

Transcript:

Region 5: Supporting Behavioral Health Programs & Personnel During COVID-19

Presenter: Dan Russell, Dave Gomel, Thomas Wright, Judith Jobe
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JEANNE PULVERMACHER: OK, well, hello and welcome, everyone. It is noon on the dot where I am, so we are going to get started. First, I want to thank you all for joining today. We are going to be talking with a couple of providers regarding supporting behavioral health programs and personnel during COVID-19.

We're going to have a discussion. You are all on mute. If you do need to ask questions, we will use the Q&A, which you can find at the bottom of your screen. And we will be answering questions live during this presentation. If you have any technical questions, again, please use the chat box, which is also at the bottom. But again, all participants are muted.

First, I just want to share a little bit about the ATTCs. We are the Great Lakes Addiction Technology Transfer Center in region 5. We are funded by SAMHSA. And we cover the states of Minnesota, Wisconsin, Illinois, Michigan, Indiana, and Ohio. And we provide workforce development for substance abuse providers.

We are one of 10 regional centers for the ATTCs. We are joined today by our regional administrator Jeff Cody for region 5 and by Kwame Gyasi, the assistant to the regional administrator for region 5.

So today's formatting is going to go like this. We're going to have Kwame and Jeff do some introductions of our providers. They're going to speak a little bit, and then you will be able to use the Q&A button at the bottom to ask some questions. We will do questions that way. Again, if you have any technical difficulties, please use the chat. But with that, I think I will hand it over to you, Jeff and Kwame.

JEFF: Thanks, Jeanne, I appreciate it. First, I'd like to welcome everybody. Thanks for taking the time to come to our discussion today. Needless to say that, when COVID sort of came on the scene, obviously the lift in the effort that many from the behavioral health stakeholders have had for providers, families, and the community, it's been a significant lift, both in terms of programmatic end, as well as in terms of taking care of our staff. We're happy to come together today to bring together really, I think, two leaders in terms of our region, Dan Russell, and Dave Gomel, in terms of their respective agencies to really talk about some of the processes that have gone on.

As Jeanne said, I'm going to start with introducing Dan. Dan is the chief executive officer of Genesee Health System in Flint, Michigan. I had the opportunity to meet and know Dan in terms of the Flint water contamination crisis. And so I wanted to mention before we get started, I know a lot of times, we hear names of certain communities, like we talk about the water contamination crisis. And I had the opportunity really to learn about Dan and the resilience and the strength of the Flint community.

And that's a story oftentimes that we maybe don't get to hear enough of, in terms of their ability to recover, their ability to respond. And when we started talking about presenters for this, I was fortunate enough to reach out to Dan, and Dan was willing to step forward and talk about some of his leadership during this time. So Dan, enough in terms of me talking. I think folks want to hear from you.

As the crisis began to unfold in terms of COVID, in terms of realizing the pandemic we're in, in terms of the efforts that had to happen within for your team and in terms of the programs, could you talk about some of the programmatic changes over time? I know most of the participants here are at some phase in terms of adjustments. So just kind of walk us through how you guys started off and where you're at now and maybe where you're thinking of going in the future.

DAN RUSSELL: Sure. Thanks, Jeff. I appreciate that. And I appreciate the introduction and everybody taking the time to listen in. Just as a two-minute intro and background, as Jeff said, I'm located in Flint, Michigan. And Flint has a pretty long and storied history. We were the birthplace of the auto industry and the United Auto Workers, at one point, the highest per capita income in the country.

In its heyday, there were over 80,000 UAW members who lived and worked in Flint and Genesee county. And now there are about 6,000. When General Motors left Flint, it devastated the economy and never quite recovered.

Flint makes most lists of whatever bad things were being measured. We're usually in the top two or three for sizes of our city on the FBI's list of murders. We usually hit the top of any kind of economic or poverty indicators, worst places to raise kids, those kind of things. So Flint certainly had its troubles before the water crisis. And that just further devastated the community.

We're about five years into that now, just starting to see a little bit of the sunlight. And then this hit. So Genesee Health System was at the beginning of the water crisis. So we have that as an experience to kind of rely on. And we knew that going through that, whatever we were going to do, we had to do it quick and do it big. And so when this first started, talking about what was going to close and social distancing, we took pretty early action and sent everybody home to do remote and telehealth. We've been doing a bit of that, but not on the scale that we did.

So we sent pretty much everybody home. We have about 500 employees. And currently, we have about 330 clinical staff doing some form of telehealth. They're using Zoom quite a bit. We have a couple of text apps that many of you probably use. We have a skeletal crew in a couple of our larger buildings, mostly psychiatrists and nurse practitioners who are doing injections. We have a couple of nurses that are going out in the community in full PPE to do injections for individuals that can't get out or don't have the transportation.

Other than that, pretty much, our buildings are still on lockdown. The congregate programs, of course, are not meeting. I'm sure you're in the same place. And we're working on when things do get back to normal, whatever that will be, will those programs ever actually be able to resume? So we're working on plans to try and do something related to that. The reports from staff on how things are going-- and I try and get as much input as I can from the front line-- all in all, it seems to be going well.

