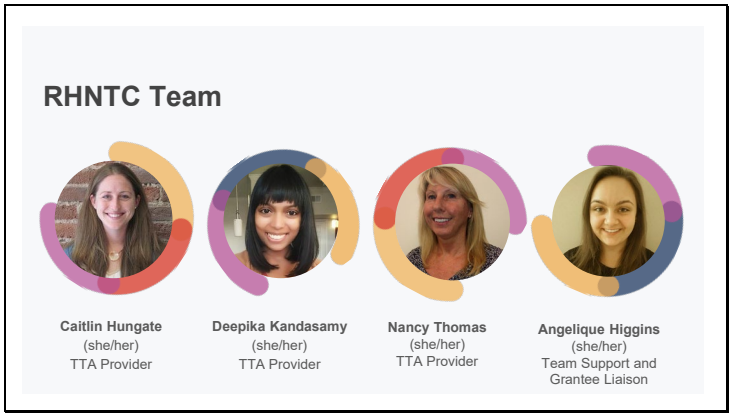
Increasing Access to Title X Through Telehealth: Lessons from the Field
February 24, 2022
Transcript

Slide 1

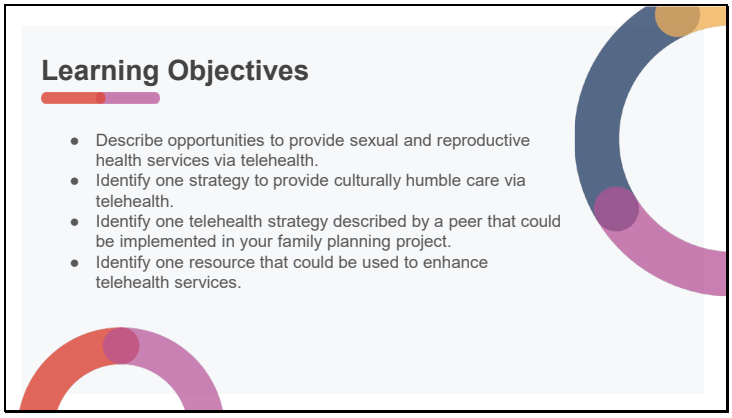
- [Caitlin] Hi everyone, this is Caitlin Hungate with the Reproductive Health National Training Center and I'm excited to welcome you all to today's webinar about increasing access to Title X through telehealth. I've a few announcements before we begin. Everyone on the webinar is muted, given the large number of participants. We plan to have some time after the virtual Roundtable for questions, and we received a lot of your wonderful questions during the registration. And while we will try to answer as many as we can, please know we may not get to every one. And you can use the chat icon at the bottom of your screen to chat in questions that you may have at any time during the conversation this afternoon. A recording of today's webinar along with a slide deck and transcript will be available on rhntc.org within the next few days. And your feedback is extremely important to us and it has enabled us at the RNHTC to make quality improvement in our work based on your comments. Please take a moment to open the evaluation link that will be in the chat shortly and consider completely the evaluation real time in our hour together. Please note that in order to obtain a certification of completion for attending this webinar, you must be logged in to rnhtc.org when you complete the evaluation. And last but not least, this presentation was supported by the Office of Population Affairs, OPA, and its contents are solely the responsibility of the authors, and do not represent the official view of OPA, OWH, or HHS. Next slide please. Next slide.

Slide 2



And I am joined today in our virtual conversation with you all with other RHNTC colleagues, Deepika Kandasamy, Nancy Thomas and Angelique Higgins. To maximize your viewing for our conversation, feel free to click on the view, and do side by side gallery so you can see all of us in our conversation with you all.

Slide 3



Today's learning objectives are on the slide on the screen and in our time together this hour, we'll hear from Title X grantees and clinical service providers to dig into these topics. We'll also have the opportunity to hear from an expert from the Northeast Telehealth Resource Center. And without ado, I'll turn it over to my colleague Deepika.

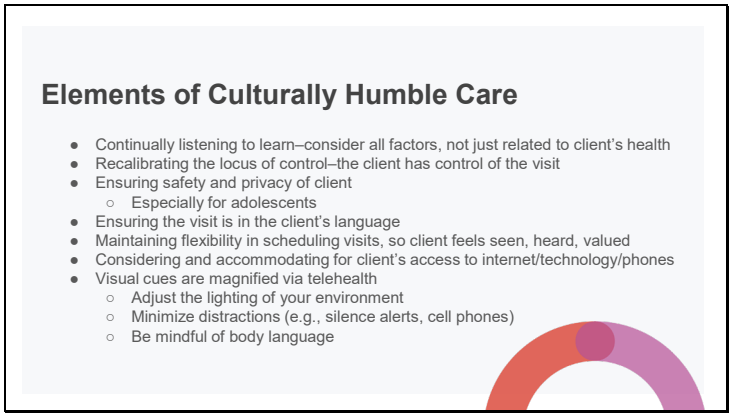
Slide 4

- [Deepika] Thank you, Caitlin. Yeah so today's webinar is a culmination of a 5-month peer learning group, which focused on increasing access to Title X family planning services via telehealth. During our time together, we covered the topics on the screen with 11 grantee participant teams. And today's Roundtable features the peer experts we engaged during the peer learning group and two grantees and their teams who have been implementing and have been improving their implementation of telehealth services. We brought in a variety of voices to ensure that we hear different perspectives, approaches, and strategies to telehealth communication. Next slide please.

Slide 5

So, as a grounding for the peer learning group, the 5 sessions incorporated the concept of cultural humility. So we often talk about cultural competency, but in truth, cultural humility is different and may better serve clients because one can never truly become competent in understanding another person's cultures and experiences. Humility is approaching clients with an open mind and a curious approach, and understanding that there will always be more to learn about others. And I'll pass back to Caitlin.

