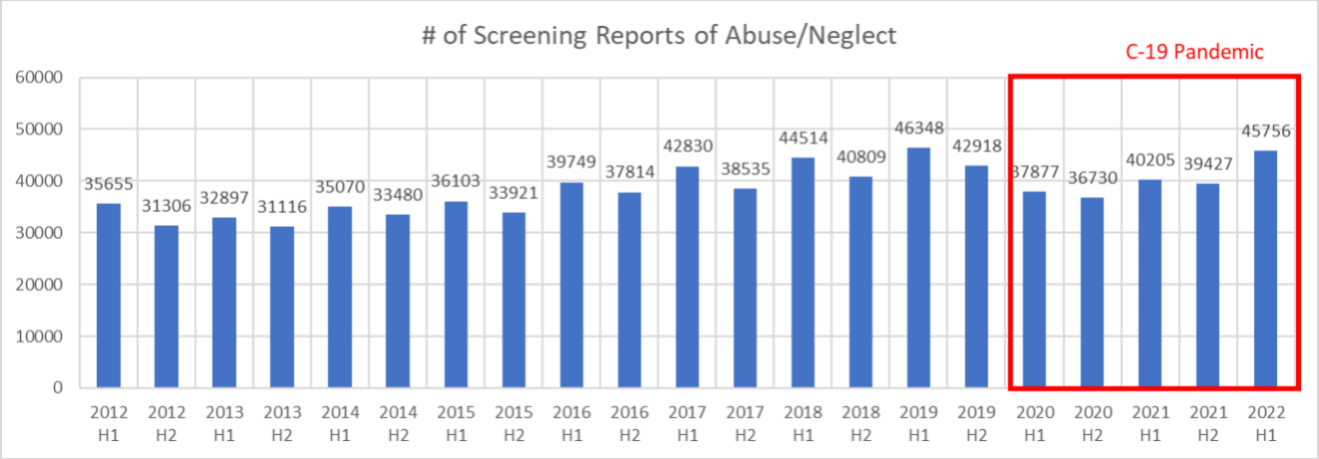
Table 10.

		Primary Race / Ethnicity						
COVID-19	**Placement Setting**	**White**	**Hispanic (any race)**	**Black or African American**	**American Indian or Alaskan Native**	**Unk/ Declined/ Unable to Det.**	**Native Hawaiian/ Other Pacific Islander**	**Asian**
Pre	Group Home	48%	12%	17%	22%	0%	1%	0%
Pre	Hospitalization	65%	15%	7%	8%	4%	0%	1%
Pre	Incarceration	63%	19%	9%	6%	1%	1%	1%
Pre	Independent Living	63%	17%	11%	6%	1%	1%	1%
Pre	Left Placement without Permission	62%	15%	11%	9%	1%	1%	0%
Pre	Pre-Adoptive Home	75%	16%	5%	3%	1%	0%	0%
Pre	Regular Family Foster Care-non relative	65%	18%	6%	6%	3%	1%	1%
Pre	Relative Family Foster Care	67%	19%	5%	5%	2%	1%	1%
Pre	Residential Treatment - Facility	64%	16%	11%	7%	1%	1%	0%
Pre	Residential Treatment - Home	61%	20%	13%	5%	1%	0%	0%
Pre	Trial Reunification	68%	17%	4%	5%	3%	1%	1%
Change	Group Home	-1%	1%	0%	-2%	1%	-1%	0%
Change	Hospitalization	-1%	-1%	1%	-1%	2%	0%	0%
Change	Incarceration	8%	-6%	-3%	0%	0%	0%	0%
Change	Independent Living	3%	2%	-3%	-2%	0%	0%	0%
Change	Left Placement without Permission	2%	-1%	1%	-2%	0%	-1%	0%
Change	Pre-Adoptive Home							

Change	Home	-4%	4%	0%	0%	0%	0%	0%
Change	Regular Family Foster Care-non relative	-2%	-1%	1%	0%	2%	0%	0%

Change	Relative Family Foster Care	-4%	0%	1%	1%	1%	0%	0%
Change	Residential Treatment - Facility	-2%	1%	1%	0%	1%	-1%	0%
Change	Residential Treatment - Home	4%	-2%	-5%	1%	1%	0%	1%
Change	Trial Reunification	-3%	0%	2%	1%	1%	0%	-1%

Figure 1.



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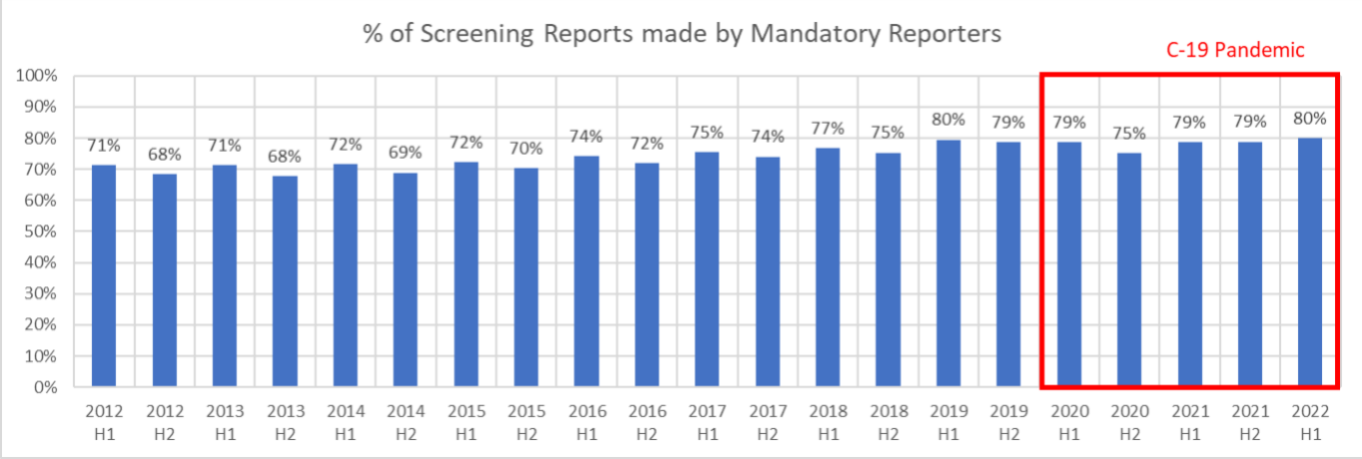

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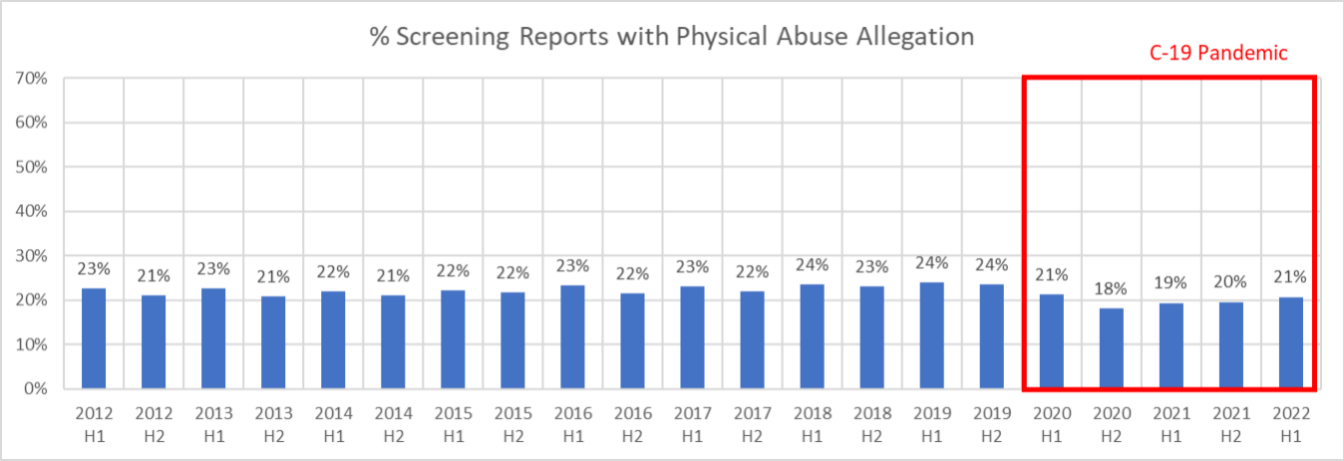

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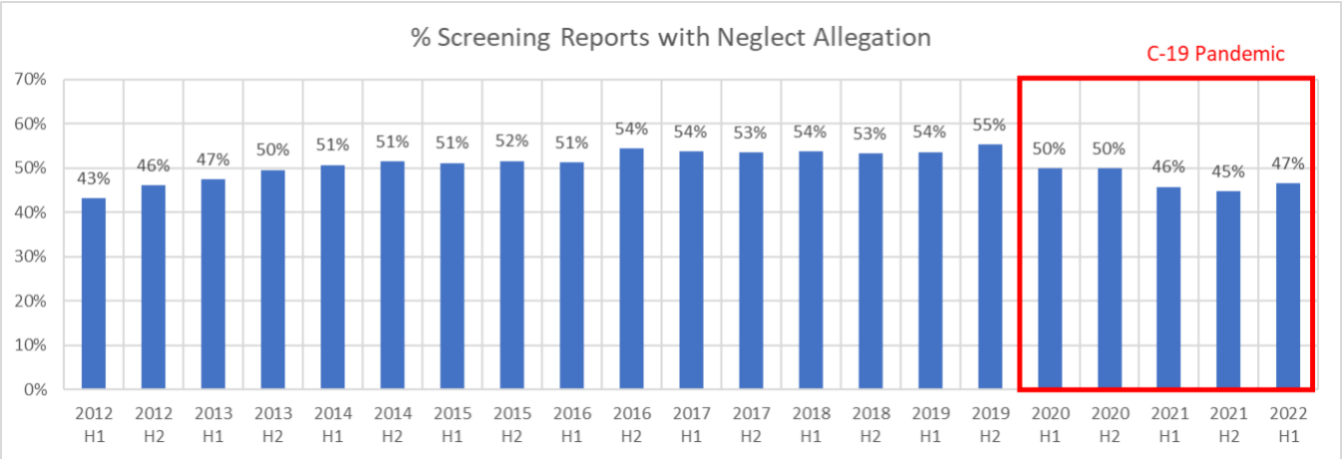

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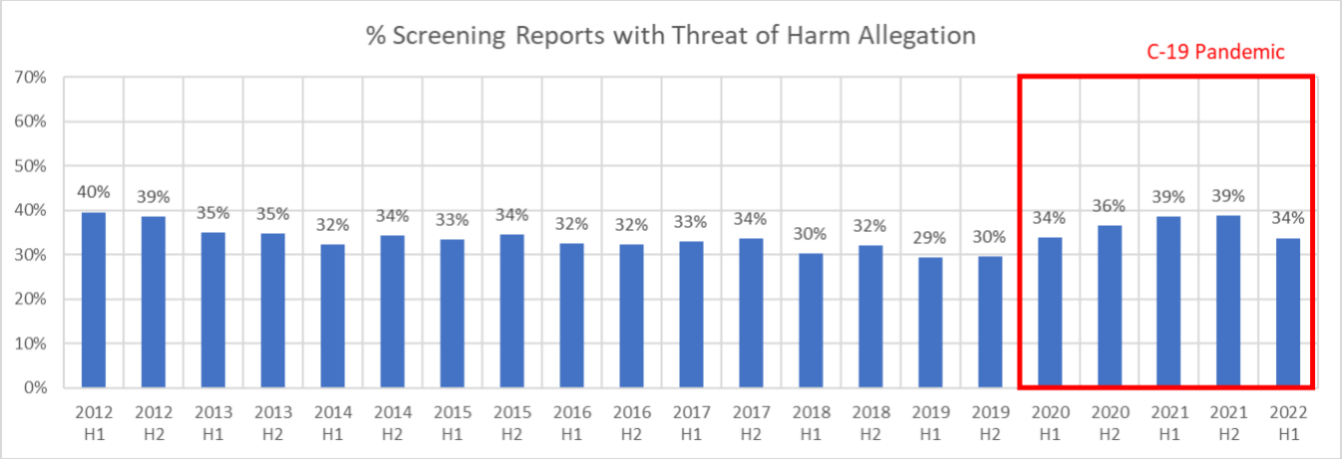