I think probably like you, the high performers are doing great. The individuals that kind of struggled with the job before are still struggling. The telehealth and the working remotely hasn't made a lot of that easier for them. Supervisors are spending more time with those individuals. And the staff that get it, they just get it. It works well. And a lot of them report that their consumers are doing fine.

They were very concerned initially that they're not going to see them, the face to face. We all think we need that face to face contact. And a lot of the clinical staff have been kind of surprised that-- I think they're a little bit taken aback by, sometimes that face to face maybe isn't quite as necessary as we think it is. They're doing fine with the telehealth. And they really do hope that is able to continue.

One of the other things we do, we also have a federally qualified health center as part of our organization. So we are doing COVID testing also on a mobile basis. We have a couple of vans that staff go in-- right now we're doing group homes, assisted living, and some of the larger homeless shelters in the area, since those are some of the hot spots in our particular county, and the state has designated those as high priorities.

So we have a couple of nurses, from the mental health side and the health center side, and one physician that are going out and doing testing in group homes for both consumers and staff. And that has just started, and it's going fairly well. I have not had any real concerns with that yet. The medical part of it is probably the easiest. The back office paperwork and test results is the more complicated issue.

So overall, I'd say things are not bad. We've only had two staff that have been tested positive. And both of those exposures were done in social situations outside of work. We contract with about 115 group homes. And early on, we provided PPE to all of them, enough for their staff. And we've only had-- and I

say only, of course, any death is tragic, but looking at the numbers that we deal with, we've had four consumer deaths and one staff death in our residential network. And that's out of 900 consumers and several thousand staff.

So it's tragic, but it is not as bad as it could have been. So we think that by taking action early, we were able to stave off a lot of this. And we're going to continue, as long as the state is cooperating and the codes are cooperating, things that we can bill. We will probably return very slowly to what things were like before. So I don't know what they were going to be like in the future, but I think it will obviously be very different.

We're currently under a governor's order for stay-at-home until May 15th. We don't think that's going to get renewed, so things are kind of looking like they're going to reopen May 18. And we're working on transition plans back to the workplace. And it is going to be very slow and very measured. We have probably a lot of staff that I'm not sure how much they're going to come back because they're doing as good of work. And they're actually more productive now than they were when they were in the office.

So that's where we are. That's probably different from a lot of you. This was something that none of us ever trained for. We didn't learn about this stuff. And again, I think the only advantage that we had was going through the Flint water crisis prior to the COVID pandemic. I think that is pretty much my summary right now. I'd be happy to take questions or we can move on.

JEFF: I don't know if there's any questions in the chat box. But you're talking about the telehealth, Dan. And is that a system that you had? Did you have the infrastructure for that prior to COVID or did you have to procure that? If you could walk us through that process, that would be helpful.

DAN RUSSELL: We had a little bit of that in place, probably like a lot of places. We purchased laptops and phones for everybody that we could. We were fortunate enough to have the funds to do that. So we got orders in early, because towards the end of that process, it became pretty hard to get some of the hardware because of the demands. But we were able to get everybody who needed the hardware.

And then we just did on-site training for telehealth training. There were a lot of good webinars. We had a couple of staff that had pretty extensive experience in doing telehealth therapy. And they were able to train staff and supervisors on some of the details of that. And I think staff, again, the staff that got it, got it fairly quickly and are doing well. And then there are still those that are going to struggle with it.

JEFF: We did have a question from Lisa. It says, "are peer support specialists or recovery coaches still offering services? If so, what does this look like?"

DAN RUSSELL: They're doing telehealth also. But yeah, we have a fairly large peer support program in Michigan. We have, oh, I think 12 or 15. And they are doing the same thing that they were doing before through telehealth. Their supervisor set them up. And that also seems to be going fairly well.

JEFF: And then in terms of other services, I know that you've offered, in terms of maybe some family support, obviously to the individuals or other community members. Are those services still being delivered via telehealth as well?

DAN RUSSELL: Everything's pretty much telehealth. The only thing is not telehealth at this point is injections. We are still screening new referrals. We do have walk-ins. Our building is open for a limited number of hours, our new building. And we do get some foot traffic. And what happens when somebody comes to the door, they are screened. They have this series of questions that are asked. Their temperature is taken.

And they are escorted to a room with a telephone and a computer. And they talk to an access therapist down the hall who is also in a room by themselves. That gets a little awkward sometimes because in crisis, you want to talk to somebody. But we haven't really had any problems with the explanation about why we were doing it this way and that they're going to get all the services that they normally would. And everybody seemed pretty accepting of that.

JEFF: OK, great. So you had mentioned-- and this is a question from an anonymous attendee-- that you've spoken about employees in terms of being more productive at home. Any sense of what makes them more productive, or is it something you're able to measure? Is it sort of anecdotal?