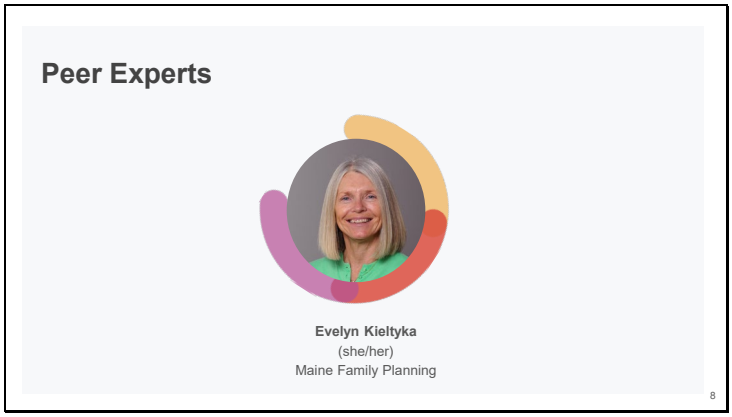
Slide 6


Elements of Culturally Humble Care
Continually listening to learn–consider all factors, not just related to client's health
Recalibrating the locus of control–the client has control of the visit
Ensuring safety and privacy of client
Especially for adolescents
Ensuring the visit is in the client's language
Maintaining flexibility in scheduling visits, so client feels seen, heard, valued
Considering and accommodating for client's access to internet/technology/phones
Visual cues are magnified via telehealth
Adjust the lighting of your environment
Minimize distractions (e.g., silence alerts, cell phones)
Be mindful of body language

Slide 7

- [Caitlin] Thank you, Deepika. And without further ado, let's dive into our discussion and hear from our peers. For the peer learning group, we had two peer experts who participated in each session. They have joined us today as well. And I'll turn it over to Evelyn Kieltyka to introduce yourself. Thanks, Evelyn.

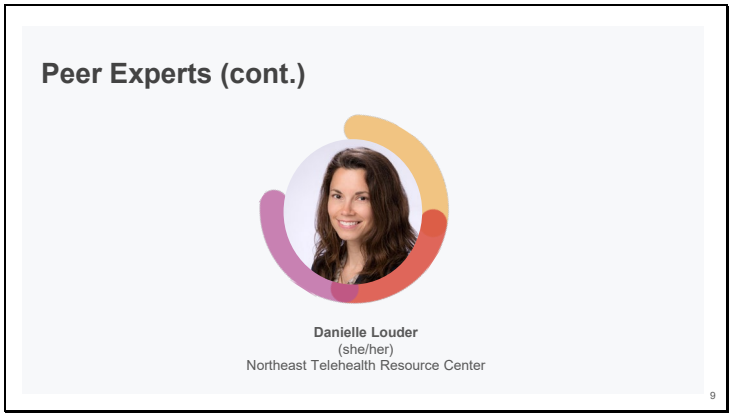
Slide 8



- [Evelyn] Hi, thank you very much, Caitlin. Good afternoon, everyone. It's a really pleasure to be with everyone, I'm seeing almost three younger people joining us, or 263 and counting. So I'm Evelyn Kieltyka. I'm the senior vice president of program services at Maine Family Planning. We are now back in Title X, yippee, as a dire needs grantee, but we have been providing Title X services for decades. We have 18 health centers, mostly in the more rural aspects of Maine, which is central Maine, if you're looking at central Maine, all the way to the Canadian border and all the way down east, as they call it to the other Canadian border, which is Nova Scotia and New Brunswick. So we started our journey in providing telehealth services in 2014. So in the good old days, as I might say, 'cause it's so much has changed and it's so much more accessible to all of us in terms of equipment and flexibility and platforms. So, and obviously with the pandemic, we've all really got our muscle memory going with telehealth services, so looking forward to being with all of you today.

- [Caitlin] Evelyn. And we are so honored with your partnership in this endeavor. I'll turn it over to Danielle. We were so excited for your partnership and collaboration as well. Danielle, I'll let you introduce yourself.

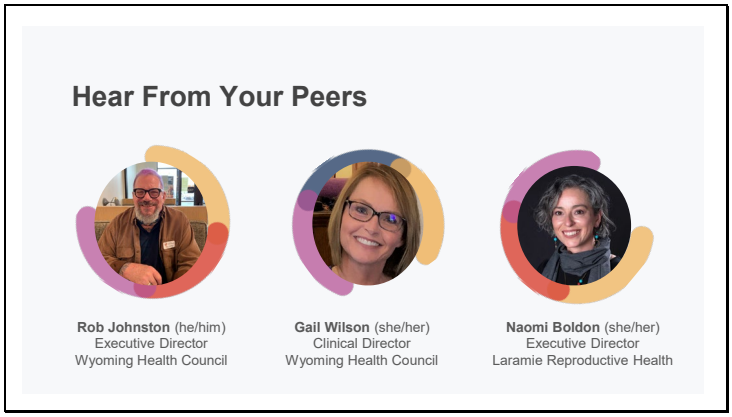
Slide 9



- [Danielle] Thank you, Caitlin. And thanks to everyone for being here with us today. It's been such a privilege to be part of this peer learning group, and now this culmination with all of you joining us. So as Caitlin mentioned, my name is Danielle Louder and I serve as the director of the Northeast Telehealth Resource Center. We are federally funded through HRSA's office for the advancement of telehealth and have been serving as the TRC for the Northeast, which includes the six new England states and New York for about a decade now. And as you might imagine, over these past couple of years with the COVID-19 pandemic, everybody wanted to be doing telehealth yesterday. So the volume of our services was needed quickly. And it's just been an amazing time, if there's one or two silver linings from COVID 19, it has been the absolute explosion of telehealth, as Evelyn mentioned, there's been so much more opportunity and there have been some pretty key barriers that have been decreased, and so anyway, as a TRC, it's been in a very exciting time and extremely busy time. And so we are one of 12 regional TRCs and we'll share some resources about how you can reach out and work with yours if you haven't already. So thank you very much.

- [Caitlin] Thank you, Danielle and Evelyn. So now we're going to into your peers and I'd like to start off by introducing Wyoming. So Wyoming, would you go ahead and jump in and talk?

Slide 10

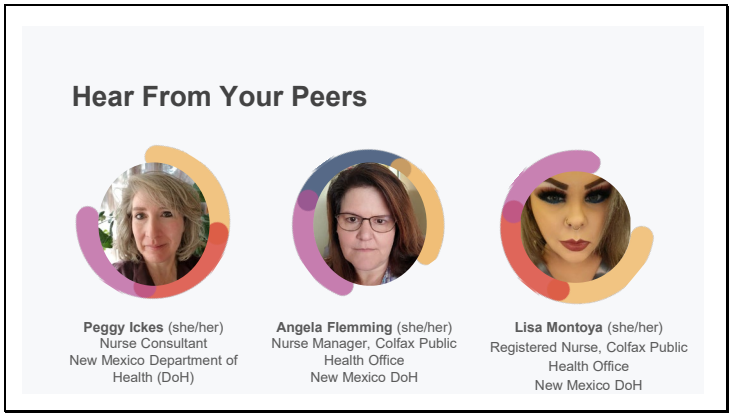


- [Rob] So, hi, I'm Rob Johnson. I'm the executive director of Wyoming Health Council, and we provide services at 11 sites through eight sub-recipients across the state of Wyoming, We have various sites where we really don't have any services. And so we've looked at the feasibility of using telehealth to increase our outreach in those sections of the state. Gail is our clinical director, and Naomi is our executive director. One of our programs, Laramie Reproductive Health. The three of us participated in the seminar where I think we learned a lot. To be honest, I think we're pretty early in the process. So when I heard Evelyn talk about starting in 2014 or whatever I'm going, no. We're still struggling with how do we incorporate this in a way that is meaningful in our community. So I'm glad we can join you all today. Thank you. Gail and Naomi, you want to say anything?

