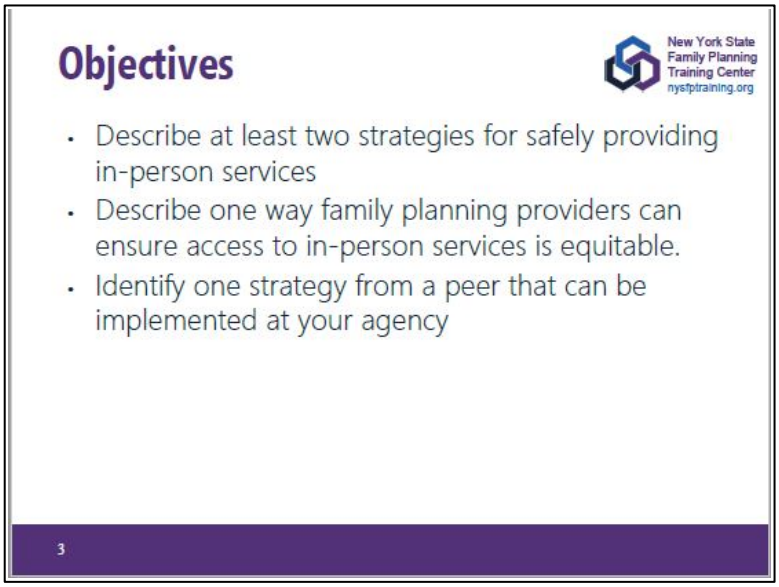
Transcript for Adapting to COVID-19: Safely Providing In-Person Family Planning Services

October 22, 2020

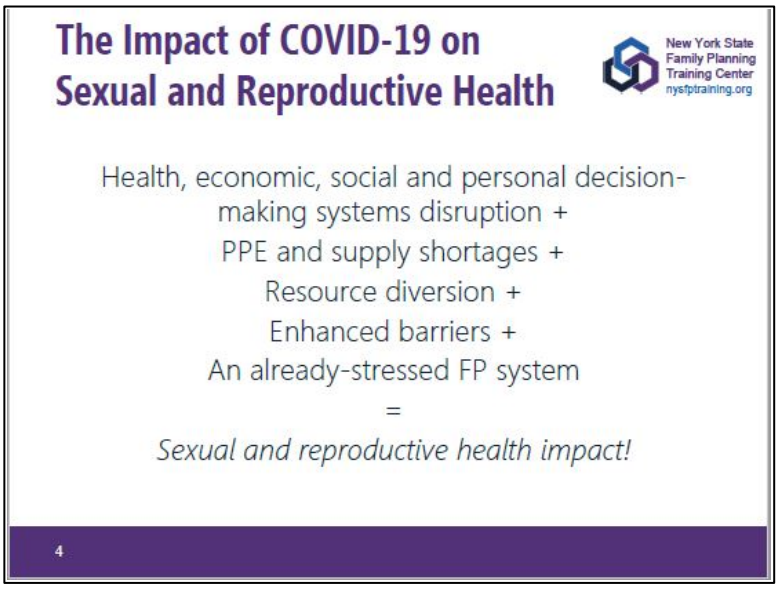
Katie Quimby: Hi, everyone, and good morning. My name is Katie Quimby and as the director of the New York State Family Planning Training Center, I'm so happy to welcome you to today's interactive webinar on Safely Providing In-Person Family Planning Services. This webinar is part three of our four part adapting to COVID webinar series. Today we'll be hearing from three family planning providers, Mount Sinai Adolescent Health Center, Sun River Health and Morris Heights health Center. We'll also have some time for small breakout group discussions to hear and discuss how you are ensuring safety with your in-person services right now. I'm joined today by several colleagues from the New York State Family Planning Training Center including Caitlin Hungate, Meg Sheahan, Jennifer Kawatu, and Lisa Seamus, who will be helping to facilitate these breakout groups. Before we begin, I have a few brief announcements. First, everyone is muted today to reduce background noise. When we do break out into small groups, you will be able to unmute yourself by clicking on the microphone button on the bottom-left of your screen. But, please remain on mute until we get to that point. If you pre-registered for the webinar today, you should have received a copy of the slides already via email, and we're also recording today's webinar and the slides and recording will be posted to our website nysfptraining.org in the next few days. We'll also plenty of time for questions during the webinar, so please feel free to chat in your questions at any time. You can find the chat pod by hovering your mouse over the webinar screen. A panel of options will come up at the bottom of the screen and from that you can click on a chat bubble. If you don't see that chat bubble icon, you can click on the three dots on the far right where it says more and you'll see that chat as an option to click. When you try to respond, just be sure to click send to everyone before typing in your response so that we can all see your comments. In addition to the questions you have today, we received a number of questions during registration and we'll be trying to answer as many of those as possible while we are on the webinar. So, I'd now like to turn things over to my New York State Family Planning Training Center colleague, Caitlin Hungate, who will be one of our moderators for today's session. Caitlin.