DAN RUSSELL: I think the numbers are looking good. That just, when I say, well, they're more productive, overall productivity seems to be fine. I think the people who are more productive are going to be your kind of high performers anyway. And they have just fell into the, I don't have to commute, I don't have to travel for home visits, and I can sit here and be comfortable and have as much contact and more contact with my consumers.

In fact, we had to put out a thing, an email to everybody saying, just because you can, we don't expect you to be in front of your computer eight hours a day. You weren't doing that when you were in the office. You had breaks. You had to do home visits. You had to travel. All of that's taken away, so we don't expect that time to be added into your productivity time. People were actually relieved to hear that.

The conscientious ones, as most of the staff are, would say, "well, I've got all this time, I should be sitting in front of my computer." And people were getting pretty overwhelmed and pretty burned out by doing that. And we just had to say, lighten up a little bit and go walk the dog. This is unusual. We're all under

new norms here, so give yourself a break and make sure you take care of yourself.

JEFF: So as a sort of follow-up question, we had a question from Jim Wise. How do your staff communicate privacy to end users when doing a telehealth session. Keeping others out of the room during the session, for example, how do you maintain that privacy?

DAN RUSSELL: If it's telehealth, you don't really know what's on the other end, what they're doing. Individual or our staff, our supervisors are always emphasizing, don't forget, you need to be private. You need to be confidential. Try and keep everybody out of the room. Find a space where you can go. And depending on your situation, that can be easy or harder. And I think we just encourage staff to do as much as they can with that, knowing that it's probably not going to be perfect all the time.

JEFF: Sort of along those lines, I'm wondering, you've had group sessions previously at Genessee. Are those groups conducted virtually? Have you all shifted to individual sessions?

DAN RUSSELL: We're just starting to try and do that virtually, but they've gone to individual up to now.

JEFF: OK. Has the average length of sessions changed at all, that your staff are doing?

DAN RUSSELL: They've probably getting shorter. Early on, before the state loosened up some telehealth codes-- and I would be remiss if I didn't give a shout-out to Michigan Department of Health and Human Services for really working quickly and very collaboratively to give us the billing codes and the encounter codes in order to do what we're doing. Early on, since everything's billing in 15 minute sessions, data usage was an issue. Because consumers wanted to conserve those minutes and our staff needed to get to that 15 in order to get that session in. And then the state loosened that up, which was a tremendous help. So I think sessions are probably a little shorter and more focused than they were in the face to face world.

JEFF: So that's something we have heard about, is the minutes that some of the consumers might have and obviously wanting to be judicious with them. Has there been any solution that you've identified to try to help expand those minutes or work with anybody?

DAN RUSSELL: In our weekly call with the state, that's probably the number one concern that everybody has, as far as, what do you need. And the ask is always, we need more minutes for our consumers so they can take full advantage of the sessions. There hasn't been a great answer yet, like I said, other than the state loosened up on the telehealth billing requirements.

There is a lot of telehealth money out there now. And we have applied for a couple of grants that actually provide hardware and minutes to individuals who are getting service. So hopefully there is more of that available. Because that is a real concern and I think that will continue to be a concern going forward.

JEFF: So I'm just being mindful of the time right now. I know we have a couple of questions that folks put forward. One of them I think really segues nicely into the next presentation. And I think then, at the end, the questions that we didn't answer, that we'll get back to them in the end and kind of go over them. But I want to make sure that, Kwame, in terms of your part of the presentation, go ahead.

KWAME: So I'm going to introduce Rosecrance. And Rosecrance is a national leader in addiction and behavioral health. And they're here to share some of their COVID-19 related initiatives for staff wellness. I'm going to start by introducing David Gomel. And David is the president and chief operating officer for Rosecrance. And he's been at Rosecrance for 25 years. Dr. Gomel also served on a number of local, state, and national behavioral health committees, nonprofit boards, and trade organizations. And he also the past chair of the Illinois Association for Behavioral Health.

Now I'm going to introduce Dr. Thomas Wright. And he's the chief medical officer and senior vice president of medical affairs. Dr. Wright oversees all medical operations for Rosecrance. And Dr. Wright has over 20 years of experience in the field and is certified as a child and adolescent psychiatrist. He's also certified in addiction medicine.

And lastly on your team is a Judith Jobe. And Judith is the executive vice president and chief administrative officer for their team. Judy directs and coordinates all activities related through organizational development and compliance. Judy has also served on numerous state and national boards. So I'm going to segue. And Dave, I'll pass the mic to you.

DAVID GOMEL: Yeah, thanks, Kwame. I appreciate you memorizing all that about our teams. That was really judicious of you. And thanks everyone for tuning in and hearing some of our story. I know all of your stories are very similar to some of the challenge that we have. And thanks to the ATTC and SAMHSA for asking us to share a piece. And we look forward to learning from you as well.

Just a little background about Rosecrance, we're located in Rockford, Illinois, which is in the very top center part of Illinois and Wisconsin border. And we're almost 105 years old, a nonprofit, about 1,200 employees and 60 locations throughout Illinois, Wisconsin, and Iowa.