- [Naomi] I'll just introduce myself, so everyone knows a little bit about our clinic too. So like Rob said, my name is Naomi Boldon and I'm the executive director at Laramie Reproductive Health. We have a 51-year history as being family planning clinic. And we also, we're in Laramie, Wyoming, which for those of you who aren't familiar, we're a little shy of three hours north of Denver. So we have very rural population. And Laramie also houses Wyoming's only university. So we're faced with some unique challenges because of that as well, when it comes to family planning in rural Wyoming. But we, I started at the clinic in March of 2020, and we implemented telehealth right away, after I had started, so we've definitely learned a lot along the way. I'm happy to be here today to share that with everyone, we continue to provide these services and yeah, just grateful for the opportunity to collaborate and to learn with everyone today. Thanks for being here.

- [Caitlin] Thank you, Wyoming team. Now I'm going to pass it on to New Mexico. If you could go ahead and introduce yourself.

Slide 11



- [Peg] Okay so my name is Peg Ickes, I'm a nurse practitioner and consultant with the New Mexico Department of Health Family Planning Program. And I'm here with my teammates Angela Flemming and Lisa Montoya, with the Raton/Colfax Public Health Office, they also cover Clayton as well. And they're my partners in crime with telehealth. So, a little bit about our services. We're the Title X grantee for New Mexico, I'm also lucky enough to be a provider in the public health offices as a part-time clinician. We have 43 health offices and 15 provider agreement sites providing services throughout New Mexico. For telehealth we focused on public health offices because they have a centralized electronic health record system, other centralized systems such as lab and pharmacy, which makes it ideal for telehealth. And we actually wrote our first telehealth protocol in 2017, little did we know it would be needed, but it was very basic at that time, we had just one type of visit, where the client was physically in person with a nurse at a public health office and the clinician was at another location at a public health office, and we used live video streaming. So we're wanting to expand those services and implement more. And Angela and Lisa, if you wanted to introduce yourselves.

- [Angela] I'm Angela Flemming, I'm the nurse manager of the Raton/Colfax public health office. We're very rural community right on the border of Colorado, so we're way out of the loop, so, telehealth is going to really help us and our community.

- [Lisa] Hi this is Lisa Montoya, I'm a registered nurse. We do Colfax county, Harding county, and Union county, so three rural areas, and fairly new at this, so it's been a learning experience and it's been very beneficial.

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- [Caitlin] All right, thank you so much, we're so happy that all of you could join us. So now let's jump straight into questions. So first of all, where do you see opportunities to offer sexual and reproductive

health services via telehealth, specific to your family planning settings, including specific opportunities to provide services to adolescents?

- [Evelyn] I think I take it first, right, Deepika? Yes, so, so we initially started out telehealth as a clinic to clinic model, we thought because as you might imagine, we have rural sites and having an MA or someone at one site, you can telehealth with another site, that really helped expand services that way. So that's originally how we started. But we've moved to, then we moved to direct to patient, and we were starting to do that before COVID hit as a way to, particularly reach out to young people. They're very, as we all know, they're very digitally savvy, they're natives to all of this. And talking to someone on a screen is not foreign to them. So it was very easy for us to reach out to them and I know we'll talk about some confidentiality issues later that we certainly addressed. But there other interesting thing I just want to, what we were doing before the pandemic is we were realizing that there are under-served populations that just for many reasons can't get to one of our health centers, so we brought out health center to them, and the reason it became to cost effective is we sent an MA to those particular agencies, we had MOUs with them, and that allowed us to meet with their clients to provide them with a host of family planning services based on their needs. And then they would telehealth back to our office with a nurse practitioner. So obviously it's not cost effective to send someone out to maybe see 3 or 4 patients, but sending an MA there and conducting that that way, so we've worked with substance use disorder treatment centers, homeless centers, places, DV centers, so again, offering those services to folks that are really in situations where it's difficult to get to our offices. I will say, I know there are a lot of disrupters out there right now, offering all hosts of telehealth services, and I will say, the one thing I'll tell all of your right now, that you have the bricks and mortar, and I can't tell you how important that is to giving patients confidence that should something that come up on a telehealth visit that they now need to be seen, they're an established patient, they can come in, you've already got their record, so it really expands your ability to reach hard to reach folks, but also have them be part of your family very quickly through a telehealth visit.

- [Caitlin] Thank you, Evelyn. Now I'm going to pass it over to New Mexico.

- [Peggy] So Evelyn, you're always to inspiring. So, although we started in 2017, so here we are 5 years later. We really also wanted to expand, the public health emergency allowed us to look at other types, modalities of doing telehealth. And so, we, for example added telephonic visits where it's an audio only visit, which really helped. New Mexico is a very rural frontier state, and so, access to services is a real barrier for our clients. So what we found through this is that, gosh, the more options we have available for clients, the better. It really gives them better access, more availability. Even things such as meeting clients where they are, limiting client travel to the public health office if it wasn't necessary. Providing clients with more autonomy over the type of visit, they get to choose what they're comfortable with and the kind of visit they want to have. Also increasing client access to services in a timelier manner. And staff shortages have been a concern, I think for everyone, and this really allowed us to utilize our clinic staff more efficiently, and in different locations.

And then Angela and Lisa, I think you had some experience with your population, adolescence, how it was valuable for them.

- [Angela] You're correct. Like Evelyn said, we have a lot of people that are used to using smart devices, Smartphones, so they feel very comfortable doing that. The challenges that we've faced is with teens, where they have trouble with transportation, or scheduling around school stuff or activities, after-school

activities, and confidentiality, so that's been very beneficial for us to get them seen, and with the proper medications that they need.