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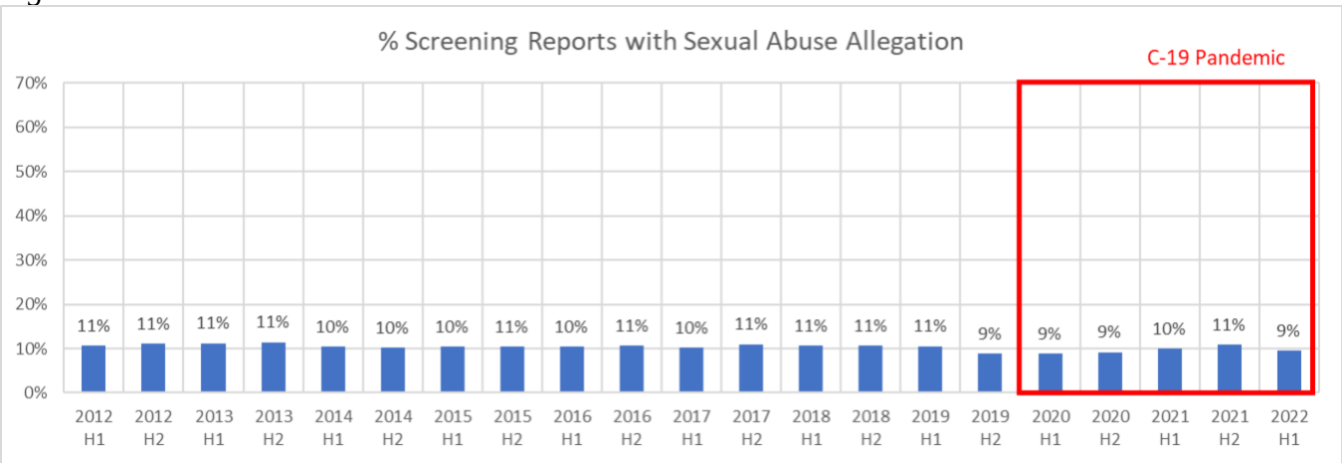

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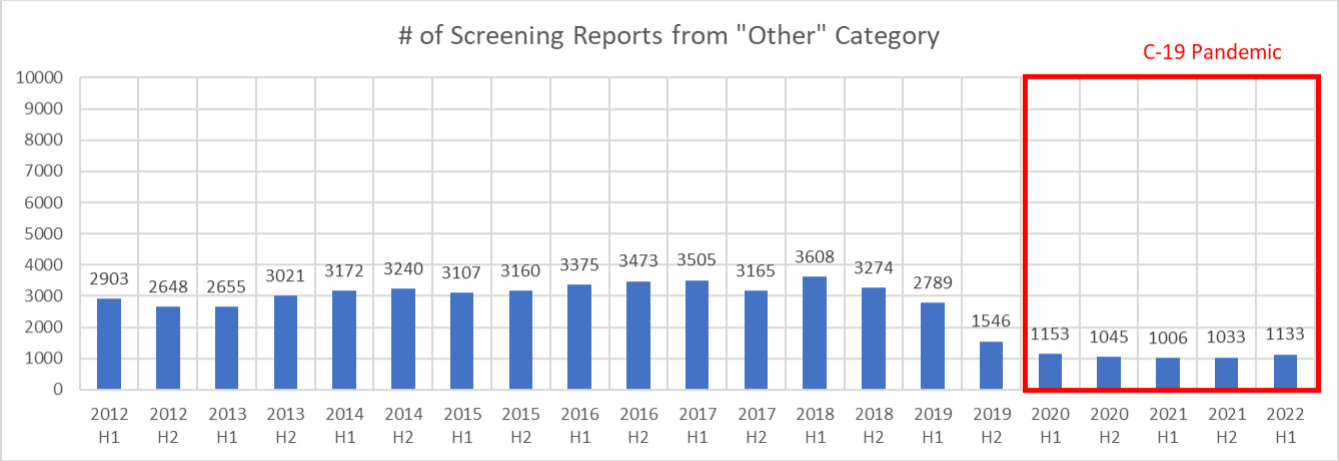

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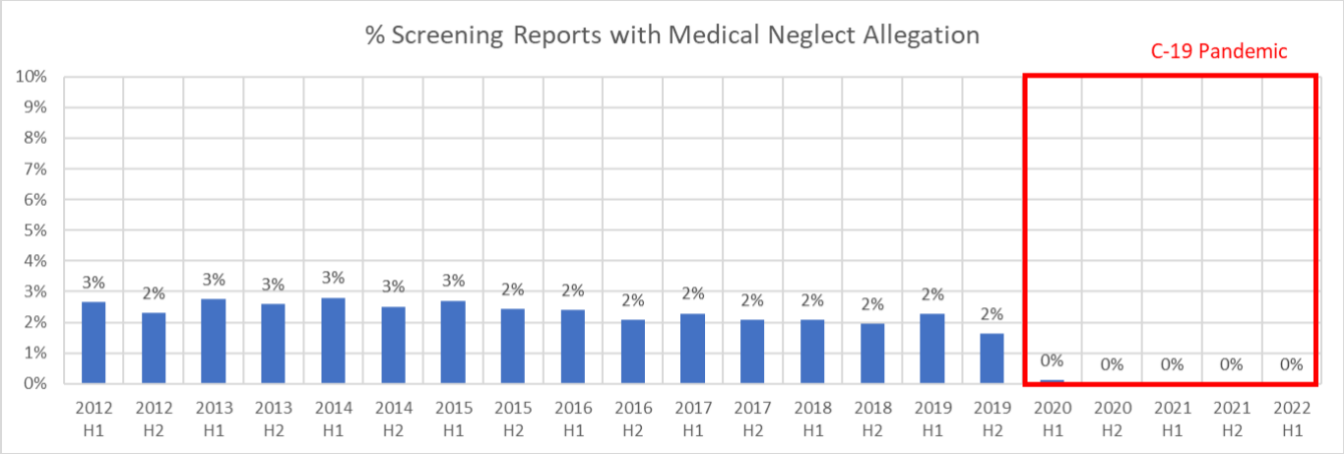

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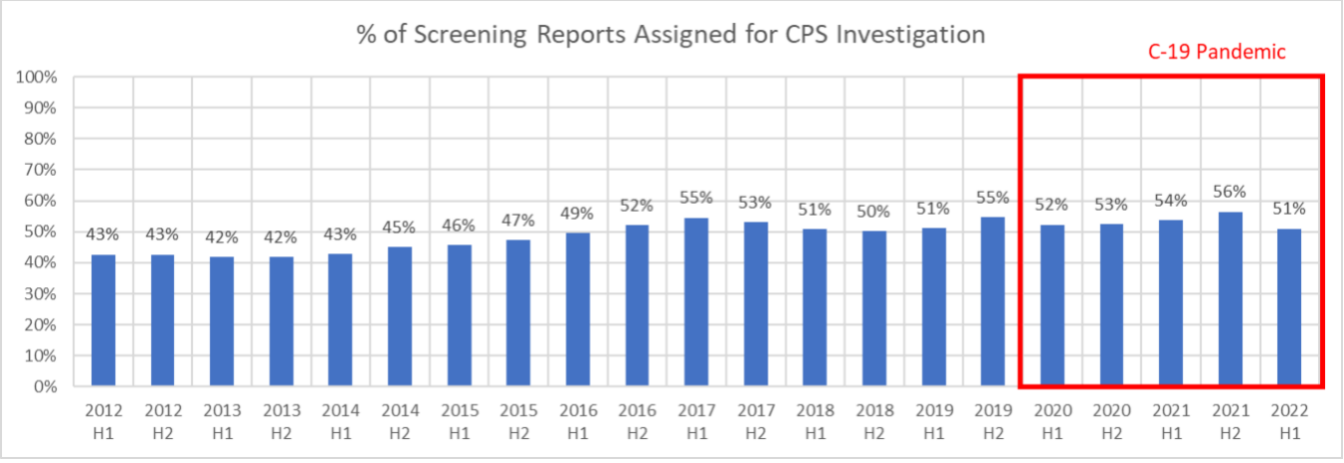

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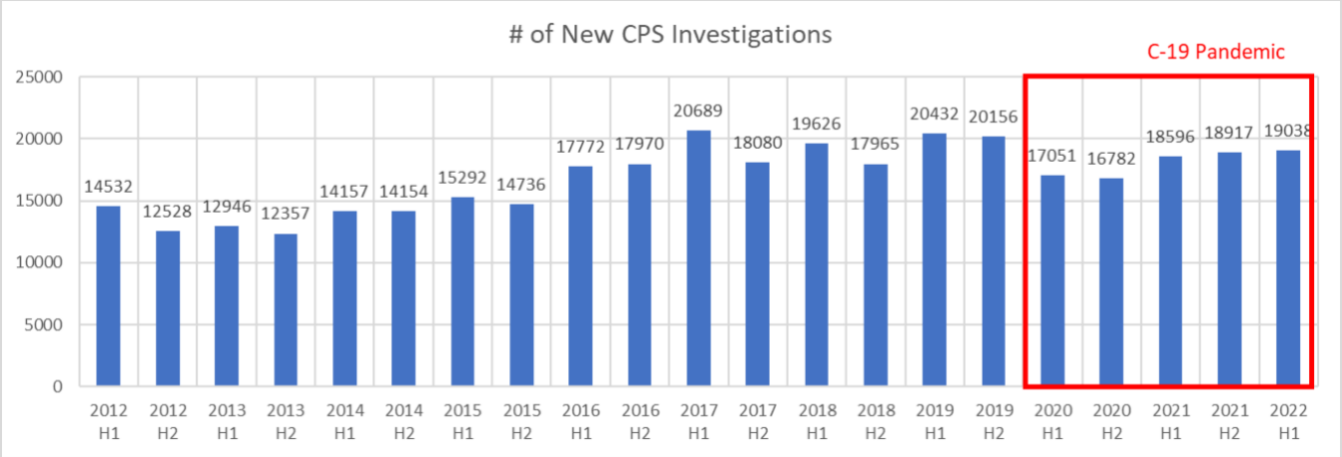