We are pretty committed to our focus. It's mental health and substance use. And as things relate to mental health and substance abuse, we will treat that.

But we say we want to keep it as simple as possible and be the best in the world at what our mission is. And so we have residential and recovery homes, detox, MAT for substance abuse outpatient care. We also have a large community of mental health contingency within our spectrum of services, and then traditional counseling clinics-- worried well, as some call them. So we kind of run the gamut.

Our funding is half state funding and grants and then half commercial insurance. So we're serving people from all over the world at some of our sites. And simultaneously, we literally have path teams looking under bridges for people suffering from homelessness and schizophrenia. So it's a pretty diverse company. All told, about 530 beds, hundreds of outpatient groups, and we serve about 50,000 clients in there.

So I think it was right around March 10, and Illinois and Iowa, where most of our locations are, had 23 COVID cases. And I suggested that we bring some of our key leaders together via Webex at the time-- we've been using the system for some time-- to talk about this coronavirus and what its impact may be. And after we met and started some preliminary plans, I said, boy, you guys, this might be a big deal. Maybe we should meet every couple weeks to discuss. And it shows you why I invited Tom and Judy to the call, because Dr. Wright quickly said, "how about every couple of days, Dave, until we can see really what the impact is going to be?" Obviously, we learned very quickly what was going to happen.

And this group of leaders met every day, seven days a week for almost five hours each day over the first few weeks of the pandemic, to identify, what is our next step. We broke this into four groups. Operations, clinical care, we have a mission to serve and we're an essential service. We're going to keep providing that care to our clients. Human resources, because if we don't have our team members, our employees, then we're not going to be able to serve our mission. Infection control quickly became a very large piece of our conversation.

And then a little surprising to me was communications. And not just external communications, web sites, all the e-blasts that you get in your inbox like I do, but more internal communications. Being so spread out throughout the state of Illinois from Chicago to central Illinois, Madison, Milwaukee, and then Iowa, from either corner of Iowa, how we're communicating our message to our employees became very important. We quickly had to add IT to this group and fiscal, all the impact.

Like you all, I'm sure, this is hurting us. We're estimating a loss of about \$2 million a month in revenues right now because of COVID. So how we plan on responding was really important from the fiscal standpoint. To date, we have not laid an employee off. We're very proud to say that our board is committed to that impact also.

We had a mantra. We're going to keep our team safe and we're going to keep serving our mission. And we've been very consistent with that messaging throughout. So I've asked Dr. Wright and Judy to join and really get into some of the details about how we've taken care of our employees, I think is our side of the focus here, Kwame. And I don't know, Tom or Judy, who's going first, but jump on in.

KWAME: David, really quickly, before we segue, there is a question. This comes from Rita Ford. She states, our staff are struggling with motivation to continue with work. Staff are feeling isolated working remotely. How do you deal with home life and children and remote school, work time, et cetera?

DAVID GOMEL: Yeah, and Rita, that's a great question. And I know Judy's going to touch on some of that also in her transition, so why don't we start there, Kwama, if it's OK.

KWAME: Yes, sir, absolutely.

JUDITH JOBE: Sure, we can jump right in. When we think about it, we have a tale of two workforces. We have the workforce that is in all of our residential. They continue to work. Their daily duties are remaining much the same but more intense because we have to do all of this special management to make sure everybody stays healthy and are safe. And then we have the tale of the force that all of a sudden, they exited work.

And for our company, we had just started an alternate schedule. We were going to go three days on, two days off, and the next week, alternate that. And we didn't even hardly get it out the door, and we immediately switched to, we're moving everybody to home. And so we had 400 employees that we moved within five days. And they moved from being in the office to being at home.

And so we had to do equipment, practices, policies. We had to change everything. We had to, I think as Dan has talked about, help our clinicians understand what the environment needed to be like in order to engage in telehealth. And so we did all of that.

And one of the things, I just hot-off-the-press got a survey. We surveyed our 400 people. And we had about a 70% response rate from it. And coincidentally, 70% of them really like working from home. But the things that they identified that were tough for them were some of the internet connections, so some of their own internet, some was on the Rosecrance side, and then just getting all of that together. So we had our IT staff available pretty much 24/7 for about 10 days running just to get everybody up and going.

The other thing they talked about was social isolation. And when we think about that, this is our business, connecting people. But we had to provide—

and our staff education department was instrumental in getting us up-to-date information, tips, strategies, best practices to implement. So the clinical staff did a pretty good job with that. The group that kind of struggled a little bit were those of us that were used to being in the office, being able to walk down the hall, get our questions answered, and have that immediate type response.

Well, one of the first things we did was send out a communication and we helped them structure what the day should look like. Like initially, let's get a check-in first thing in the morning, make sure everybody's got their IT up and rolling. Make sure they know what the goals are for the day and connect with everybody. And then we eventually moved that-- and every team operates that a little bit differently. But they check in at least three or four times a week. Some teams check in every day because there's that much fluidity to what they're doing.