- [Peggy] Perfect, thank you. And I'll pass it over to Rob from Wyoming.

- [Rob] So I think one of the biggest challenges we've had in Wyoming is just our geography. We are so rural. We have two communities in the state with populations over 60,000 and that's it. And then our total state population is around 550,000. And so we have mountain ranges that intersect at various areas. We don't have a really robust highway system. We have maybe three interstates that crisscross the state. So it's been a challenge for us. And I think I'm going to defer to Naomi because I think Naomi has probably done more with telehealth than any of our other clinics, and so she's going to be able to address some of these questions much more explicitly than I would be, so, Naomi, if you're willing to go, go for it.

- [Naomi] Thanks Rob. I really just echo what everyone else had said. Peg's comments, Lisa's comments, we have definitely felt that as well. With the rural challenges, as Rob was saying that we face, it's also just basic internet access. And access to, if they have a cell phone, that's great, but do they have reception? 'cause it's really questionable throughout the state that we're in. Weather also plays a major role, being in a mountain range, it's really challenging as far as transportation is concerned. The level of poverty brings into those questions about, do they even have access to transportation? So we've definitely faced some challenges, and I really would just, I just echo what everyone else has said too about that.

- Thank you. All right, and so, Danielle on a high level, where do you see opportunities to integrate telehealth generally and in family planning based on your work with the Northeast Telehealth Resource Center?

[Danielle] Certainly have learned a lot at being part of this peer learning group, and there were some pretty strict limitations, for example with Medicare policy before the public health emergency and COVID. Well the door has been blown wide open with respect to different types of providers being able to use telehealth, telemedicine. Different services being allowed, and I wish I had a crystal ball and I could tell you exactly what that policy's going to look like after the PHE ends, although that can keeps getting kicked down the road. But I think it's become very clear that there are a lot of additional innovative use cases. We've had some real innovators for decades, for example, doing speech language pathology extremely effectively, if not more so effectively than in person, because they've kind of perfected the craft. But social determinants of health, and we take a very broad definition of telehealth, to include traditional telemedicine, that's provider to patient, peer to peer, like e-consult models. That's a huge utilization and people are seeing great benefits from that. And then for example, using telehealth, whether it's telephone or audio/video to sign clients and patients up for WIC, for Medicaid programs and then when they're able to address those issues, then they're much more able and open to dealing with their day to day healthcare issues, right? So it's this bigger, global impact that it's having and it's really nice to see. So correctional, many different use cases that we hadn't necessarily seen before, and with respect to reproductive health, certainly this team has been super innovative, and I see there's a comment in there, but STIs, STDs, absolutely, that's a great use case. Specific components of that. Contraception, pre-natal care, some limited applications, like OBs, psychiatry, men's sexual health, care for sexual assault victims, we've helped programs develop TeleSANE or the Sexual Assault Nurse Examiner programs, we've helped folks adapt that program, whether it's the preceptorship that has to

happen to get folks certified as a SAEN, and/or to actually do the evals in the middle of the night, typically, right? So amazing use cases and innovation among folks with use of telehealth. So.

- [Caitlin] Thanks so much, Danielle. So Evelyn, my next question is to you, and I'm going to look in the chat to integrate that as well. So we often hear workflow is a challenge for family planning agencies integrating telehealth visits and services. Can you describe what your telehealth workflow looks like? And if you can also integrate STD, HIV testing in your answer to reflect the question in the chat, that would be most helpful.

- [Danielle] Yes. So workflow is always a challenge because whenever introduce a new sort of way of not coming into the bricks and mortar. So we just developed basically algorithms, and patients can come into our system in a variety of ways for tele, they can call our call center or they can click on our website and say, I want virtual visit. And it will walk them through the virtual visits that we have available. And then they can then self, if they answer yes to all the questions, then they can set up a telehealth visit. So they don't have any complications. So say if they want an uncomplicated UTI visit, there's a certain algorithm that we take them through that suggests that they are appropriate for a telehealth visit. The call center has the same sort of list, they will sort of select, based on how they're asking questions, they will then offer, this visit could be done through telehealth, it sounds like you want a birth control, pill, patch, ring, restart, or a renewal or a new patient. They'll take them through an algorithm, and that will say then you have these two options for a visit. And then the patient, again, being patient-centered, they select. And we've heard things like, oh, that's great, I don't have to find a babysitter. It's more private because first many folks it's interesting, even just, if you have a health center that's in a very visible location in a small town, just parking your car in our parking lot might be a problem for some patients, as we know, and that's not just adolescents, but people that are in domestic violence situations and got a very controlling partner. So we've found that that has been a nice way to expand options to patients, but the key is workflow and working with your, and what works for your staff, 'cause staff, some like the algorithms, other staff want to list in terms of when they get into our workflow, they're always picked up by an MA first and then screened and then seen by the provider, so we've done that. Regarding STD services, back in the height of the pandemic, and we know STDs have just gone, particularly chlamydia and gonorrhea have gone through the roof. We developed a process where we would mail them the Aptima, that's the test we use, which I think most folks do. And they collect their urine because it is a self collection, so we determined based on going back and forth, that that was certainly, we weren't running into any QC problems because we gave very clear instructions, but they did have to bring the sample back to our office to drop it off. We weren't allowing them to mail it back. It just didn't work for lots of different reasons. So that's how we addressed STD services. And then we run the sample and then connect with the patient over the phone or through a tele visit to kind of give them the results. So that was helpful. Now, typically those are folks that are asymptomatic. So we have a lot of folks that say, I'm in a new relationship, I want to get screened, I'm not having and symptoms. If they were symptomatic, we really would want to bring them in, as you all would want to do that. But that did help us with some of the getting over some of those barriers.

- Thanks, Evelyn so much for clarifying. And so Peggy and your team, when thinking about the peer learning group, what workflow successes or ideas did you you walk away with and how have you integrated these into your practice or that you will plan to do so?