Caitlin Hungate: Thanks so much, Katie. Hi everyone, we are so grateful to join with you today in our third session. As Katie said, my name is Caitlin Hungate and I'm a training and technical assistance provider with the New York State Family Planning Training Center and the Reproductive Health National Training Center and I am so excited and honored to be with you all today and hear from our three peers, presenters, panelists today and I'll turn it over to Meg to briefly introduce herself as well.

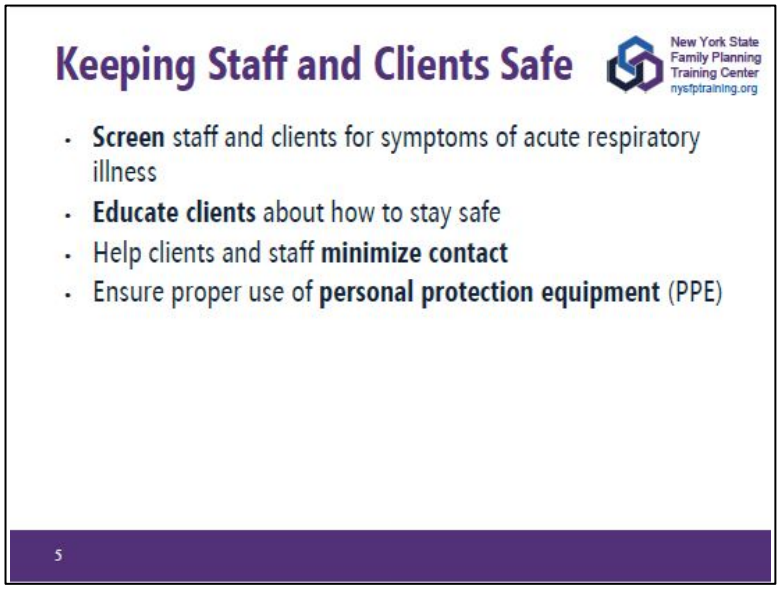
Meg Sheahan: Good morning everybody, my name is Meg Sheahan, it is a pleasure to be with you all today. I'm a certified nurse midwife, and I've been providing clinical sexual and reproductive health services for over a decade. I also have nearly a decade of directing a family planning program under my belt. I've been a lead on the COVID response team for the US Virgin Islands, so I've been very involved in every aspect of adapting our family planning activities to the pandemic, including determining whether, when and how to provide in-person family planning services. I work as a consultant for JSI to support the US family planning network and I'm so happy to be with you all today. Thank you.



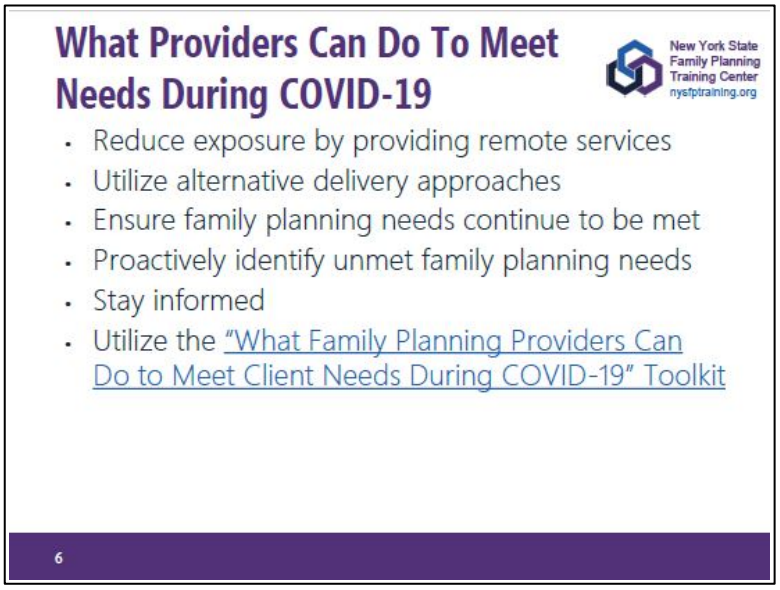
Meg Sheahan: At the end of our discussion today, we hope that you will be able to describe at least two strategies for safely providing in-person services. One strategy to ensure that access to in-person services is equitable, and one strategy from a peer that could be implemented at your agency. Here is how we will accomplish this. Following a brief overview of the impact of COVID on sexual and reproductive health, we'll have a virtual Roundtable with peers, we'll then have some time for Q&A, and then we'll break into smaller groups for the opportunity to share your experiences. We'll then come back together as a group and discuss what we've learned and then share some useful resources before signing off at noon until we meet again.