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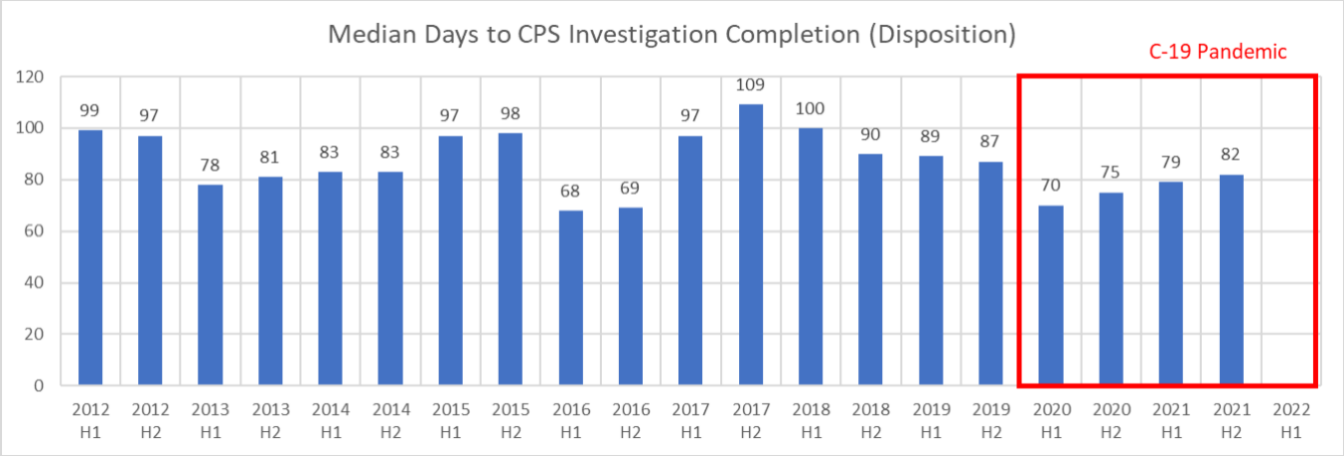

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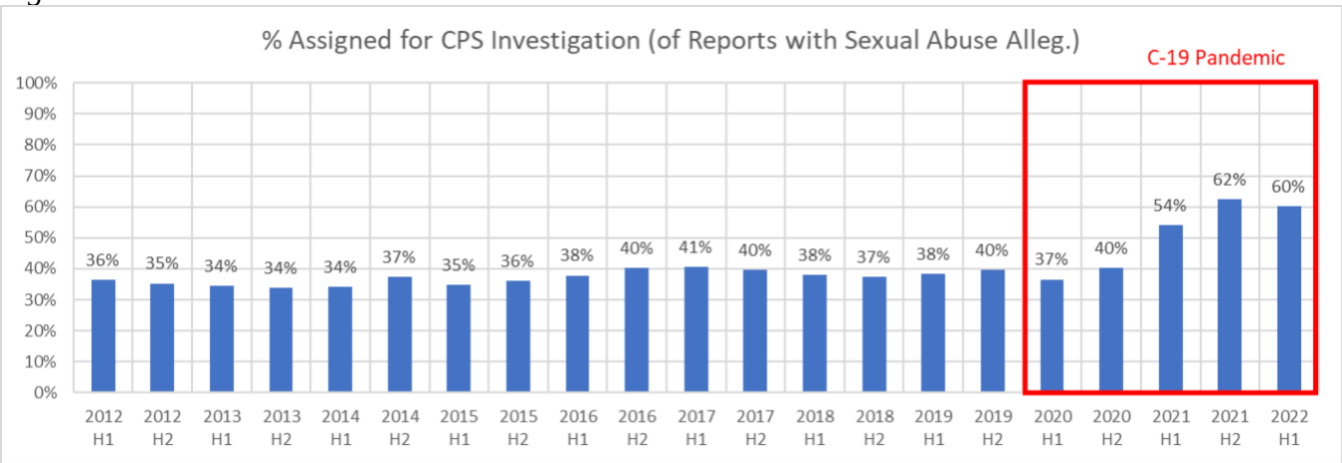

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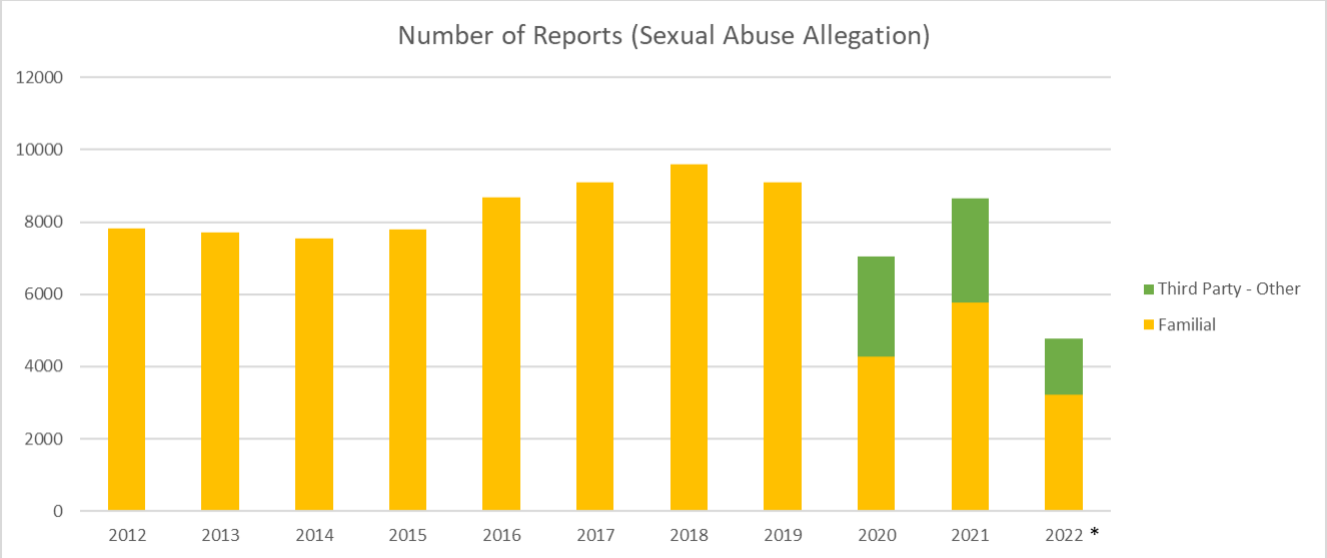

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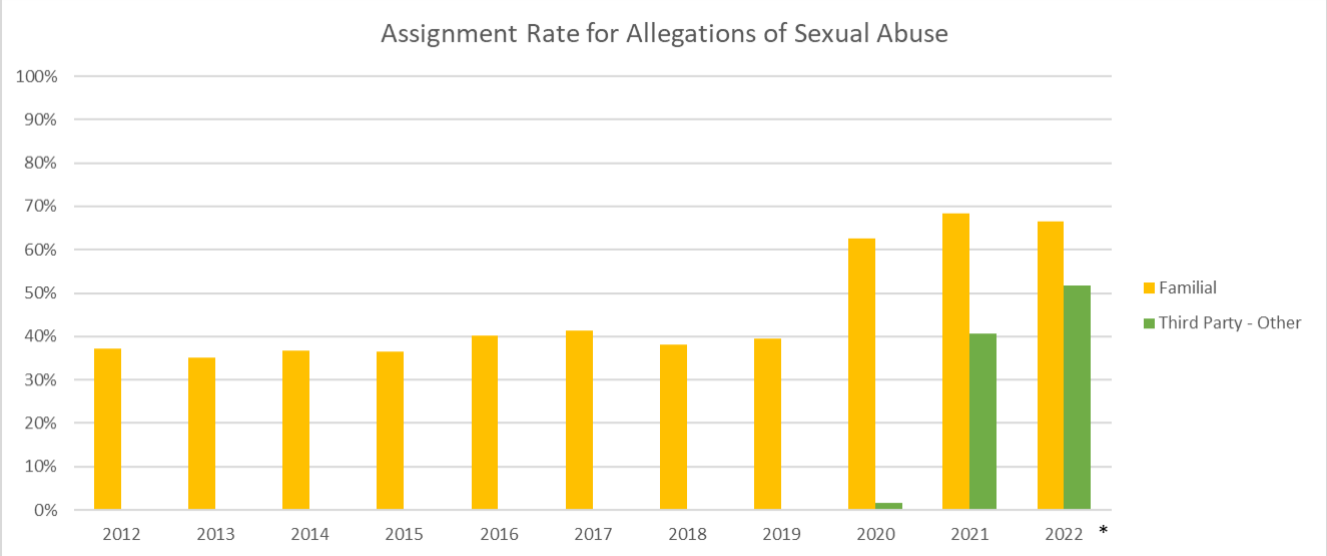
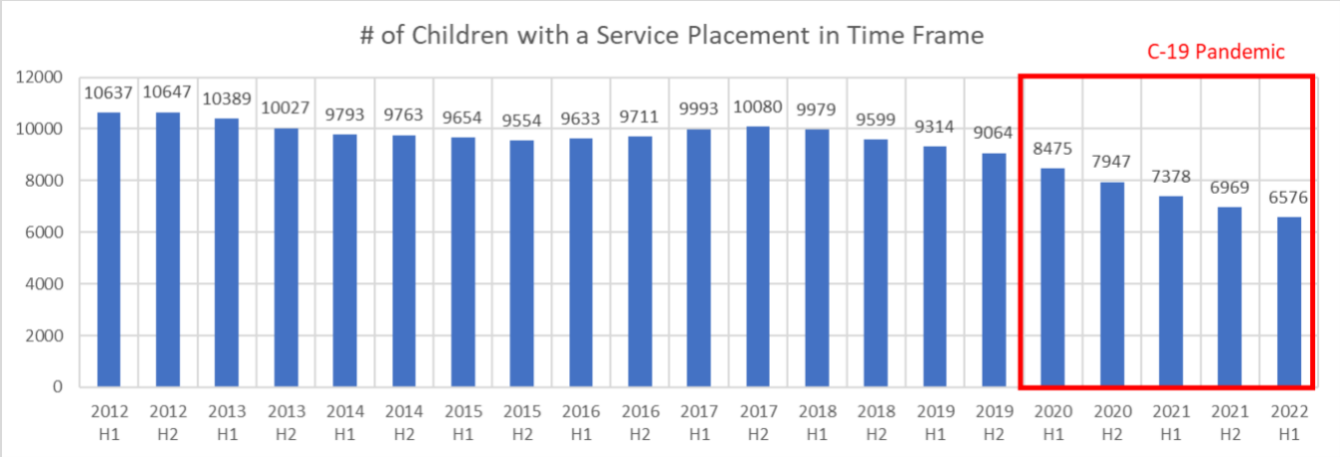


**2022: Mid-year report*

Figure 15.