- Well, there were so many, the peer learning group was fantastic. It was wonderful to hear what everyone is doing in Title X around telehealth. So one thing that really resonated with us, and I think a lot of those us that participated were the safe word or the safe gesture. So it's something that's

determined, established with the client before a telehealth visit that allows the client to just discreetly end the visit so that the clinical provider knows they're no longer safe or for whatever reason they want to end that telehealth visit. And that really, again, resonated with us. We are hoping, we're actually hoping to expand our telehealth services to eventually have video conferencing for the client to have a smart phone device, so they don't have to come to the health office. And this is something that we'd like to implement at that time, too. For our telephonic visits, we have implemented the nurses, Lisa and Angela are just amazing. And our are really good about counseling clients when they make the appointment for the telephonic visit. So to let them know, consider this as you would a normal visit, allow the time that you need, make sure you're in a secure, safe location. Don't have your phone on the car speakers with your friends in the car, all those pieces. They also let them know the phone number calling them on their visit day is going to be different than the health office number and who the provider is that's going to be calling them just so they have those pieces in place. And then the last thing that I took away that Evelyn was doing in her site was a survey through text after a telehealth visit, collecting information from the client, how the visit went and those pieces. We have just, after a telehealth visit, we check in with staff and the client to see what we can do differently, what we can, but we don't have a systematic approach, so we'd like to do that as well.

- Thanks, Peggy. And how about Rob and your team in Wyoming? What did you walk away with from the peer learning group around workflow?

- Part of it had to do with kind of really looking at who we had doing what okay? And what their licensure allowed them to do versus not. And so in Wyoming, we had some real restrictions in terms of the services that nurses could provide as opposed to an NP. And so, and then in some of our sites, we have a part-time nurse practitioner, two hours a week or something. And so we're really limited in terms of what some of those pieces can be. Naomi kind of talk a little bit about, you implemented a good bit of telehealth and using phones and other kinds of things. So if you could talk about that.

- Yeah, for sure. So Peg totally stole my number one thing that I took away from the PLG and that was the safe word, because we had really done a lot of work with scheduling and the intricacies that are involved in that. Can we do Zoom? We have a HIPAA compliant Zoom that we've gotten through our state network, and we have several accounts for providers or for the front desk, or whoever might need to utilize them. The working on out just the workflow with when you schedule a telehealth appointment, how long do you schedule it for? And we schedule it for the standard duration of whatever type of visit they would be coming into the clinic for. Is it going to be telephone or video conference? Do they have those capabilities? And we really would push towards the video conferencing if at all possible so they can maintain that face to face contact with their provider, we think that's really important. But if it's phone, are we calling you, or you calling us, even just those little details, it took us some time to work out. Being able to communicate amongst all members of the team, how that's actually going to play out was another challenge. How do we get it on the schedule so that even though we're scheduling the same type of appointment and the same appointment duration, how do we convey what type of appointment it is, how we're going to contact them? So just increasing our communication within the clinic was a big thing. Learning like what exactly do we need to document for billing purposes, and what are those codes by the way? Or what are the requirements are there that go along with that? How is the flow going to work if the provider's running behind and just some of those basic logistics. But yeah, the safe word was something that we hadn't implemented yet, and I just thought that was, it was absolutely brilliant. Just having some word, especially when we're looking at targeting adolescents who are, they're social creatures, like all of us are, but there's always people around them. So what if somebody walks into the room and they no longer feel comfortable? What can they just say that doesn't tick any concerns, but yet still alerts the provider to start asking those yes, no questions at that point in

time. And of course, rescheduling if we need to. So that was one of my big, huge takeaways from this meeting. But yeah, there was so many things that we learned and continue to learn, even some of the things that Evelyn's mentioned with the STI testing. Like we too, we were doing drive by depos there for a while, and we would have patients come and we would give them sample packages to go and do their own self collected samples, and then bring those back to the clinic and then we would run them or, if they really did need other testing, like how can we make that happen outside? We got outdoor furniture so it was more comfortable to be outside when we had to do blood pressure checks or more minor type things. But yeah, definitely some challenges along the way, but I think it's been such a great opportunity to learn together and to know what our strengths and weaknesses have been along the way, I think it just helps build confidence in knowing that we're doing the right thing, we're heading the right direction, and we'll get there, all the little hiccups along the way just helped to make us stronger.

- Absolutely. Thank you, Naomi, all the hiccups are opportunities for learning and improving. Danielle, what are some best practices or promising trends that you're hearing or seeing when it comes to workflows?

- I think we've heard some of them here and it sounds like this team, which is always super interested and willing to share algorithms, protocols, workflows, et cetera. So that's awesome you have a wonderful group here. But I think it really goes back to something Rob said, assessing who your team is, who are the different roles, making sure everybody understands what their role is. Every organization's a little bit different, right? And I can't emphasize enough the importance of the training. It's about the people, right? It's telehealth is a piece of, it's a different way of approaching things, but it's a tool in the toolbox. So if people are confident in their ability to provide their role, whether it's doing the pre-screening call and asking questions about their technology ahead of time, so that you know if they have a phone or audio video or what whatnot, that's another kind of a trend that we've seen great success with, like doing that pre-screening so that people understand this is a telehealth visit, what might you run into for roadblocks or how can you hopefully prevent those roadblocks from happening, because you understand what the limitations on the technology or the understanding of the technology might be. Those are all key, but yeah, making sure that your team is well trained and that they practice, right? Then you're going to run into those little scenarios that you might not have thought about, and you can proactively address them ahead of time. So that's huge. This is kind of a workflow question, but I noticed Julia asked about, does anyone do integrated scheduling of telehealth visits and in person visits? Yeah, that's fairly common. A lot of times people are, or organizations are very limited on space. So they might set up a special telehealth room, so they don't have to keep moving things around, and so you know the technology works great every time. So they might kind of tend to do block scheduling from that respect. And then whoever's using the technology is very used to where it's at and how it's set up, et cetera, cetera. So I would just kind of, from a workflow perspective, I thought I would hop in and answer that question.

- [Caitlin] Thank you so much. Of course workflow is so important with regards to telehealth, right? So yeah next question, Evelyn, we can start with you. How are you integrating culturally humbled care during telehealth visits?