And then we came up with, hey, this is great, we're doing work, but we also enjoyed some of the socializing that happens at work. And we, as a leadership, had to recognize that there are going to be dogs in the room. There are going to be kids who come in and need a hug or need to do something with their mom or their dad. And so we quickly had to give permission that that's going to be OK. When we were probably traditionally a little more formal company, one of the first things we did as leadership was recognize that we had to change what we were doing and make it OK.

And so then we started this, what does my workspace look like? And then everybody shared pictures of their workspace. And different groups created different mimes. And some groups, we have a whole bunch of activities that people did from remote. And they have to do with virtual bingo, virtual team building. They created a scavenger hunt for your house. People had so many minutes to run around their house and grab these things and come in front. And so that has been very helpful in putting those practices in place and talking with them.

And of course, we, like everybody else, has to make sure that our business continues. And so we do have some focus on what we call key performance indicators. But that really isn't the essence of it. And we also had to make sure that we talked with our employees about how they were making sure they understood that we have an EAP, what are the wellness things that you can do, connecting with others.

We even talked about, hey, let's get together outside of our company's time and just do a social interaction. And I just had one with the team that I work with. And we work together all week, but Friday night, we got together. And it was like about an hour and a half past, and it was like, oh, my gosh, we got to get going. We all miss that time together, and so really building in that has been instrumental for our teams. I think the other tale of the workforce is those that are continuing to work and come to work.

So things that we did there, many of them are residential sites. So we have to feed our clients, and so we made sure that our staff all had food, free meals from our place. And then we also developed this whole camaraderie and how can we give special meals to people. And so we had Uber come and deliver something or one of the other groups came and delivered things. We wanted to make sure that our frontline staff understood, one, that we recognized them and that we were appreciative of the time that they spent there and how they put themselves at risk to make sure that our clients remain safe. And they have done a wonderful job with that, and I know Tom will talk about that.

So when we talked about communications, we had to make sure we didn't overload one way or the other. Those that were working were wistful, like I would like to be home and not have this part of my job. And some of the people that were at home missed some of that social interaction. So it was really important that we built that up.

From a benefit standpoint, if I could just jump back to that for a minute, we did a couple of things to help ease some of this for our employees. Because we had a very aggressive employee monitoring program. And we stuck with the CDC guidelines and had staff checking in before they worked. But one of the things we did for benefits is, our board of directors allowed us to offer 40 hours of PTO negatively for every employee. And so when we did that, that lightened up that, oh, I have to be there. It's more like, well, I can have 40 hours now.

And we've had three pay periods since we've begun this. And we had 183 people who participated in that and about 2,041 hours. So we know that this was an important something for our employees. The other thing we did is we loosened up the medical restrictions. Usually, when you're talking about an FMLA, you have to have a medical release. We said, if it's COVID related, we don't need a medical release. We're going to go with the guidelines, 14 days or 7 days, depending on what it is.

And the other thing we did was, again, we looked at decreasing the time that they could ask access their short-term disability. So for those who did have COVID, that it went from seven days to five days. So again, the five days kind of lined up with the 40 hours of paid time off, and then you could immediately access your short-term disability.

So I think right away our employees knew that we were thinking about them and that we put some packages together that were going to help them maintain their income while they were sick. So those are some of the things I think that we did. And we also had small gifts that we gave the people who were here. We have Rosecrance pens, so we gave them out and said, thank you for being de-pen-dable. So little things like that, it made people smile.

JEANNE PULVERMACHER: Judy, we lost your sound. Can you hear me, Judy?

THOMAS WRIGHT: I'll text her.

JEANNE PULVERMACHER: OK, yeah, we can't hear her sound, unless I'm the only one that can't hear her.

DAVID GOMEL: Judy, we lost you. I don't know if you want to transition to Dr. Wright.

THOMAS WRIGHT: I texted her. I can go ahead and start, and she can finish up then if she gets her sound back if that's OK.

JEANNE PULVERMACHER: Sounds good.

THOMAS WRIGHT: So I'm Dr. Wright. And I was in charge of the staff infection control response to it. At Rosecrance, as Dave said, we have 530 residential beds and a lot of outpatients. But because of residential beds, we're sort of aware of infection control issues and we have to monitor that and sort of respond to that, largely every winter for influenza. And so in late January, myself and the director of nursing got together with the infection control nurses at our different sites, just to talk about where we were at for influenza, sort of this topic of what was happening.

Wuhan came up. And sort of jokingly-- we had a new nurse manager at one of our largest sites. And she had ordered PPE for us and thought she had ordered 600 surgical masks, about two boxes. She had accidentally ordered 10 cases, so we actually had 6,000. We started joking about that. Oh, now, we'll be prepared for it. Little did we know that's only still a drop in the bucket.

But we were sort of amused by how many extra masks we might have at that point, we appreciate her pre-thought with that too. So as Dave said, we started responding to this in early March. And I sort of divided up my presentation into some prevention things we did, some management of illness, and then management of positive or presumed positive patients. So I'll talk a little bit about each one.