Caitlin Hungate: Thanks, Meg. At this point, we are all far too familiar on the impact of COVID-19 on sexual and reproductive health. So, on the slide, we've got a few of these factors that all compound and have incredible implications for access and delivery of care, so, hopefully, through the conversations today, we will unpack some of these challenges and identify some strategies for continuing to ensure access to sexual reproductive health.



Caitlin Hungate: Eight months into COVID-19, many of you are already doing these strategies to ensure your staff and your clients are safe, but we put these strategies up as a reminder and also as a celebration of all that you have accomplished in these last eight months and you will continue to ensure staff and clients are safe as we enter a potentially dark phase of the pandemic with the winter months compounded with flu and COVID-19. On the next slide, you'll hear more from Meg about additional resources and strategies for meeting client needs during COVID. So, Meg, I'll turn it back to you.



Meg Sheahan: Thank you. So, I'm quite sure that we all agree that family planning services are essential services, and to continue to ensure access, family planning providers have adapted creatively and innovatively working remotely when possible in order to stay safe for providing in-person services when necessary. During this pandemic, family planning providers are advancing the field and protecting the capacity to provide in-person services. Providers are expanding the scope of telehealth and introducing alternative delivery approaches such as curbside pickup or mail delivery of medications and supplies. Many are exploring the pros and cons of online platforms for contraception and STI testing. Also, providers are ensuring that family planning needs are met through innovative approaches such as self-administer Depo-sub, and when counseling clients with an expiring IUD or implant, including the evidence that methods are effective longer than their FDA approved duration. Family Planning providers have stayed proactive in identifying unmet family planning needs by using social media to communicate with clients about how they can access services. Some family planning providers have reviewed charts to identify clients who will soon run out of contraceptive supplies, or who are due for their Depo in order to invite them in for a scheduled appointment at a safe time, or come in for curbside supply pickup or receive supplies by mail or at the pharmacy. I'd like to call your attention to a very useful toolkit hyperlinked at the bottom of this slide. The toolkit is called, What Family Planning Providers can do to meet client needs during COVID-19, and it's available through the Family Planning National Training Center. This toolkit provides lots of really useful suggestions and resources to help family planning providers continue to meet client's needs while keeping themselves and clients safe during the public health emergency.

Caitlin Hungate: Thanks, Meg. So, we want to now spend the bulk of our time hearing from your peers today, and we're so excited and honored to be joined with colleagues from Sun River Health, Mount Sinai, Adolescent Health Center and Morris Heights Health Center. So, we are so excited and grateful to be hearing from them and hearing their experiences, knowledge and insights that they've learned around safely providing in-person services. So, my first question I'm going to direct to Camille at Sun River Health, Camille Robinson. How has COVID impacted the number of clients your family planning program has provided clinical services for as the pandemic unfolded?

Camille Robinson: Good morning, Caitlin. So, the rapid spread of the COVID-19, as in every area, it affected our patient volume significantly. At the onset of the pandemic, three of our 12 sites were temporarily closed. So, we now had to redirect our patients to other sites as well as transitioning into the tele-med business and what that looked like for our family planning. So, services like the PAP, the annual exams, the LARC, they were reduced, but we put them in certain time blocks. Oral contraceptives, as you mentioned, previously, we did the curbside pickup, and we just tried to get really innovative of what that looked like. Again, there were certain time blocks for that as well. So, there was a little bit of a limitation to our patience. Given all this parameters, our patient volume declined by 50%. Then, there was a factor of the documentation piece. So, as many of us, we had to furlough a lot of our clinical support staff, and just completing that CDR wasn't necessarily happening. And, if it was, it was about 20%. So, with that said, we had to get together, myself, Dion and Dr. Walsh and just figure out what that would look like. So, we collaborated with our internal informatics team and developed some reports to capture that 50% patient volume, documented in the CDR. A lot of tedious work, but definitely something that had to be done so that we can see what the volume was and work through that, as we transitioned to resuming in-person services. So, it was a lot of workflow redesign, collaboration. Just trying to capture those missed opportunities, and trying to make sure that in some way shape or form, our patients were getting the services they needed, bringing our value back to what it needed to be. I hope that answered your question.