- Yeah. Well, it's sort of what you said earlier about really being open to what the patients needs are and being respect of where they want to go with the visit. So I think interestingly enough, when you're facing someone on the screen, one provider says I'm much better at listening because I've got this sort of, so that piece is really improved in terms of just being humble to the different needs. Now in Maine, we're fairly white. We are the whitest state in the country, so the humble, cultural humble piece we're

working on, we certainly do have pockets of our state that are diverse, and we're working on how we actually, actually hiring some folks to do what we're calling cultural health workers to kind of tell us how we can better reach out and reach out to that community for us and engage them and hopefully expand our telehealth that way. So that's some of the things we've done. I just want to jump in that quickly, that staff buy in. I think basically you all have a culture of staff who are very, very provider centered. They will want to meet the patient's needs. So when we found out, when we were doing our survey and we found out how overwhelmingly patients like this and were giving us feedback on how much it was working for them in terms of their busy lives, that that was the buy-in like, oh, my patient wants this, so I'm going to step up and do it. So that's one thing I would say that really was helpful. Getting supplies, we would mail supplies to patients, or they could come and just simply pick it up at the door. And we had that way, depending on their needs, or if they had a prescription plan that they wanted to use, we would certainly call it into a pharmacy. So that's how we got supplies to folks. And then one other quick thing that we haven't touched on is consent. Every state's a little different and every payer is a little different. So Danielle will tell you, you really need to know who's your payer and what are the state regulations or statutes around consent. And we have actually built the consent into our telehealth template, because we're only human and sometimes staff forgot. So the patient cannot get past that window without answering and consenting to the tele, which goes through you can ask for an appointment, if this isn't working, that sort of thing. So it kind of the things that are expectations on that. So that really allowed us to be assured that we were getting proper consent with regard to a payer or to a statute.

- Thank you, Evelyn. And we had a pretty great conversation on consent during the telehealth PLG, so if anyone needs resources or has any additional questions, we could definitely get those answered or send something along. Yeah. So I'll turn it over to Peg. So how have you been integrating culturally humble care during telehealth visits?

- Yeah. So as a standard, all staff in our network who provide the telehealth visits must meet the same requirements expected of any family planning encounter that are necessary during a traditional in-person encounter. So that includes the culturally humble care. We felt like when we added telehealth as an option for clients, this actually gave the client more flexibility. It gave them the autonomy to choose what visit works for them, what environment do they want their visit to be in? So it kind of recalibrates that locus of control, the idea of that with cultural humility. So in addition, we ensure safety and privacy with all of our visits, including telehealth, so before we would start a telephonic visit, we would ask the client, are you in a safe, secure location? If for any reason they're not comfortable with the visit, is okay time? Giving them that control over the visit again. And then thirdly, for cultural humility, we include this in our staff trainings. And as of last year, we set a new requirement that our Title X staff have to complete the RHNTC, I'll put a plug in for you, the RHNTC, and it's called cultural competency and family planning care e-learning. And it's fantastic. It's based on cultural humility approach that providing care that respects the dignity of the individual. There's videos, self reflect activities, and helpful suggestions of how to implement culturally humble care during the family planning visit. So again, for all visits, telehealth included.

- Thank you, Peg. You all are definitely doing some amazing work in New Mexico. And I'll pass it over to Rob, what's happening with your telehealth program and cultural humility?

- So, I mean, I think with the cultural humility piece, we've really been focusing on kind of who is it that we're trying to see? Who is it that we're trying to reach out to? And what is our relationship with those communities? I think a lot of our focus in the past year has been looking at the LGBTQ community in terms of kind of the comfort level of staff to even discuss what some of those issues might be. If we

have clients who are transgender, where are they in that transition process? And then what are some of the healthcare needs that may be there. Some of our clinics have started investigating the feasibility of doing hormonal treatments and how do they do that? In our new grant, we've asked to really focus on really looking at the disabled community in terms people living with disabilities. Because we think that they're an underserved population. And so we're working with various statewide groups to help us assess kind of what we are currently doing and what we need to do. I think, from a, and Gail, you might address kind of what's going on in terms of just using the RHHNTC for some of the training pieces.

- Yes, of course training includes the cultural competency. And I have to agree with Peg in the sense that really, how do you explain how you're doing something that you've always done? Regardless if it's an in-person visit or a telehealth visit. But that's about all I have to add.

- [Caitlin] Thank you. And Wyoming you all are doing such a great job, considering historically marginalized populations, delving into all of the important populations that we haven't even considered serving or haven't done well yet. So that's always so appreciated. Great, so I will ask one last question to Danielle from a systems perspective, how do you believe that cultural humility contributes to the goal OPA has recently set for the Title X program?

- I think certainly cultural humility is vital and the integration is vital too, for all of us, right? In any types of services that we provide and the impact that it can have on patients, clients, families, and how effective that is. Right? One example of one person who either got information that was provided in their language, that was according to their culture and met their needs. They're much more likely to understand, and then integrate what's being taught or prescribed, et cetera, as part of their treatment plan, which from a systemic level, I mean, there's such a huge potential benefit there for the system, for your organizations, for the patients, for the families, because then they're likely to follow through with whatever that is. And, oh, sorry, I'm looking at the chat and making sure that's not for me. No, it's not. And they're more likely to come back right? And to follow through with, and they become part of your family, like I think Evelyn mentioned at the very beginning. So it's this snowball effect that I think is just incredibly important and it should be the blanket that all of us wear, that it's not a check mark as part of, that we need to off that we're doing this, it applies to everything that we're doing. And then when the patients and clients and families feel that as part, that they're being heard and that their culture is being respected and that you you're adjusting to that and providing what they need, whether it's medications, education, language an example with outside of reproductive health is diet, right? That's huge. If it's part of your culture, that vegetarian diet is important to you, but you're not being, that's not being considered as part of your treatment program, you're probably not going to be compliant, and we all hate that word, right? But it should be the blanket that we all wear and that we are constantly, it's constantly part of how we're working with the people that we serve.

- Thank you so much.

- Not sure if that really answered the question, but that's a big question.

Slide 13

- It is, we ask you those really difficult questions, Danielle. So we have so many more questions for our panelists, but in the interest of time, we're going to attend to as many of your questions in the registration and in the chat. So keep them coming and we'll try to get to as many questions in the time that we have remaining. So the first question, Evelyn, I'm going to direct it to you. This, and I, help me clarify, because if this is not the case, when you first implemented telehealth, when you were, I believe it was when you were still in the Title X network, and you sent a medical assistant to another office, did you have to receive approval from OPA or was approval needed? Can you talk about, I believe that was when main family planning was in the network. So can you talk about requirements and approvals?

- [Evelyn] We definitely talked to our RPC and back then they were all regional, so we had a new England RPC at the time, and we connected with her and we talked about what we were planning to do and that we wanted to provide this to our Title X clients, and she said, that sounds fabulous, and I'll run up the flag pole, and we were able to actually get their ability to pilot this and go forward with offering telehealth services.

- [Caitlin] Great. So the lesson is, if you're interested in this model, talk to your project officer, they may be supportive of this.