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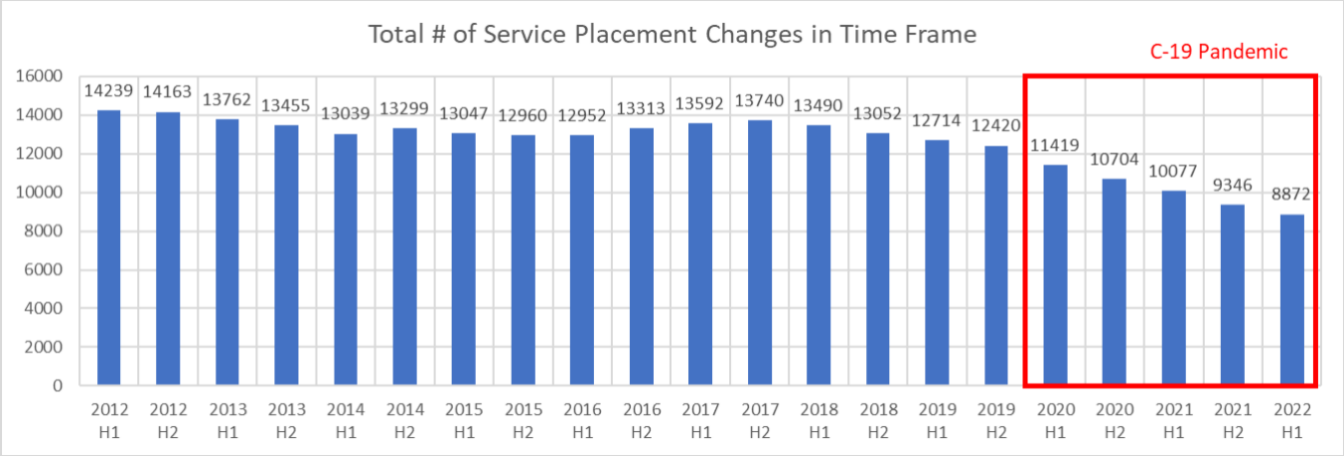

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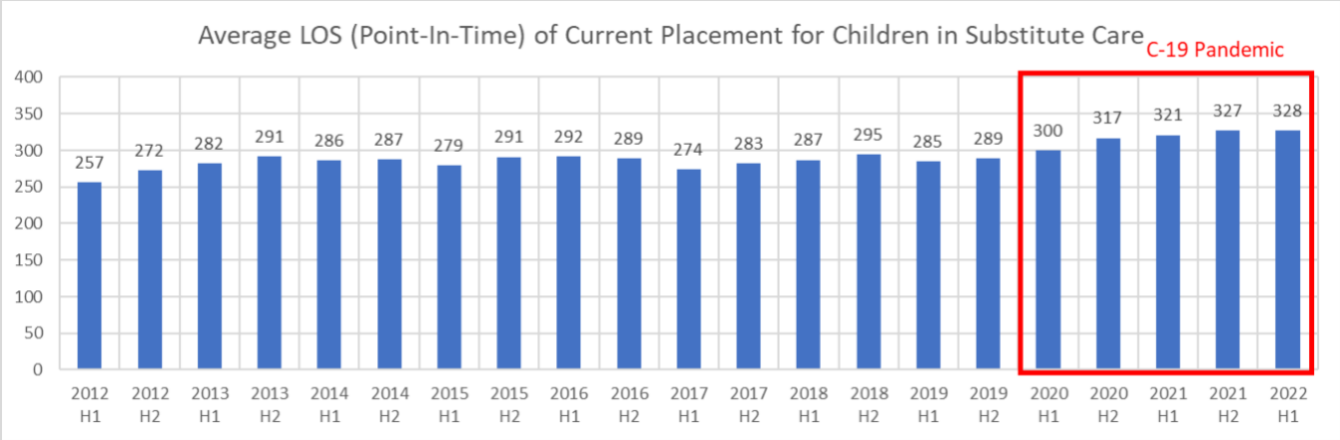

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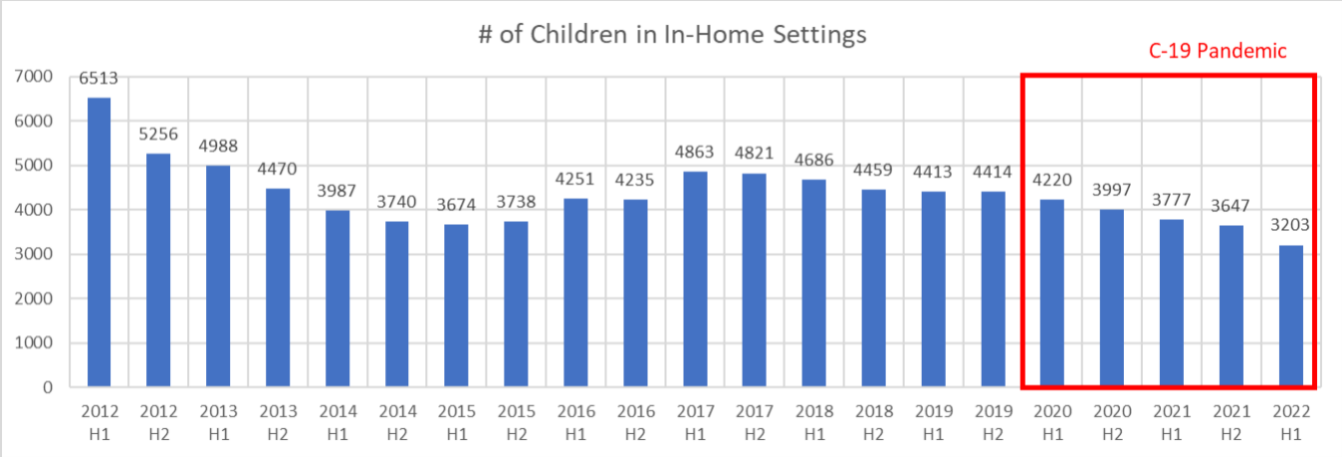

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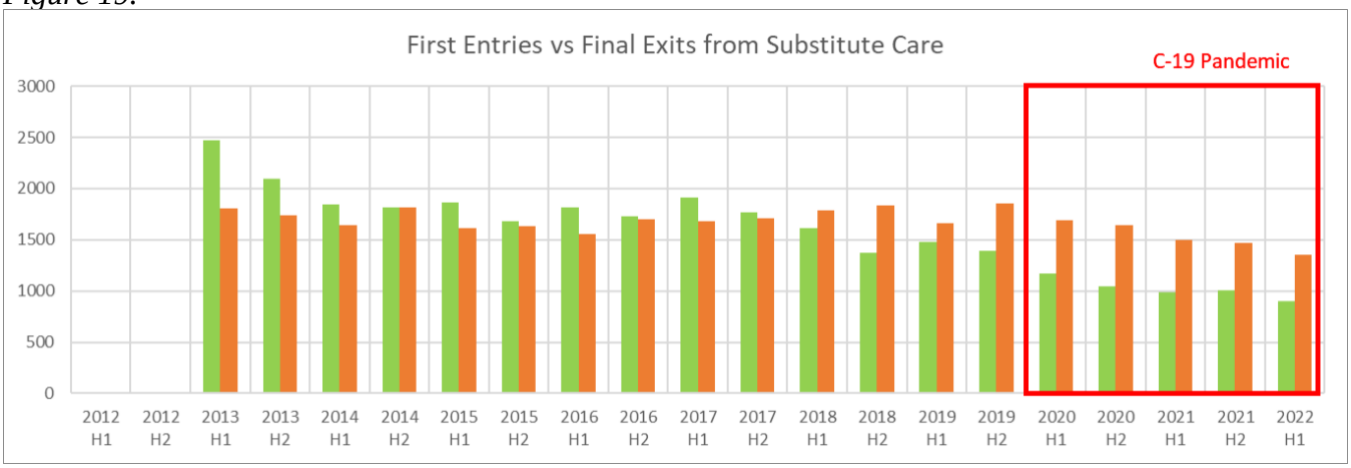

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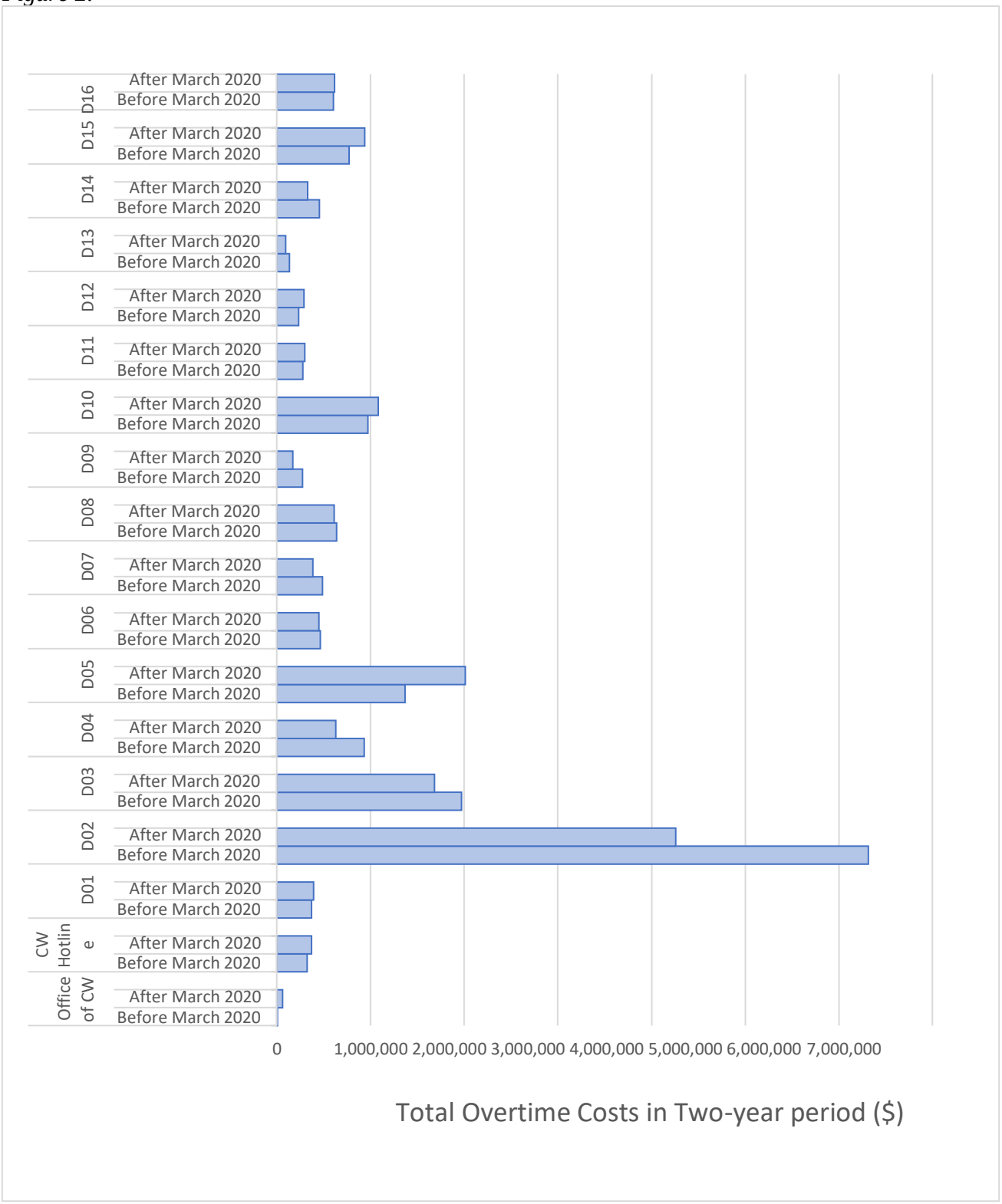

D16
D15
D14
D13
D12
D11
D10
D09
D08
D07
D06
D05
D04
D03
D02
D01
CW Hotline
Office of CW
After March 2020
Before March 2020
0
1,000,000
2,000,000
3,000,000
4,000,000
5,000,000
6,000,000
7,000,000
Total Overtime Costs in Two-year period ($)

Figure 3.