Caitlin Hungate: Absolutely. Thanks, Camille. A lot of challenges and changes. I'm curious, Dr. Nucci-Sack, how did COVID impact the number at Mount Sinai Adolescent Health?

Dr. Anne Nucci-Sack: I'm sorry I'm not available by video, I'm having technical issues here. But, we too saw a drop off in the number of young people who accessed our services. In quarter one, which is just the very beginning of the COVID pandemic, we had a 10% decrease from the previous year. Quarter two is where we got slammed. Again, as Camille just said, we saw about a 50% drop at that time. But, in quarter three, we're about 20% of where we were last year at quarter three. So, the idea was that we never closed. We decided, at the very onset, that not only will we not close, we will expand our hours and we expanded the ages of young people who could access our services. Understanding that a lot of places in New York City would be closed.

We're so mission-driven, and our idea is that reproductive and sexual health needs are essential needs, and we really believed that it would be a terrible disservice to the young people to not to have some resource to come to, and that we also needed to make sure that they got the supplies they need. They rely on us. They often come here... They're adolescent. This is who we serve adolescents and young adults, they don't have insurance, they come for their supplies, and they don't have an insurance product that we can even do something remotely like call it into your local pharmacy. So, we really decided to stay open, expand our hours. We did that, basically, through redesign of our practice flow. So, we re-engineered our complete clinical practice flow. We went from having one team here on a regular basis, to we created a three team system, and we rotated. So, to minimize the risk of the staff getting sick, they were here for three days, and then we created work from home scenarios, so that they could continue to work but still be involved. Then, as part of that three team system, we also put into place some redundancy, because people were getting sick, and not just people were getting sick, family members were getting sick. Their children were suddenly home, and unsupervised. So, if somebody called in, we had a really clear system of who would cover for that person if there was a call in. So, we really strategized down to the very detail of patient care, we created new roles. Clearly, we didn't want the young people to come in if they didn't have to, so we had manned phone... People answering the phones, just giving advice. Then, we also... And, I think I'll talk about this a little bit later, have the luxury and the good sense to have overstepped... Well, at the time of the pandemic, 70% of our patients were activated in MyChart. So, using that as a platform for blast information, and then also one-to-one information. If you got a question, you think you want to come in, MyChart message your doctor first and then see if it's legitimate or not. So, those are some of the strategies. We maintained an infrastructure, so that we know that if we have to move back, if we get into a time where it gets dark again, we have an infrastructure in place that we can go right back into place.

Caitlin Hungate: Thanks so much, Dr. Nucci-Sack. How about the team from Morris Heights? I'm curious to hear how did COVID impact your numbers in your family planning program?

Susan Billinghurst: Hi, good morning. This is Susan Billinghurst. So, just like Mount Sinai, it did impact our numbers. Even though our [inaudible 00:14:34] incorporates as part of the clinical record in the electronic medical records, we still had to [inaudible 00:14:41] to do is, make sure that patient who came in, gets seen and [inaudible 00:14:49]. We actually had a hybrid schedule. We did not close also. We had a schedule where [inaudible 00:14:55] at home, and three days in the clinic. Sorry, just accidentally... We have somebody operating the system, sorry. So, we had a schedule where the providers who work from home, they will actually call the clients, review the chart and make sure that they have their contraceptive birth control pills. If they need something beyond that then they will have the patient come in. We have late nights at some of our clinics. We brought those late nights up from eight to five instead of eight to eight. So, pretty much, the main site, which is where we are right now, Burnside. That's the only site that had one late night. We stopped all Saturday clinics at our site, and, of course, the social distancing protocol as for New York State, CDC, and the guidance that we need to do. Of course, we follow the family planning for the calls. We also follow [inaudible 00:16:02] as reproductive health is essential. It was also a time that we experienced where the patients or clients were more active, so at one point, maybe March, April, it was slow. Dropped to maybe about half, like Mount Sinai. But then, we [inaudible 00:16:23], with various STI complaints and stuff like that. I'll let [inaudible 00:16:32] to [inaudible 00:16:32] the adolescent piece.