One of the things we did early on to prevent is that we started screening staff and patients for illness. We actually just redid both of our screening instruments now based on the six new criteria for COVID that has come out over the last week. Although I struggle with two of them, which seems odd. And Kwame's a doctor, too, and he'll understand it. How do you get chills-- there are two separate symptoms-- chills, and then chills with shaking. To me, they're the same thing. I don't know how you get chills without shaking.

But we managed to put that into our staff screening, as well as the patient screening device too. We began screening every client as they called in for an inquiry or assessment about illness, as well as service travel at that point of time. We began increased cleaning and sanitation at all facilities. We invested

last year in a device called the Clorox 360, which does extra deep cleaning, and I think we're pretty happy that we have.

We've always done a really good job with that. And I think that's why, even when we've had minor outbreaks of influenza or rotavirus at any of our sites, we've always managed to contain that to one or two rooms. It doesn't spread throughout the facilities. I think part of the reason is we're pretty good at all these sanitation issues.

We addressed things at our food service, such as increasing the number of individually wrapped food. We took away the salad bar because people didn't respect it, many times there. We reduced the sizes of our units and groups in a way to be able to allow better social distancing. That was sort of individualized in some ways based on a site and the size of space that they might have.

And as Judy said, we moved many staff to work from home. We also had been doing a lot of telepsychiatry already, so we actually moved virtually all of our psychiatrists and psychiatric mental health nurse practitioners to telehealth, just because they didn't necessarily need to be there to do it. We developed a staggered admission process so that families did not overlap in the admitting area. We actually tried it at 60 minutes. It was a little too much. Family started overlapping. We moved it to 90 and that seems very good.

We extended our admitting times during the day. Although we'll take somebody 24/7, generally, they usually come in within a 12-hour span, and so we widened that a little bit more. Like everybody else, we began quickly looking for more PPE. And as most of you know, it wasn't available in the beginning. We ran out of sanitizer very quickly.

Along with it, we got lucky somehow and a friend of Rosecrance contacted Dave and had these 55 gallon drums of sanitizer, which we've never bought before. We just weren't sure how to distribute it. And our environmental services people quickly developed a plan about how to distribute using a 55 gallon drum, and now we have plenty of sanitizer.

One of the things we were seeing on our adolescent unit in particular, was not understanding what this was or why it was affecting them. So we began an educational group that we did each of the separate units what a virus is, what a bacteria is, what terms out, how is this virus different, why are people reacting so much. Kids were getting anxious about it, and our adults were too.

So since they don't have as much access to the news and the 24/7 cable news that we have, we developed an initial group and then ongoing groups to talk about the status of where we're at in this pandemic. That seemed to decrease anxiety a great deal. One of the real benefits to that was they stopped having anxiety about that and they were able to pay attention why

they were, managing their mental illness or their substance abuse treatment again too. So that was a pretty helpful intervention we did.

But some of the ways we managed sickness after they were admitted is, once we did get enough surgical masks, we started using masks for everyone. We were able to get some of the homemade masks. We have a lot of supporters of Rosecrance in Iowa, Wisconsin, and Illinois, and they started sending in some local-made cloth masks. So we started using that with all staff and clients and developed a SOP, a process to launder them every night and to distribute them back to them. Now we have enough surgical masks that we have received. And we're confident about receiving enough to be able to maintain using surgical masks and then dispose of them daily.

We're screening clients like everyone, with temperatures and then symptom screening every day. What we've done so far is, if someone does trigger our temperature or our fever protocol or screening questions in terms of a client, as long as it's not a cluster in a particular unit, then we evaluate them for being able to send them safely home for the duration of the illness. And so far we've been able to do that. A couple of them have come back as positive, but we've not had any outbreaks or any other infections as a result of that. And that's worked out pretty well for us. And it looks like about 70% of the clients that we have sent home were until their illnesses passed have come back into treatment too.

One we had to send home for-- it was kind of funny. We really wanted to be back. He was a little 16-year-old. He wanted to be back in treatment so bad. He actually had 100.2 when he came in. And we were going to send him back home again just for another couple of days. But he wanted to come back in so bad, he went to the bathroom and threw cold water on his face so that his temperature ended up being a little bit cooler later on. So they do want to come back in treatment and we really appreciate that about them.

Like most places that have residential facilities, we did plan for some isolation rooms. So if people were ill and before they could go home or manage otherwise, we would not necessarily-- it was sort of a floating isolation room. We kept the patient in the room that they were in, the one that triggered the fever stuff, and moved the other people out. We thought that was better than picking them up and moving them and eventually infecting another room.

We have instituted a PPE process for everyone. Largely, our nurses are the ones that have contact with these patients. And their wearing full PPE, including masks, gowns, face shields, when they do have to come in close contact with the patients. Largely, that's not very often, mostly just to do nasal swabs. That's what's appropriate with it. And luckily, we haven't had to manage a cluster in any particular group, but we do have a SOP for that. And largely, it is isolating them and then working with staff in order to make sure they get their food and what they need to take care of everything else.