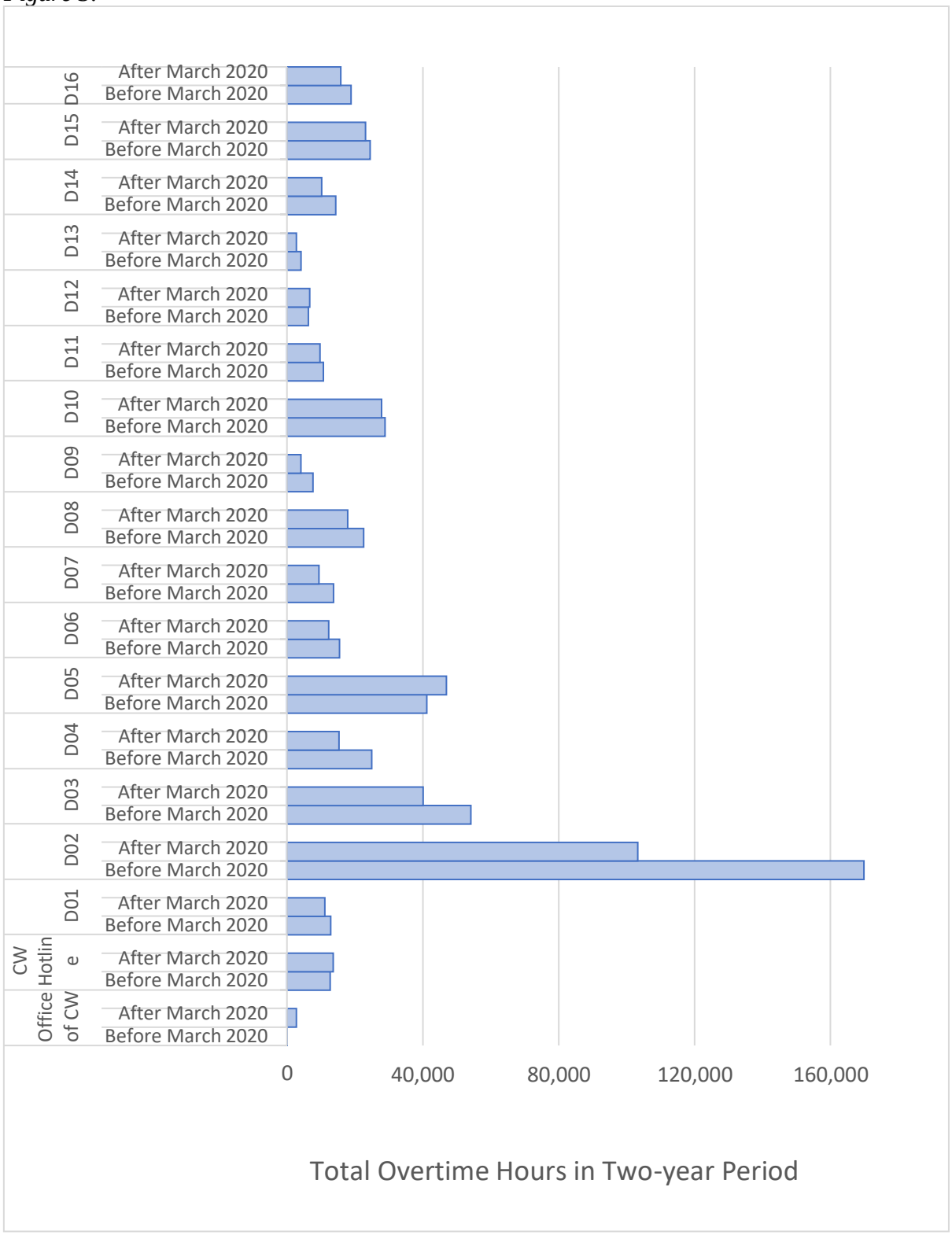
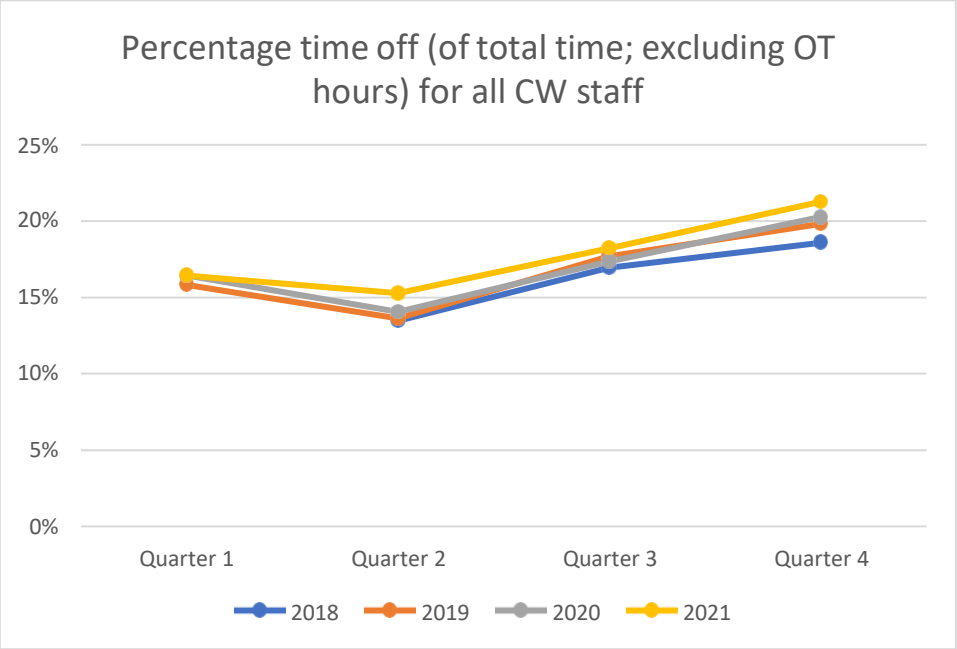

D16
D15
D14
D13
D12
D11
D10
D09
D08
D07
D06
D05
D04
D03
D02
D01
CW Hotline
Office of CW
After March 2020
Before March 2020
0
40,000
80,000
120,000
160,000
Total Overtime Hours in Two-year Period

Figure 4.



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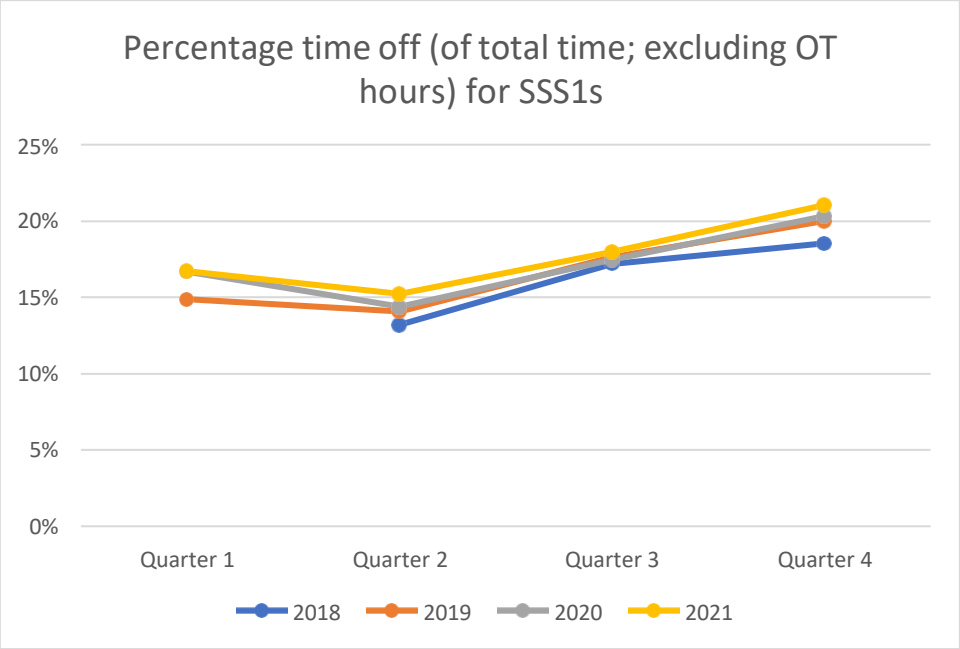

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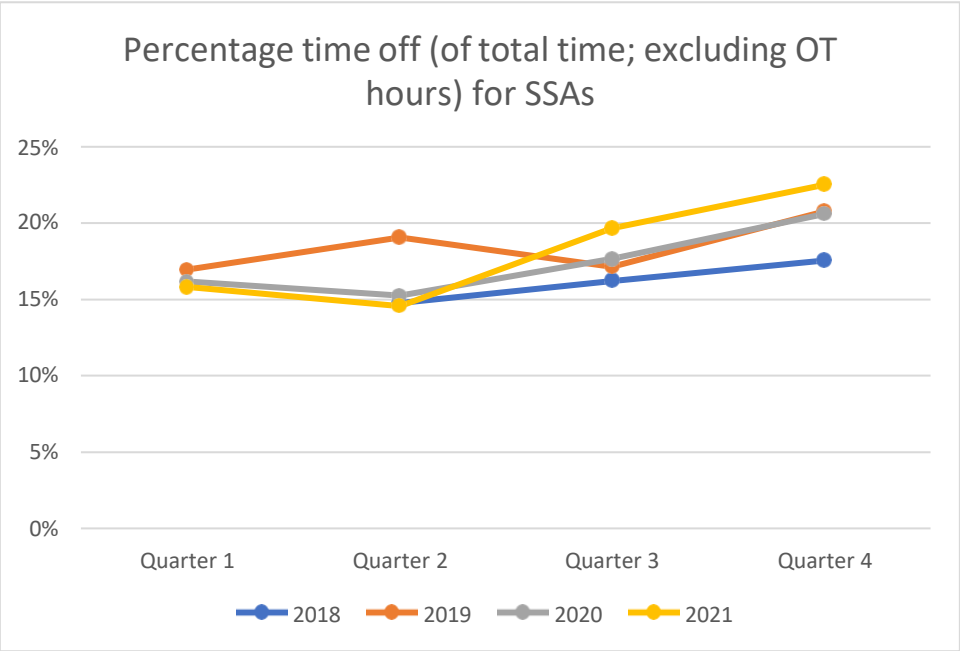

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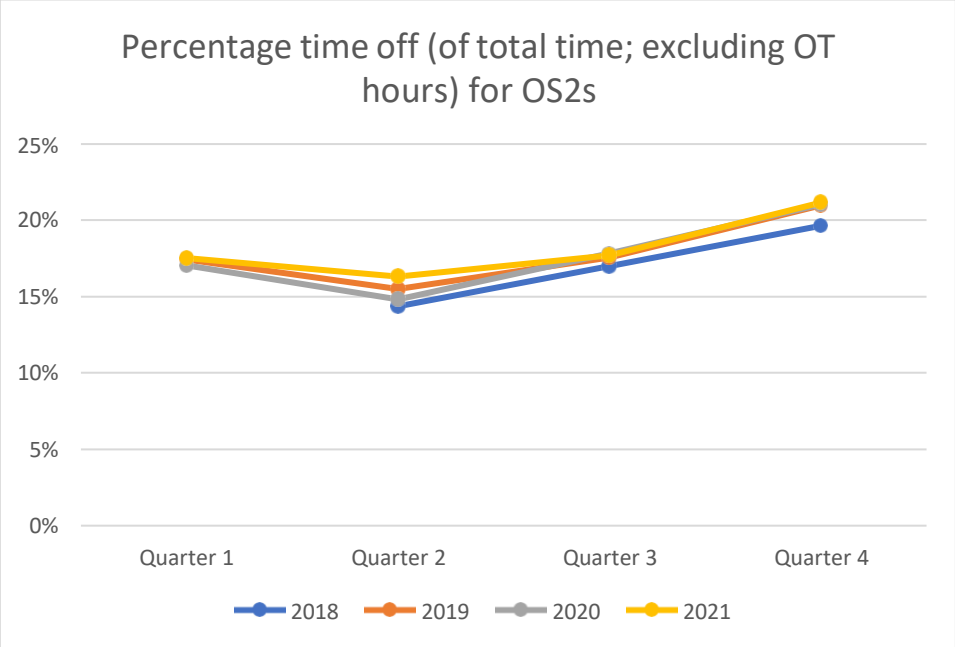