Ebony Copeland: Yeah, so I think we saw initially a drop. We're also in a unique situation, because we're down a provider for the adolescent. It's usually myself and [inaudible 00:16:43] provider, and it was just me, and I only have three clinical days. So, initially, we saw a drop when nobody was going anywhere, but then not long after that, we did see... I personally saw an increase. I think part of that, though, was because we have about 21 school-based clinics, and those were all shut down. So, we really made a concerted effort to try to meet the reproductive health needs of the school. So, we went through all the reproductive health lists for all the schools and tried to get them plugged in, tied in, seeing whether it was virtual, or in-person. Young people tend to prefer... I don't know if Dr. Nucci can add to this, but in-person visits over the virtual, which is interesting, because they're facetiming all the time. But, our patient population, if you gave them a choice, they usually would pick to come in. Part of that is also because they're born at home with eight

other people, and they just want to get out of the house, too. But yeah, we then saw an increase, but I think that was just from our outreach from the school to try to close those gaps, which were big. We did what we could, but there are definitely now we're seeing girls who are coming in who haven't had birth control since the beginning of the year, because they just didn't go anywhere, and they didn't leave their house. Now, they're trying to access those services.

Susan Billinghurst: We also have an increase of taking loss. During that time, two patients will come in and they want to make sure they aren't alone after [inaudible 00:18:16] for contraceptives. We also had a few of the staff follow-up, but it didn't really affect what we do as it relates to family planning.

Meg Sheahan: Thank you so much. That is such good information and good strategies for us, in terms of what we can do in our own clinics. Before I direct the next question to Dr. Welsh, I just want to offer a friendly reminder, please, if your phones or computers are not on mute, to please mute them so that we do not have so much feedback and interference, background noise. Dr. Welsh, can you tell us a bit about how services were prioritized, and how your strategy has evolved as the pandemic has unfolded in your area?

Dr. Welsh: All right. Thanks, Meg. I'd like to say that family planning was a priority for our institution. Although, we did stop annual visits, annual GYN visits, the prenatal patients and our family planning patients were of utmost importance. As we know, during tragic events that happen, that's when we see a spike in unwanted pregnancies, and being that we were shut down, I did not want to have patients without access to birth control, so we continued those visits. But, we did do things like curbside pickup for pills. Even Depo, we did those via telehealth. We would question patients, did you miss any pills, how did you feel? Then, they were allowed to come and pick up their pills with a nurse coming to the car. They would come in just for Depo. We wouldn't worry about vital signs, we really wanted to get patients in and out.We also set up waiting rooms for patients that were healthy and patients that had symptoms so that they were not together. In addition to that, anybody that was requesting a LARC, we had them come in. Now, back from July 1, we have had all patients on-site. We do continue telehealth, but I think, for the most part, our patients feel more comfortable coming on-site. We require patients to have a mask in the beginning when PPE wasn't so readily available. That was a concern. Now staff wears PPE, which includes N95's and goggles, when in front of any and all patients. Sorry. Patients are required to wear a mask. We do not allow family members in patient rooms with patients, including our adolescents if they're coming in. We kindly ask mom to wait out in the waiting room for the large majority of the exam or the visit, unless there's some really big concerns that the patient would allow their parents to come in. So, we're trying to move patients in and out. We're trying to make sure that patients are safe, and we have not stopped our family planning visits.

Meg Sheahan: Thank you. Colleagues from Morris Heights.

Ebony Copeland: So, I really can't speak to the Tammy... The women's health, how they prioritize the Obstetrics and Gynecology. Like I said, I know, for us, on the adolescent front, we worked very diligently to try to fill in the gaps for all of our school-based patients that were getting reproductive health services and tried to make sure there were no gaps. If we knew they were coming, we ran all those lists, we called everybody who was up for Depo, we called everybody who getting refills. If they had the ability to get to a confidential pharmacy, we would try to prescribe to supply to a pharmacy that they felt like they can get the medications at. Extended amounts of refills during the pandemic as well. So, that's kind of what we tried to do with regards to the young people. Was really try to reach the kids that we knew were going to have gaps, because they were getting all their reproductive health care services provided for them in the schools. So, we really put in an effort to try to close those gaps as much as we possibly could.