Testing is a big question that sort of came up earlier before the seminar started with a group of us here too. We're pursuing testing also. We're probably lucky in Illinois in that our Illinois Department of Public Health has had access to a large number of tests. And they've opened about 40 sites across the state, including two in Rockford, which are our two biggest residential sites, that are drive-through sites.

And really, there is no barrier to coming there. You don't have to have illness or not have illness. You can just drive up. You don't have to have insurance. Or you can have insurance. It doesn't make any difference. They'll test anybody.

It's a self-swab. It's just a nasal swab versus the nasopharyngeal that we used to have to do. We actually have one site that does nasopharyngeal, ones that uses just the nasal swab. And then free of charge, they'll send it in. And they'll call us back or call the patient back with the results. So that's one thing we've been doing for about the last, is asking everybody that comes into residential to get a PCR test. That's sort of the gold standard.

What we would love is the Abbott Labs instant ECR test. Right now, it's available, but only used in hotspots. We do have access to that in our site in Sioux City, Iowa, our residential site in Sioux City, Iowa, through a hospital there, because Sioux City is a hotspot. And that's a hotspot because they've not had as much social distancing there. And that's a meatpacking area. So if it's not the fastest growing, it's one of the top 10 fastest growing sites of positive COVID patients right now. So we do have access through a hospital there also.

We are looking at antibody testing. And I probably know more about that as a psychiatrist than I probably should at this point of time. But as you know, antibody testing does not test for the presence of the virus. It tests for exposure. And Kwame can probably tell us a little bit more about this. But if there is a national emergency, the FDA is allowed to do what's called an emergency youth authorization.

And there is a number of antibody tests that have pursued that and have been approved for that through the FDA. The other ones are still selling it, but their approval is pending. So there's sort of, in my head, two different categories of it. Those that have been approved, EUA approved, are fast going off the market. We've, through purchasing, made some deals on some of those. But then they quickly, within days, come back and say, the governor of Iowa or the governor of Illinois has taken over these and so we can't sell those to you.

It is something we'd like, not as an exclusive test, but it's something that can be done in a very short amount of time at the admission time to get some idea of their exposure to COVID-19. Our plan is, if they do end up being positive with it-- and it sort of depends on your community, what percentage are going to be positive. But if they are positive for the antibody, then we send them for

the PCR testing and probably hold that admission until we got the results back. Right now, we're not holding any admissions at all. We'll just admit them with the PCR test and wait for the results of that.

Our other big question is, how long is this going to continue? And that's the \$1 million question for all of us right now. It's certainly become a way of life for us to understand screening and to understand illness and how to prevent it. I feel personally very proud of our staff. We have 1,200 employees and it's a lot of people to distribute information to. But I feel very proud of how quickly they react and how quickly they institute some of the processes that we put together in order to reduce the number of infections.

And knock on wood, we've only had a few staff come back as positive, and certainly no clusters and just a few patients. Most days we're operating just as we always have, focusing on mental health and substance abuse and not having to focus on it. Because it's become more of a way of life, how to manage infection control.

KWAME: Dr. Wright, I don't mean to interrupt. We're at the 10 minute marker here. So we just want to ask some additional questions. This question is for both Rosecrance and Genesee. Have you currently had to implement a productivity log, or do you foresee implementing it down the line?

DAVID GOMEL: Well, we have a lot of systems that track productivity closely. And we have loosened the standard. We use kind of that national standard that most CMHCs use. Our productivity in our community mental health line has diminished by about 30%. And that's where, honestly, I lost sleep last night thinking about some of our most vulnerable clients who are most at risk and we're serving them less. Our substance use clients in outpatient have declined about 7%. And I think it's just because they have a greater capacity to do things like we're doing right here.

And Dan talked about the minutes and things like that. So those that are at a reduced productivity level, we have three counselors in a group and each are running 60% productivity. And so we would combine the caseload into two, and then reallocate or reassign that third person to one of our other lines that we may need more help at. So we're a little more flexible than normal trying to make sure we accommodate these needs. Dan, do you have a comment?

DAN RUSSELL: We monitor the productivity. We do not have a strict productivity requirement. Supervisors stay on it. And if there are issues, they talk with the staff. But at this point, it is not a rigid requirement. And I think, like Dave said, in general, our productivity has gone down. We have seen spikes of people that really take to this modality of working and their productivity has increased. But overall, that is not the case.

KWAME: I have another question from Loni Tucker. So a two-part question-- first part is, how trusted is the data with these new pop-up testing sites? And

what are the setbacks in your efforts for shared ideas for provider services, leaders, and program developers? So that's the question. And then he has a statement. So Mr. Tucker would like to see, across the board, consistency with practices for those responsibilities in shaping a trusted delivery system of community-based services in areas of clinical and case management practice and mental and substance use disorders. Let me know if I need to go back and ask the question again.

DAVID GOMEL: I think, Dr. Wright, that first question was for you.