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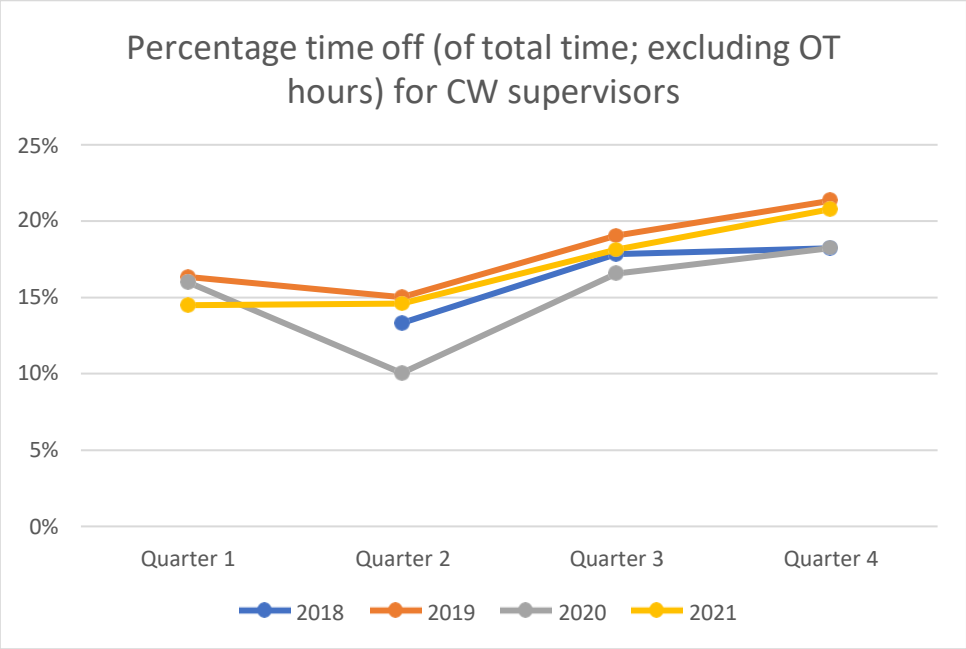

Percentage time off (of total time; excluding OT hours) for CW supervisors
25%
20%
15%
10%
5%
0%
Quarter 1
Quarter 2
Quarter 3
Quarter 4
2018
2019
2020
2021

Figure 9.

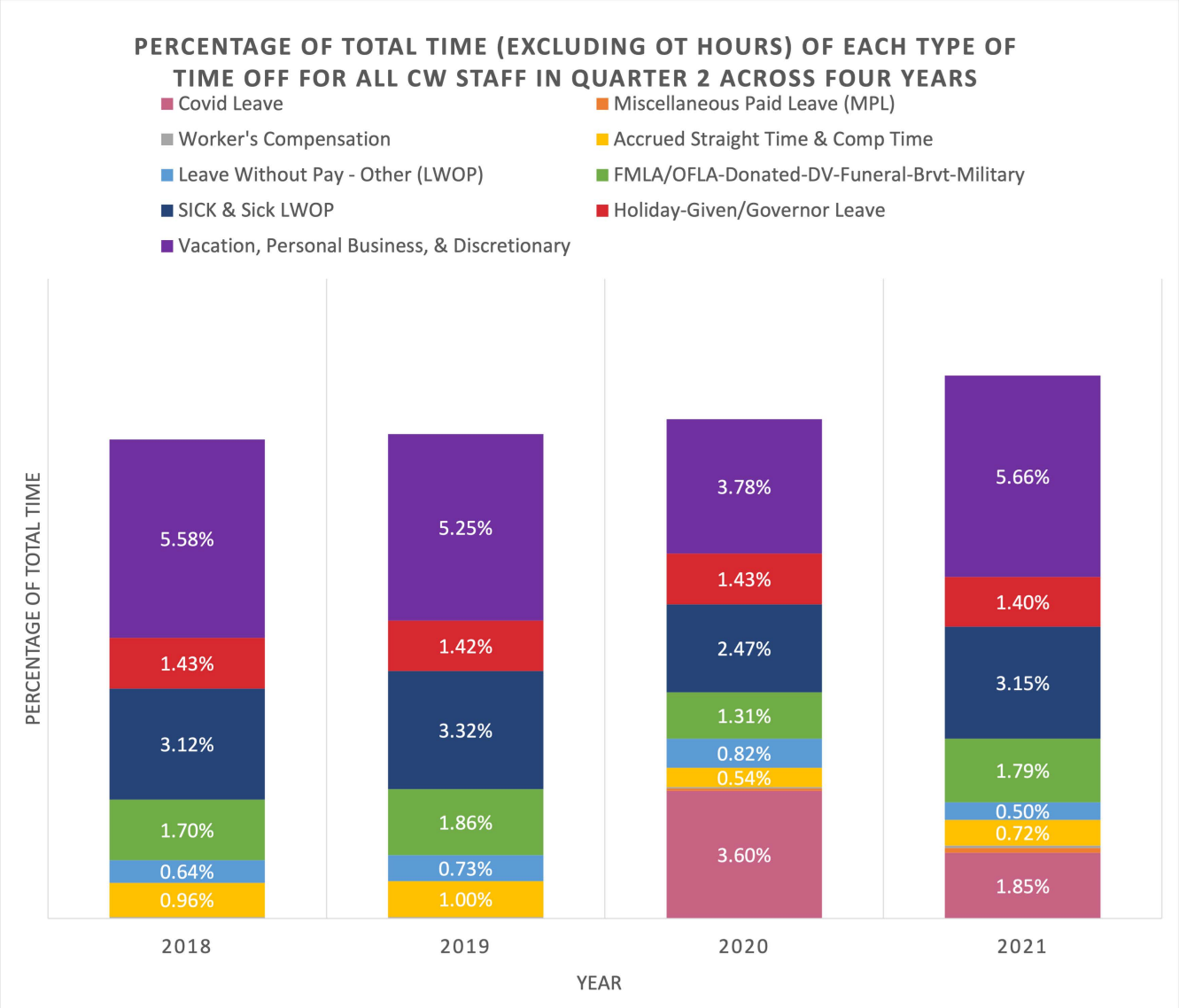

PERCENTAGE OF TOTAL TIME (EXCLUDING OT HOURS) OF EACH TYPE OF TIME OFF FOR ALL CW STAFF IN QUARTER 2 ACROSS FOUR YEARS
Covid Leave
Miscellaneous Paid Leave (MPL)
Worker's Compensation
Accrued Straight Time & Comp Time
Leave Without Pay - Other (LWOP)
FMLA/OFLA-Donated-DV-Funeral-Brvt-Military
SICK & Sick LWOP
Holiday-Given/Governor Leave
Vacation, Personal Business, & Discretionary
PERCENTAGE OF TOTAL TIME
5.58%
1.43%
3.12%
1.70%
0.64%
0.96%
5.25%
1.42%
3.32%
1.86%
0.73%
1.00%
3.78%
1.43%
2.47%
1.31%
0.82%
0.54%
3.60%
5.66%
1.40%
3.15%
1.79%
0.50%
0.72%
1.85%
2018
2019
2020
2021
YEAR

Figure 10.

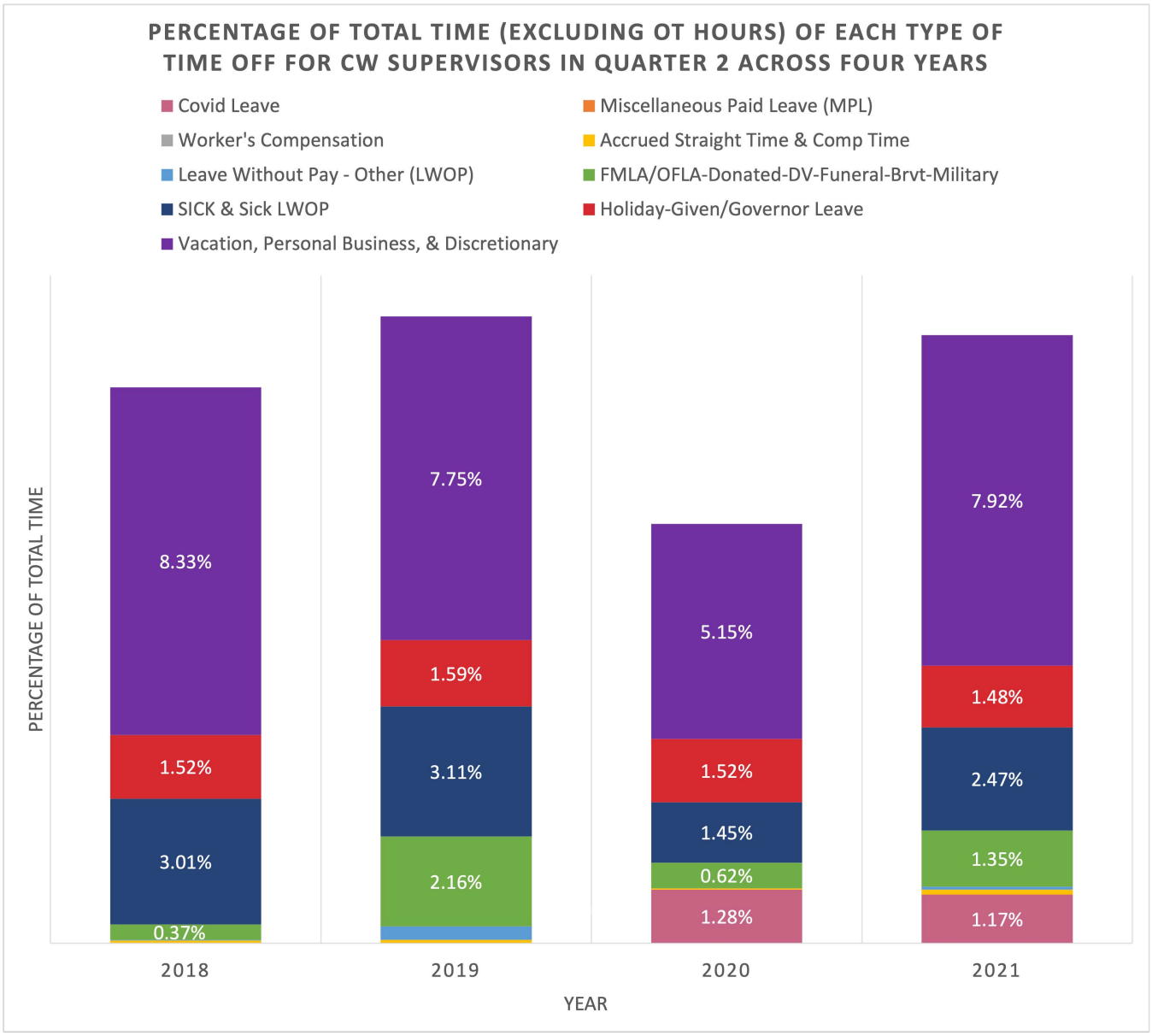

PERCENTAGE OF TOTAL TIME (EXCLUDING OT HOURS) OF EACH TYPE OF TIME OFF FOR CW SUPERVISORS IN QUARTER 2 ACROSS FOUR YEARS
Covid Leave
Miscellaneous Paid Leave (MPL)
Worker's Compensation
Accrued Straight Time & Comp Time
Leave Without Pay - Other (LWOP)
FMLA/OFLA-Donated-DV-Funeral-Brvt-Military
SICK & Sick LWOP
Holiday-Given/Governor Leave
Vacation, Personal Business, & Discretionary
PERCENTAGE OF TOTAL TIME
8.33%
1.52%
3.01%
0.37%
7.75%
1.59%
3.11%
2.16%
5.15%
1.52%
1.45%
0.62%
1.28%
7.92%
1.48%
2.47%
1.35%
1.17%
2018
2019
2020
2021
YEAR

Figure 11.

