



DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

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Governor

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Director

Therapy Survey 12

Introduction and Contact Information:

Please only provide information as it pertains to the services outlined in this survey for DDD. If your agency provides additional services, do your best to estimate the portion of information that applies to these services for DDD members.

We understand that you've provided answers to many of these questions in prior survey rounds. To ensure we can trend information reliably over time by survey we need the answers repeatedly, so we appreciate you providing them again. Please save your answers so you can reuse them in additional surveys.

1. What is your organization's name? (Drop down menu)
2. Please enter your AHCCCS ID?
3. Please enter your Employer ID?
4. Please enter the following contact information:
 - Contact Name
 - Email Address
 - Phone Number
5. Does your agency provide therapy services? (OEA, OTA, SEA, STA, PEA, PTA, RP1)?

Staffing & Members:

6. How many therapists/ assistants were employed or contracted and working on August 31, 2021 that provided services to DDD members in these programs?
 - Employee (FTE 30+ hours per week)
 - Contracted
7. How many therapists/ assistants were employed or contracted and working on September 30, 2021, 2021 that provided services to DDD members in these programs?
 - Employee (FTE 30+ hours per week)
 - Contracted
8. How many therapists/ assistants left the agency (laid off, terminated, etc.) in:

- ☐ July
 - ☐ August
 - ☐ September
- 9. If there was a reduction in therapists/assistants due to COVID-19, please answer the following:
(Provide the number of **FTE** therapists/ assistants for each reason (count))
 - ☐ Family issues
 - ☐ Laid off due to low demand
 - ☐ Sick Leave
 - ☐ Refused to work
 - ☐ Other
- 10. Please enter the total number of work hours reduced.
- 11. Please enter any additional comments about the reduction in Therapists/Assistants serving members.
- 12. How many therapists/assistants hired in:
 - ☐ July
 - ☐ August
 - ☐ September
- 13. How many applications for therapists/assistants have you received in the following months?
 - ☐ July
 - ☐ August
 - ☐ September
- 14. How many applicants were qualified for therapists/assistants (including passing background checks) in the following months?
 - ☐ July
 - ☐ August
 - ☐ September
- 15. Is your agency receiving more or less therapist/assistant applicants currently when compared to the same time last year?
 - ☐ More/less/about the same
- 16. Is your agency receiving more or less qualified therapist/assistant applicants currently when compared to the same time last year?
 - ☐ More/less/about the same
- 17. Is your agency retaining more or less qualified therapists/assistants currently when compared to the same time last year?

- More/less/about the same
18. What was your vacancy for therapists/assistants on September 30 for the years listed below?
- 2019
 - 2020
 - 2021
19. Has your agency experienced an increase in demand for therapists/assistants' services?
- Y/N
20. If there has been an increase in demand, please provide the following information. If there has been a decrease, please include a subtraction sign (-10).
- Member change
 - Total unit change
21. How many total staffing hours were scheduled in the following weeks?
- Week of September 6-10
 - Week of September 13-17
 - Week of September 20-24
 - Week of September 27-October 1
22. Has your agency experienced an increase in overtime due to increased demand?
- Y/N
23. How many clinics do you operate? Non 3rd-party clinics
24. How many are currently open? Non 3rd-party clinics
25. How many temporarily closed service sites (clinics) will reopen by the end of the year?
26. How many temporarily closed service sites (clinics) will not reopen by the end of the year?
27. Please tell us the number of service sites (clinics) that were closed by week, if N/A, please enter "0"
- July 1 -7
 - August 1 - 7
 - September 1 - 7
 - Are still open
28. Please enter additional comments about the reason for closure. Please enter, "N/A" if not applicable
29. How many service sites does your agency operate when all service sites are open?

30. Please list the number of service sites open by week

- ☐ September 6-10
- ☐ September 13-17
- ☐ September 20-24
- ☐ September 27 - Oct 1

31. When operating at full capacity, how many DDD members on average does your agency serve per week?

32. Please tell us the number of members your agency has served or is expecting to serve by week, if your sites are closed, please enter "0"

- ☐ September 6-10
- ☐ September 13-17
- ☐ September 20-24
- ☐ September 27 - Oct 1

33. Concerning service sites and staffing, when does your agency expect to be operating at full capacity?

- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November

34. Please provide any additional comments concerning when your agency expects to be operating at full capacity.

35. How many distinct members were served in the following weeks:

- ☐ Week of July 19-23
- ☐ Week of August 16-20
- ☐ Week of September 6-10

36. Reduction in members served (count)

- ☐ Members who refused or cancelled services
 - ☐ in person
 - ☐ telehealth
- ☐ Members impacted by lack of staff
- ☐ Members impacted by clinic/site closing
- ☐ Number of members impacted due to COVID-19

37. Reduction in members served (detailed response)

38. Have you seen an increase in Paid or Unpaid Time Off due to COVID-19? Y/N

- ☐ Y/N

39. If Yes, please provide the number of hours per month vacated with Paid Time Off due to COVID-19:

- ☐ July
- ☐ August
- ☐ September

40. If Time Off due to COVID-19 is Paid, what is the total cost of those hours?

- ☐ July
- ☐ August
- ☐ September

Services:

41. Does your agency currently conduct therapy services through telehealth? (yes no for each service)

- ☐ OT
- ☐ PT
- ☐ ST
- ☐ None

42. If yes, what telehealth platform are you using?

- ☐ Zoom for Healthcare
- ☐ VSee
- ☐ PTEverywhere
- ☐ TheraNest
- ☐ eVisit
- ☐ CORA Vision
- ☐ MW Therapy
- ☐ Other (description for other)

43. Do you believe members/families will opt to continue receiving services via telehealth – even after a return to home or clinic-based services becomes possible?