THOMAS WRIGHT: The pop-up sites I assume are the drive-through sites. I think there's a whole variety of how good they are or how reliable they are. We've been lucky in Illinois that the Illinois Department of Public Health has been sort of managing a lot of that. The PCR testing, the sensitivity and specificity in the beginning was pretty low. I was seeing some sensitivities of 60% or less. Now I think it's much better.

And I think we're seeing the same thing with the antibody testing, that there were some manufacturers that were just putting things out that really had some low sensitivity and specificity. We're looking pretty closely at the data for that before we rely on the antibody testing. But I do have to monitor that pretty closely. So there's no short answer, I would say. Look who's running it. Look what the tests are doing. Look at the sensitivity and specificity, and then make a judicious choice from that.

KWAME: We have another question here from Lisa Fockler. What recommendations do you have for increasing SBI screening in primary care settings to help with identifying an increase in substance use during isolation?

THOMAS WRIGHT: So as for screening, how to increase that-- I don't know if Dan is here using that very much. We usually use that through our hospital personnel. And I'm not sure that we've just changed in how we're doing it at all. Maybe Dave or Judy knows that. I think we're still doing it. We have what's called MCR staff in Illinois, mobile crisis response staff. And I know that they use that and they still are going out with proper PPE to hospitals and sites. I don't think they're increasing or decreasing. I think it's staying about the same.

DAN RUSSELL: Yeah, I think I would probably share the same thoughts as Dr. Wright. I don't know that it's increasing or decreasing right now.

KWAME: Judy, someone posed a question for you. Are you also seeing increased productivity among your clinicians?

JUDITH JOBE: I think as Dan has mentioned, there are some that have really embraced this and have done a good job of engaging with their clients. And so we see some increase with that. Others, the clientele that they're working with have some struggles with connectivity or some struggles with minutes in their cell phones, so a little bit different. We're kind of all over the place. And I

think as Dave mentioned, we really look at where most of the productivity is and try to move our staff around so that our clients get all of their needs met as much as we can.

KWAME: Judy, one more question for you. David Schilling asked if you would expand on your employee PTO measures.

JUDITH JOBE: Sure. Well, we have what we sometimes refer to as a bucket. And so all time goes into that bucket. And it doesn't matter why you are not here at work today, whether it's vacation time or personal time or sick time. And so we added to that time and we added 40 hours that people can go negative in their time. And so we front-loaded it in at the very beginning so people had access to that 40 hours from day one.

And as we said, our staff have been very, very welcoming of that. They understood that this was going to be a pandemic and we were going to all endure some illnesses. And I think our response was very good. And I think in the end, it really showed us to be concerned and compassionate with our employees, as well as with our clients.

DAVID GOMEL: Kwame what we didn't want was people to come to work sick. And if they didn't have enough PTO in their bank, their desire is, well, I can't go unpaid, I need it. So Judy and our board put this together, where essentially, you go into a deficit, into a bank, just to be sure that people stay home who are ill.

DAN RUSSELL: We did a similar thing. We have a system very similar probably like that to what Judy described. And early on, before a lot of the stay-home orders came out, we made available 40 hours for anybody who said that they were exhibiting symptoms. There obviously is a little bit of trust involved in that, but if staff say they're involving or that they have the symptoms, we said, you have 40 hours an additional 40 hours of PTO to take without dipping into your personal bank.

JEFF: Guys, I think we're cut off in the hour. And there's a couple of questions we didn't get to. And if our panelists are willing, we'll follow up with them, in terms of trying to get a few of the answers and can post and send them out along with the webinar. Thanks to the people who asked questions and participated. We like this to be an exchange of ideas.

As you see, there's not a presentation and it's just sort of having a dialogue, I think, with folks who are on the ground doing the work and where the rubber meets the road. So Judy, Dave, Dan, Tom, thank you very much. We really do appreciate your insights.

And if folks have other thoughts or suggestions on topics that we might have similar conversations with, please let us know in the chat box. We'll try to do our best to accommodate it. And just finally, I just want to say, I think we

heard about both the-- I don't want to say the soft side, but in a sense of really taking care of people's emotional health, in terms of building the camaraderie and making sure that we're connecting with our staff and keeping our team and resilience up, as well as in those really policy sort of issues that we can implement.

So it really is not an either/or, but it's a both/and. And I think we just really appreciate your thoughts across this continuum of care, that really can keep up those services that we're all in this for. So thanks again. And Jeanne, unless there's anything else, we'll probably sign off.

JEANNE PULVERMACHER: Yes, no, thank you to all the panelists. Thank you to Jeff and Kwame for helping to host. Again, we will answer the questions that we weren't able to and we will get those out to you. This presentation is recorded and it will be posted on our website. And we'll send out a message when that's ready, but give us a couple days. But otherwise, thank you to everyone. And stay safe and stay healthy out there. Thank you.

JEFF: Take care.

DAN RUSSELL: Thank you.

JUDITH JOBE: Thank you.

DAN RUSSELL: Goodbye.