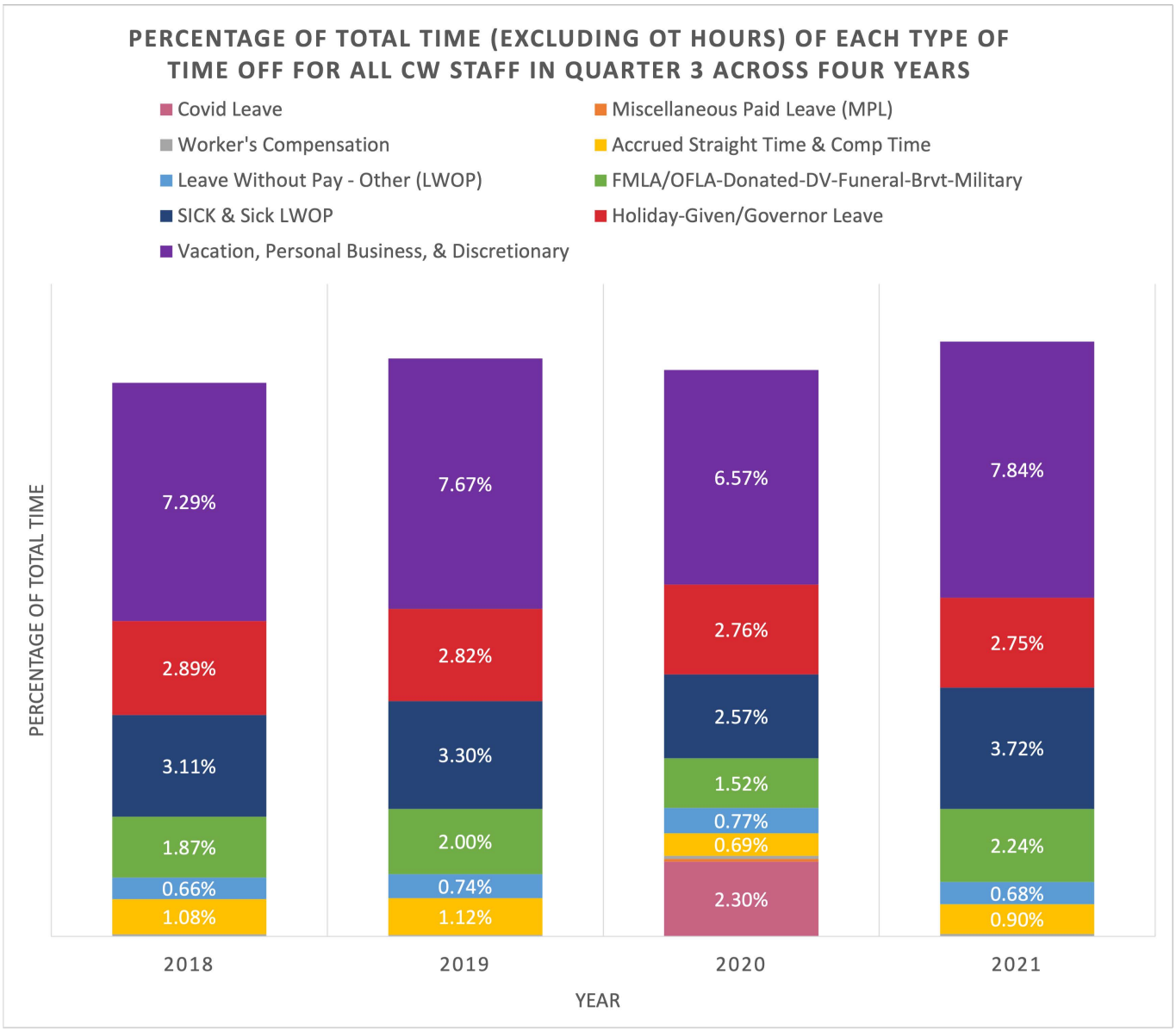
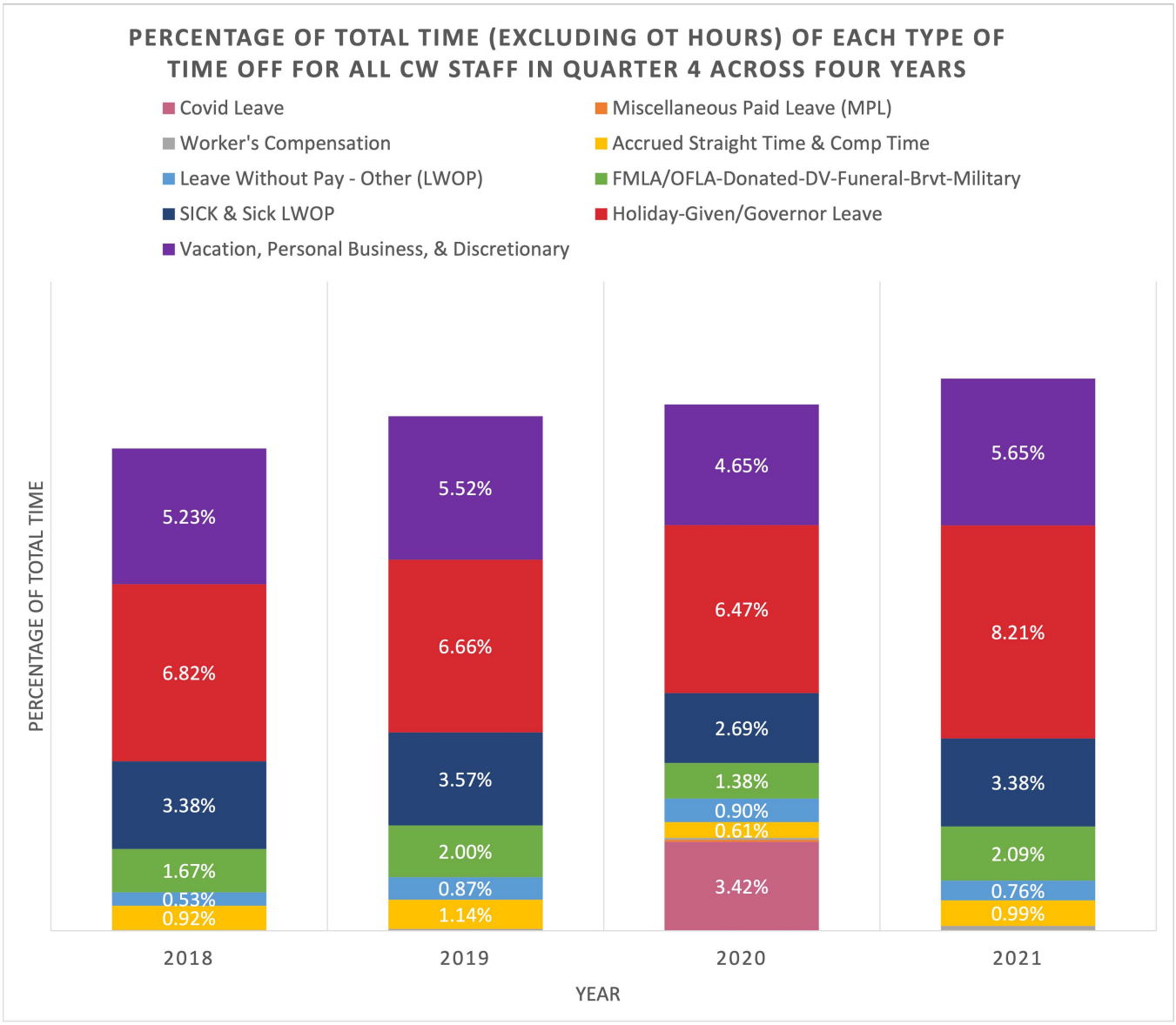

PERCENTAGE OF TOTAL TIME (EXCLUDING OT HOURS) OF EACH TYPE OF TIME OFF FOR ALL CW STAFF IN QUARTER 3 ACROSS FOUR YEARS
Covid Leave
Miscellaneous Paid Leave (MPL)
Worker's Compensation
Accrued Straight Time & Comp Time
Leave Without Pay - Other (LWOP)
FMLA/OFLA-Donated-DV-Funeral-Brvt-Military
SICK & Sick LWOP
Holiday-Given/Governor Leave
Vacation, Personal Business, & Discretionary
PERCENTAGE OF TOTAL TIME
7.29%
2.89%
3.11%
1.87%
0.66%
1.08%
7.67%
2.82%
3.30%
2.00%
0.74%
1.12%
6.57%
2.76%
2.57%
1.52%
0.77%
0.69%
2.30%
7.84%
2.75%
3.72%
2.24%
0.68%
0.90%
2018
2019
2020
2021
YEAR

Figure 12.


PERCENTAGE OF TOTAL TIME (EXCLUDING OT HOURS) OF EACH TYPE OF TIME OFF FOR ALL CW STAFF IN QUARTER 4 ACROSS FOUR YEARS
Covid Leave
Miscellaneous Paid Leave (MPL)
Worker's Compensation
Accrued Straight Time & Comp Time
Leave Without Pay - Other (LWOP)
FMLA/OFLA-Donated-DV-Funeral-Brvt-Military
SICK & Sick LWOP
Holiday-Given/Governor Leave
Vacation, Personal Business, & Discretionary
PERCENTAGE OF TOTAL TIME
5.23%
6.82%
3.38%
1.67%
0.53%
0.92%
5.52%
6.66%
3.57%
2.00%
0.87%
1.14%
4.65%
6.47%
2.69%
1.38%
0.90%
0.61%
3.42%
5.65%
8.21%
3.38%
2.09%
0.76%
0.99%
2018
2019
2020
2021
YEAR

Appendix C - Qualitative Interviews: Focus Group Questions

Level 1: ODHS CW; ODHS ODDS; and OCFBH Leadership

A. What are three to five practice and/or policy changes that your organization or department implemented as a direct result of the COVID-19 pandemic? Consider:
   - Emergency rules with which you were required to comply
   - Operational changes (i.e., Changes such as virtual meetings with staff and stakeholders; decrease or change in monitoring programs, etc.)
   - Communication with programs and/or families
   - Communication with partners, tribes, and providers
   - Additional services and supports provided/available
   - Other?

B. What are the three greatest challenges your organizations and/or department faced throughout the pandemic? Consider the degree of impact - i.e., resources, impact on staff morale, vacancy rates by job classification or work area, placement availability (i.e., youth on waitlist for programs; time from referral to program/home placement; etc.)