- [Evelyn] Yes. And I will say, I believe in the service grant, they do reference telehealth services, so clearly they're blessing it as an FR available service. So that was nice to see that as well.

- Exactly.

- Yes.

- [Caitlin] Exactly. So my next question is going to go to Peggy and your team, and then Naomi as well, because this, folks are really interested in hearing more about the safe word and how have you figured out how that's going to be implemented into your workflow or the safe gesture or Evelyn, if anyone that wants to weigh in, how that will look like in your setting, and if not, we can stay tuned for that, so I'd love to hear Peggy and Naomi and hear from you around that.

- [Naomi] So I'll jump in and just say that for us, how we have instituted it is it's one of the very first things that the provider touches base with with the client before you start getting into any of the medical or any of that, it's establish that contact, verify that we've got consent, the requirements. And then it's this question, which is just really, really important. And it's just establishing what is a word that you can use that if you need to stop having our conversation, what is that key word? So then at that point, it's explained to the patient that they will, whenever they say that word, the provider will then

switch to simply yes/no question. So the provider can then ask, is it okay for us to continue this visit? Do you need to reschedule? Are you in a safe space? Or whatever those questions are that are yes/no questions. And that's established right front at the beginning of the session.

- [Peg] And I thought, Naomi summarized it so well. So, we haven't implemented yet the video conferencing where the client's using a smartphone, and that's where I really want to, we really want to add a lot more to our protocol around the safe word and gestures, but for the telephonic visits, absolutely. Because I can't see on the other side what situation the client is in. And so it's been very valuable.

- [Deepika] Thank you. So another question, this was for the panel in general. So Peg, Rob, any of you if you have the opportunity to answer even Evelyn, how have you had advertised sexual reproductive health telehealth services to teens and such, or gotten appropriate education to teens so that they know that services are available?

- [Evelyn] Well, we find that with the teens, it's all, they go directly to Google and our website. So we made it very clear on our website, right up front, when you hit our landing page that they can see that virtual, and we call them virtual visits because we realized telehealth is a little too inside baseball, so we called them virtual visits, 'cause I think that was a word we thought made sense. But we're revamping it, we think it's still clunky, we still want, everyone wants something right away. And so we're looking at revising that and making it even more streamlined. So when you hit that virtual visit, you can either call us or you can go right and see the list of things that you want to do. So that's been the best way to advertise to teens in our, it's been so disruptive over the last, I mean, typically we'd have a whole, another group of our offices going into the schools and doing things like that, but that has not been as readily available as you might imagine with the pandemic. So it's really been through our social media, our Facebook, our Twitter, our Instagram, and then our website.

- [Rob] This is Rob we, to be honest, we haven't done much with that. And so we're still learning kind of how we want to approach that and what our system might look like. We don't have a call center set up, we don't have some of those other things that Evelyn and some others have mentioned. And so I think, some of that may be left to the individual site to sort out for themselves, as to what's going to work best for that specific program as opposed to us implementing something statewide. Naomi, would you agree with that?

- [Naomi] Yeah, I would definitely agree with that. And Wyoming is unique because of also just the different political climates throughout the state. So I think different clinics throughout the state have to advertise differently or use their social media differently as well. So definitely clinic specific, I'd echo that.

- [Deepika] And Peg I saw you on mute for a second, did you go have anything to add in as well?

- [Peg] I was just going to echo the same, we're, before the pandemic, we did outreach, we'd go to the schools, we'd go to different meet teens where they were, but COVID really has pulled, we're all doing things differently, a lot of things we could do, we can't do now, but it is on our radar. We're hoping now that we can really focus on outreach and marketing to adolescents. I'll probably be reaching out to you, Evelyn, to get more ideas.

- [Deepika] Thank you. And I'll pass it over to Caitlin for the next question.

- [Caitlin] Thanks. Thanks Deepika. So I know that some of you address this a little bit, but we're seeing a lot of questions around staff buy-in and getting providers interested. Do you have any words of wisdom or tips around additional information around getting providers a little bought into the notion of virtual visits or providing care via telehealth?

- [Evelyn] Yeah. I'll just jump in and I'm sure other people have great ideas. We started out with our champions. We knew, I mean, you all know people on your staff that love this stuff. They love the technology, they love the, they're not scared away by it. So we started with them, and then they then sold it to everyone else saying, 'cause there's nothing like peer to peer. I can't, it's much more effective when you have a peer saying, oh that happens, here's what you do. Or here's your lifeline. Or we said to staff who are really intimidated by this, if you're having trouble connecting to the patient, for whatever reason, the video's not working, we always get a phone number first, right? And we tell them if, go right to the phone, don't stress about it. At least with the PHE that we have right now, as long as you document why you switched over to a telephonic visit, it's billable, it's fine, and that giving patients or staff the permission to say, oh, I don't have to struggle for 10 minutes to get this video going, or the patients can't get their video going. That's what I recommend. Give them that lifeline that you can easily switch over. And that permission getting was huge for getting buy-in. But I'll be honest with you, there's still staff that aren't as comfy with this, there's much training and coaxing and coaching that we've done, we know there's just simply certain staff. You know what we decided to do? You know what? That's okay. You're really good at doing this, we have enough other folks that are really interested in this, aren't scared with the technology, because last thing you want is someone who's not comfortable because that will come screaming through to the patient as we all know. So we just kind of gave it up and said, we have enough folks, we have our tele group now, and we kind of customize who's in our tele group, because they're so comfortable with it.

- [Caitlin] Thanks that Evelyn, anyone else have any other ideas of getting provider buy-in?