- ☐ Y/N

44. If yes, what percentage of the members/families you serve do you believe will opt to continue receiving therapy services via telehealth?

45. Can you share when your agency expects to see a shift back to in-home or clinic-based services?

- ☐ July
- ☐ August
- ☐ September

- We have already returned or continuously provided in-person services
 - comment option
- 46. Would you like to see telehealth as a standard service delivery method going forward?
 - Y/N
- 47. Please provide any other information or feedback you have regarding telehealth.

Vaccinations:

- 48. Are you requiring that your providers get the COVID-19 vaccine? Y/N
- 49. Are you tracking staff vaccination? Y/N
- 50. Does your organization anticipate a difficulty in retaining and hiring therapists as a result of the new vaccination mandate by the federal government?
- 51. Please mark all reasons that you've heard for refusing vaccines:
 - Safety concerns/limited testing
 - Concerns about effectiveness of vaccines
 - Religious and disability-related objections
 - Want to continue telehealth
 - Not tracking reason why they are refusing vaccines
 - All staff have indicated that they want the vaccine
 - Don't Want It/Did not provide reason
- 52. Have your providers had issues accessing the COVID-19 vaccine? Y/N (if yes comment option)
- 53. Is your agency incentivizing that providers get vaccinated? Y/N
- 54. Is your agency notifying staff of vaccination appointment availability?
- 55. Are you offering paid or unpaid time off to staff who want the vaccine?
- 56. Are you notifying members and families when providers are vaccinated? Y/N
- 57. How are you confirming that providers are vaccinated?
 - Getting copies of vaccination cards
 - Staff attestation
 - We're not tracking staff vaccination

58. If yes, what percent of providers that work directly with DDD members are fully vaccinated against COVID-19 as of the following dates: please enter 0, If not applicable.

- ☐ 07/01/21
- ☐ 07/15/21
- ☐ 08/01/21
- ☐ 08/15/21
- ☐ 09/01/21
- ☐ 09/15/21

59. If yes, what percent of providers that work directly with DDD members have/had received their first dose of the COVID-19 vaccine as of the following dates: please enter 0, If not applicable

- ☐ 07/01/15
- ☐ 07/15/21
- ☐ 08/01/21
- ☐ 08/15/21
- ☐ 09/01/21
- ☐ 09/15/21

60. Please provide any comments you have regarding the COVID 19 vaccine.

Personal Protective Equipment (PPE):

61. Do your therapists/ assistants have enough personal protective equipment (PPE) to implement your pandemic performance plan for one month?

- ☐ Y/N

62. If no, which of the following PPE is needed?

- ☐ Gloves
- ☐ Gowns/Aprons
- ☐ Masks and respirators
- ☐ Goggles
- ☐ Face Shields
- ☐ We have sufficient PP

63. What extra precautions has your agency and therapists/ assistants taken in response to COVID-19 emergency?

64. What have your additional monthly expenses been to obtain PPE?

- ☐ July
- ☐ August
- ☐ September

65. Please provide the number of providers trained on your Pandemic Plan and how to mitigate exposure to COVID-19 through each of the following methods from March 13, 2021 to September 30, 2021.

- In person
- On-line

66. Please state any other issues impacting therapy services.

Coronavirus Aid, Relief, and Economic Security (CARES) Act

Economic Injury Disaster Loan:

“The Economic Injury Disaster Loan provides economic relief to small business and nonprofit organizations that are currently experiencing a temporary loss of revenue”.

<https://www.sba.gov/funding-programs/loans/covid-19-relief-options/eidl/covid-19-eidl#section-header-3>

67. Did you apply for the Economic Injury Disaster Loan? Y/N

68. Have you qualified for the Economic Injury Disaster Loan? Y/N/Didn't apply

Financial Statements:

Please contact DDDFinancialStmts@azdes.gov if you are in compliance with this requirement or if you have any related questions.

69. To qualify for potential funding, do you attest that you've submitted (or will do so before 10/15/21) at least the last two annual financial reports in accordance with section 6.3.3 of your qualified vendor agreement with DDD/DES? Y/N

To qualify for potential round 12 funding, you must have completed the CARES Provider Relief Fund attestation and be in compliance with the section 6.3.3 of your qualified vendor agreement with DDD/DES. If you have submitted your financial statements there is no additional action needed at this time, unless we reach out directly.

Insurance:

70. Do you attest that you've submitted (or will do so before 10/15/21) all applicable insurance documentation in accordance with section 6.7 of the Terms and Conditions of your Qualified Vendor Agreement DES/DDD? Y/N

For any questions regarding insurance requirements or the necessary documentation, contact your assigned Contract Management Specialist. You can use the Manage Dashboard in FOCUS to look up contact information for your assigned Contract Management Specialist.