C. Are there practices that were put in place as a result of the pandemic that your organization or department will retain post-pandemic? Which ones and why (rationale)?

D. What are the top three "takeaways" or lessons learned? What words of wisdom would you offer another agency or department going through a future pandemic (i.e., pitfalls to avoid)?

E. What are some of your greatest needs that still remain?

Level 2: Residential Providers (Child Welfare, Developmental Disabilities Services, and OHA funded child-serving residential programs)

A. What are three to five practice and/or policy changes that were implemented as a direct result of the COVID-19 pandemic? Consider:

1) Programming

- What changes were made to better ensure a safe **physical environment** for youth, staff, and families? I.e., Were there additional sanitation protocols mandated/implemented? Temperature checks? Restricted areas? Please describe?
- Were changes made to how **treatment** was delivered? If so, what were these changes? I.e., size of groups; virtual sessions; new curriculum; logistical changes, etc.

- Were changes made to **education** service delivery? If so, what were these changes?
- Were changes made to the type of **services provided to families**? What were some of these changes? Were changes made to the approach to working with families? If so, what were some of these changes?
- Were changes made to **family visitation** practices? If so, what were these changes?
- Were changes made to **other programming** offered by the program – i.e., additional activities; additional privileges; changes to recreation; etc.?
- Did the program make changes to the **length of stay/program** as a result of the COVID-19 pandemic (i.e., youth discharged earlier than usual? Youth staying in program longer than typical for your program?)
- Did programs make changes to the type, frequency, or approach to delivering **transition services**? If so, what changes were made?
- For your agency specifically, and in your experience and observations, were **homes more likely/least likely to recertify** during the COVID pandemic? What reasons were provided?
- Did you make changes to the **process and/or frequency of recertifying process?** If so, what were these?
- Were there **other changes made in the area of programming** that you'd like to share?

2) Communication

- Did the pandemic cause changes to the way in which you communicate with **families**? Consider the method/type and frequency of communication. What were these changes?
- Did the pandemic cause changes to the way in which you communicate with **partners and/or stakeholders** (i.e., Those that we are in contractual and payment relationship with, advisory and affinity groups, as well as general communication)?
- Did the pandemic cause changes to the way in which you communicate with **tribes**? Consider the method/type and frequency of communication. What were these changes?
- Did the pandemic cause changes to the way in which you communicate with **other residential providers**? Consider the method/type and frequency of communication. What were these changes?

B. What are the three greatest challenges your program and/or agency faced throughout the pandemic? Consider the degree of impact - i.e., resources, impact on staff morale, vacancy rates by job classification or work area, placement availability (i.e., youth on waitlist for programs; time from referral to program/home placement; etc.). What strategies did you employ to address each of these challenges?

C. To what degree did the COVID-19 pandemic impact the program? Using a scale of 1 to 3 with a score of 1 defined as "no impact"; a score of 2 defined as "some impact"; and a score of 3 defined as "significant impact" to what degree did the pandemic impact your agency/program's:
   - Daily operations?
   - Staff ratios?
   - Parent and caregiver morale?
   - Youth morale?
   - Staff morale?
   - Family engagement?
   - Agency/program resources?

D. Are there practices that were put in place in response to the pandemic that your program or agency will retain post-pandemic? Which ones (see responses to question A 1-3 of this section) and why (rationale)?

   1) Programming:
   - Physical environment (i.e., sanitation protocols)
   - Treatment services (I.e., size of groups; virtual sessions; new curriculum; logistical changes, etc.)
   - Education service delivery
   - Services provided to and/or approach to working with families
   - Family visitation practices
   - Other program activities (i.e., additional activities; additional privileges; changes to recreation; etc.)
   - Length of stay/program as a result of the COVID-19 pandemic (i.e., youth discharged earlier than usual? Youth staying in program longer than typical for your program?)
   - Transition services (i.e., type, frequency, or service delivery approach)
   - Home recertifications process

   2) Communication
   - Communication strategies and/or frequency of communication with families
   - Communication strategies and/or frequency of communication with partners and/or stakeholders (i.e., Hispanic and Latinx community, black and African American etc.)
   - Communication strategies and/or frequency of communication with tribes
   - Communication strategies and/or frequency of communication with other residential providers

E. What are the top three "takeaways" or lessons learned? What words of wisdom would you offer another program or agency going through a future pandemic (i.e., pitfalls to avoid)?

F. What support do you need from ODHS/OHA/ODDS now? What are some of your greatest needs that still remain?

Appendix D: Qualitative Themes

OVERARCHING THEMES

A number of themes across departments emerged through the qualitative and quantitative analyses. The chart below shows the common experiences reported by agency leaders and contracted residential providers. An "X" indicates that study participants from all three agencies – ODHS CW, ODHS DD, and OCFBH - reported this experience and/or perspective. These commonalities are discussed more fully in the Discussion section of this findings report.

Effects of the COVID-19 Pandemic on the ODHS Child-Serving System

Qualitative Data Category	Theme/Response	Level 1: Agency Level	Level 2: Provider/ Program
Experience and Challenges	**Staffing issues**– i.e., Challenging to recruit and retain staff; overtimes costs; staff burnout and exhaustion; turnover rates; needed additional staff to do remote schooling; running lower staff to children and young adults' ratios because of quarantining	**X**	**X**
	Finances/Revenue - Increased financial costs; decreased revenue (resulting from lack of referrals and inadequate number of staff); delayed funding at times		**X**
	Team Impact - Staff morale and/or sense of teamwork negatively impacted - i.e., staff stress; burnout; etc.		**X**
	Impact to services to children and young adults and families – i.e., Decreased service provision and or less effective methods for service delivery; virtual visits from case workers, mental health providers, medical; limited opportunities for skills practice; family visitation impacted; home schooling was difficult, etc.	**X**	**X**
	Impact to children and young adults' morale, health, and well-being – i.e., increased children and young adults' frustration and aggressive behaviors; regression in basic living skills; increased mental health issues; prolonged states of urgent mental health need; children and young adults' feelings of isolation		**X**
	Children and young adults served in residential treatment unable to go on home visits as part of transition and as a result, children and young adults stayed longer in programs		**X**

	Decreased access to resources – mental health and medical providers; limited access to respite care; difficulty finding cleaning supplies and COVID tests		**X**
	Decreased bed capacity and/or program closures (due to lack of referrals or not enough staff to staff program)		**X**
	Adopted virtual/remote education – Approximately 68% of providers (n=15) who mentioned virtual/remote learning specifically stated that remote learning was difficult and presented numerous challenges (i.e., staff and foster parents serving as a teacher and trying to supervise; needed extra staff to sit with children and young adults; etc.)		**X**
	Adopted virtual mental health and counseling appointments		**X**
	Community activities halted and consequently, adopted different recreational activities – i.e., hikes, walks, river, etc.		**X**
	Additional funding and resources provided – i.e., Provided emergency fund dollars to further support children and young adults and families; temporary rate increases for providers; etc.	**X**	
	Increased communication from CW, ODDS, and OCFBH		**X**
Practices to Retain	**Retain some remote working/hybrid model**	**X**	
	Retain the use technology for trainings, meetings, telehealth for children and young adults, family therapy sessions, etc.		**X**

	Retain emergency procedures and sanitation practices - i.e., individualized boxes with thermometer, gowns, masks, sanitizer etc. in case children and young adults get sick.		**X**
Key Takeaways/ Lessons Learned	**Allowed us to shift and prioritize projects –** i.e., explored equity and race more deeply; increased understanding of anti-racist values; drew attention to mental health and suicide prevention	**X**	
	Changed the way we view staff - i.e., learned increased need for flexibility and trying to meet staff needs; need to listen to staff; show greater appreciation for staff; importance of work life balance		**X**
	Negative impact on children and young adults – i.e., increased mental health issues; decreased social skills practice; etc.		**X**
	Improved teamwork, morale, and team cohesion		**X**
	Highlighted/exposed deficiencies-i.e., staffing issues; no advertising/recruitment budget; communication barriers; long-term solutions, etc.		**X**

Remaining Needs	**Funds to address the staff recruitment and retention crises** • Need to address staff vacancies and workforce shortages; need to increase rates and benefits to entice staff; • Need to streamline processes related to staff recruitment and retention; • Need to improve screening tools to determine if staff qualified • Need to continue to support staff and working through traumas; • Need to shift thinking and create an environment where people want to work	**X**	**X**
	Additional Service providers, beds, and/or resources for family – i.e., Psychiatric Residential; proctor homes; etc.	**X**	**X**
	Need to improve communication and coordination across divisions and with counties; increased communication needed between programs and case workers		**X**

Recommendations/ Future Considerations	**Additional funds and supports are needed from ODHS/ODDS/OCFBH –** need long-term funding for the following areas: • In-home services to prevent out of home placements • Workforce development – recruiting and retaining qualified direct care staff • Funding for alternative work schedules • Additional mental health services for children and young adults (i.e., acute mental health needs) • Respite and crisis options including a mobile crisis unit to prevent hospitalization • Increase in rates for foster/proctor parents and behavioral services • Have children and young adults come with SNAP benefits (i.e., children and young adults come with medical Oregon Health Plan but cost of food has skyrocketed) • Funding for hazard pay for individuals working on the front line during a pandemic or emergency situations • Activities to continue to help children and young adults develop social skills • Peer to peer support group for proctor and residential staff (to share their fears, frustrations, concerns, and ideas) • In a crisis situation can create pods of social groups for children and young adults by pairing up families based on		**X**

	social dynamics (i.e., give an outdoor forum to visit) • Provide/allow for educational/behavior support specialists in the homes • Childcare for proctor families		

	Need to streamline processes in the following areas: • Accessing and tracking funds for county children and young adults – i.e., OHA oversee Community Care Organizations (CCOs), but every county manages and oversees the Medicaid money; if have a children and young adults from certain county then have to do their specific authorizations; also, when children and young adults moves to a different county there are often gaps in services and insurance • Program reporting requirements – i.e., some of these were paused during pandemic; question raised, "Is there value add in continuing with them?" • Referral process – i.e., sometime cannot open referral emails; question raised, "Can we have a meeting once a week with providers to discuss referrals?" • Documentation requirements for foster and proctor parents – i.e., those individuals interviewed reported having to document 10 hours of notes per week; question raised, "Can we make these notes online?" • State audits – i.e., question raised, "Can we streamline the audit processes to occur at the same time" (e.g., licensing audits, contracting audits, etc.)? • Need process for working with people with co-occurring disorders – i.e., current process involves ODDS and OCFBH stating "s/he is yours."		**X**

	• Develop and/or adopt a standardized response protocol from CDC and public health department for all providers		
	Need to evaluate our response to the pandemic and develop a more robust emergency response plan – i.e., emergency kits set up for quarantine/isolation; making sure respite is readily accessible as needed; emergency staffing plan; adequate technology; strategies for ensuring quality education continues; system for ensuring no gaps in children and young adults receiving mental health and medical medications, etc. Once the plans are built need to accurately estimate the financial cost of responding to the crisis at hand		**X**
	Need to allocate the funds more swiftly to have the intended impact – I.e., many providers reported not receiving the funds for over a year		**X**
	Need more coordinated - need improved/coordinate communication between OHA, ODHS, and ODDS; need more communication between case workers and programs		**X**

This document can be obtained in an alternate format for individuals with disabilities upon request by contacting Sara Fox at sara.b.fox@dhsoha.state.or.us. Available formats are: large print, Braille, audio tape recording, electronic format and oral presentation.