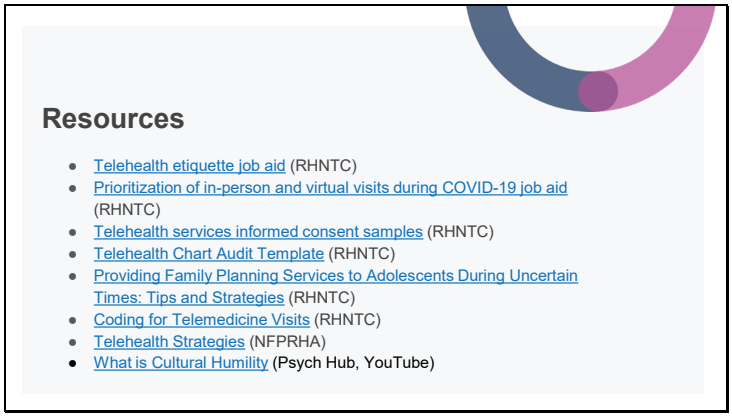
- [Naomi] I definitely echo what Evelyn has said. Being able to have the opportunity to just sit with your providers and walk them through it is so key. And then we're a small clinic, so we don't do a lot of telehealth visits. So remembering that you're going to have to sit by your provider again the next time they do it, because they've probably already forgotten, we're human. And absolutely that lifeline is essential for them to know, if you're having troubles or you can't log in, or whatever, here's who you can just go to this person, and they will help you. Is essential to know that they have backup too. And obviously like Evelyn said that instills their confidence for when they're going to meet with that patient. And it takes some time, right? None of us really, like, we'd all prefer to be in person right now and being able to see people face to face, but for so many reasons it's beneficial for the client. And our providers are so passionate about what we do, they're willing to put their uncertainties and their insecurities on the line to make sure they can make contact with that patient and get that patient the services they need.

- [Gail] Caitlin, I would like to add something. Maybe there's other agencies out there that are struggling with the providers just absolutely want blood pressure, absolutely want that physical assessment. And I sit here to tell you, I don't know how to do that. It is a struggle. And I continue to try to see what I can do to help out the providers, but it is true, like Evelyn said, you can't make somebody do something, especially when it is their license.

- [Evelyn] Yeah. And I'll just, that's a really good point, Gail, about the blood pressure piece. And I saw that in some of the things. Believe it or not, that was one of the biggest hurdles. And we worked with our medical director. We basically follow, the Society of Family Planning put out a protocol that we ask them, have you had your blood version taken in the last year? If they're an established patient, we say,

we look at the record. And then we determine based on their health history, whether or not they've ever had hypertension. Now we're dealing with mostly young, healthy people. That's where I'm at. That's who you're dealing with. And an unintended pregnancy is way worse than whether their blood pressure is normal. And then we'll have them come in within a certain time period if we really want them. But we absolutely say you are not going, this is where I got a little bit, I wouldn't say, I rarely go this way, but I got really off, what's the word I'm looking for? Very authoritative, I'm like you will not not prescribe that hormone, that combined hormone method because of a blood pressure. I don't want to hear it. I don't want to see it. It is not going to happen. You've got plenty of lifelines if you have concerns afterwards, you do not deny that based on a blood pressure. And there's plenty of good stuff out there that supports that, I know we follow the medical eligibility criteria and there's lots of ways to assure yourself. I mean, in Europe you can get them over the counter. So I think we really try to coax them, but then at some point I'm going to be honest with you guys, I put my foot down and just said, and with our medical director and our director of CQI, I was like, listen, you got to do it. That's just the way it is. And talk to me offline if you really want to yell at me some more about it.

Slide 14



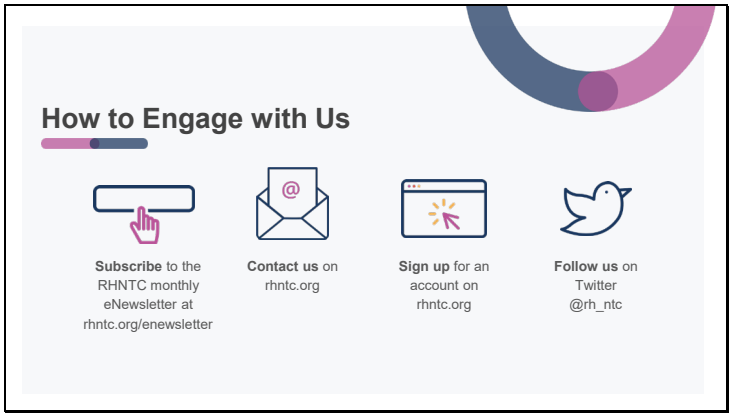
- [Caitlin] Thanks, Evelyn. I really appreciate that. And Gail, thank you for bringing up the pressure. Thank you everyone for your time. We are almost the end of our hour and we just want to share a few resources on the next slide. And, but before, instead of going through all of these, Peggy, maybe I could turn to you. And what was one resource shared during the peer learning group that was helpful to you and your team?

- [Peg] Sure. Well, that's very hard to answer because there were so many, and I think it depends on where you are in adopting telehealth, but on the screen, I would say the coding for telehealth visits, I'm clinical and so coding and billing are definitely my weakness, I'm still learning. Behind that, the RHNTC has some great recorded trainings around that. NFPRHA also has some great trainings. And one other I want to mention that isn't on here is our peers. There wasn't a time that I didn't reach out and say, Hey, I have a question about this, that someone always got back to me and were really gracious and generous with sharing their experience. And this is what we have, this is what we have. And that's a huge resource too.

- [Caitlin] Great. Hey, Rob, how about you and your team? What was one resource that was helpful for you during the peer learning group?

- [Rob] I would say actually looking at the telehealth services informed consent samples. Looking at some of those pieces and thinking that we had things in place and then realizing, no, we need to adjust this or change this up a little bit. And then I echo everything that Peg said in terms of just kind of, we held Evelyn in esteem. It was the kind of thing that we would be listening to her and I'd be going, oh my God, I hadn't even thought of that. And so just acknowledging that we're all at different places. I think that was the big thing for me is that acknowledging that we're at different places for implementation. And but I do agree that you need to have your heroes. You need to have somebody who is willing to step out like Naomi has been able to do and Laramie and some others who say this is what we're going to do and then not be afraid to share it.

Slide 15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Slide 16

- [Caitlin] Wonderful. Thank you so much, Rob, and thank you all for joining us today in our hour. And thank you, immense kudos and gratitude to all of us, to all of our panelists for joining in our conversation this hour. As a reminder, we will have the materials from today's session available within the next few days on rhntc.org. If you have additional questions for us or our panelists on this topic, please don't hesitate to reach us at rhnt@jsi.com or contact us through the website, through rhntc.org. Our final ask is for you to complete an evaluation for today. This will help us improve and help continue to serve you and meet the telehealth and virtual visit questions that you have. Thank you again for joining us. And we know that there are still so many questions around telehealth, so please do keep an eye out on our e-news for more resources, events, and opportunities to support you in meeting clients needs in a virtual manner. So thank you all for your questions, your participation and panelists, thank you so very much for this conversation, it was truly an honor. So thank you and have a wonderful day.

- [Deepika] Thank you everyone.

- [Rob] Thanks Evelyn.