Susan Billinghurst: We also had the support staff reach out to clients to make sure that the cancer screening and birth control that they haven't had a refill in a long time, to call these clients to make sure that we can do the refills over the phone, or telephonic visits. We have patients who delay some of the routine stuff. But, we had patients who was so nervous, based on the pandemic, and then the community that we saw, also want to make sure that the fear of getting something and the fear of not knowing when this pandemic is going to be done. They said, "I want to come in and get a routine check still." So, we did not deny that but we made sure that we had the proper social distances for these signs. So, we, pretty much, whatever the client needs, were, we catered it while we have a safe environment for them to come in.

Ebony Copeland: What I'll add is that, what we may have wanted clinically and what happened operationally with call center and actually making these appointments, ideally, we would have liked to not have routine visits. We tried to not do physicals and we tried to minimize them, but it just wasn't happening on an operational level, to be perfectly honest, so we honored whatever was put on the schedule.

Tammy Gruenberg: At Women's Health, because there's a separate building then where Susan and Ebony, Dr. Copeland are... We did exactly what Dr. Welsh did, we prioritized the OBs and we also prioritized the women who were wanting family planning services. So, those were considered emergencies. We had a little bit of pushback with some of our patients who walk in for STI checks, and the pushback was that sudden emergency. I reminded them that reproductive services is considered an emergency and that a lot of patients use the STI check, as, "I want to make sure I'm not pregnant." So, there was a little bit of pushback, but, I think, overall, the staff came along. Yes, initially, our numbers were lower, but then they went back to normal really, because our OB and our reproductive services were considered emergency services, and ACOG was very good about putting out bullets and notices about, just, remember that our reproductive health services are considered emergency services. So, I think there was definitely buy-in here from the staff that that's something that we needed to do, and it was just done.

Susan Billinghurst: I would like to add, Morris Heights is very unique that we have a lot of primary care sites. So, reproductive health is integrated into the medical model. So, when the patient comes in, for whatever other reasons they think they may fall in the family planning site, the providers also prioritize reproductive health to make sure that the clients also receive refills or whatever else they need, or the appropriate referral to reproductive health to get what they need. So, that was also a plus. We do that at all of our sites.

Meg Sheahan: Thank you. I can say that, at my facility, we experienced some of the same challenges and processes. So, thank you so much. Dr. Nucci-Sack, can you tell us a little bit more about how your services were prioritized and how your strategy has evolved as the pandemic has unfolded?

Dr. Anne Nucci-Sack: Just to remind everybody that I am on audio and no video, sadly. But, this was something that we decided that the prioritization was on those patients who felt they needed to come in, and we just... Remaining open, I think, was the biggest issue because many places slowed down, closed down. We decided not just to do that, but we doubled down and we actually extended hours so that young people... And, we extended the age so that young people could come in. This was not only because we know that our patients, they connect and they need to come in.

Dr. Anne Nucci-Sack: I agree, I think it was the people from Morris Heights who had said that their adolescents tend to like the face-to-face. I have to agree. I would say 80% of our young people absolutely, positively don't want to do anything remotely, they want to come in and be seen because they want to be checked. So, denying them that anxiety... They're already in a situation where they're stuck at home. None of these young people live in really large homes, most of them don't have rooms of their own. They don't even have a private place to have a conversation either by phone or certainly by telehealth, so the necessity to come in, it was crucial for them. Then, I think the other thing in terms of safety is that, by having them come to the adolescent health center, was we tried to screen them as much as possible. With that, we kept them out of already overburdened emergency departments and urgent care centers... Which I mean, it was crazy. So, just keeping them safe and separate, I think was a big issue in terms of looking at safety and weighing risks versus benefits of coming in versus staying home. Again, our staffing patterns, we redesigned everything over 24 hours. By redesigning the staffing, we were able to accommodate more patients coming in with extended hours. Then, we were also able to do social distancing and move things with more people. We could have expediters. We created new roles to get the young person from the front, bring them to the back, get them into a room, get them seen, get them out and somebody's following behind and doing all the sanitation and the cleaning. So, just a real... and, it was a staff effort and they did great. Everybody was so on board. We did daily huddles. Then, the next day we would talk about what worked and what didn't work. Our school-based health centers, we have six school-based health centers but service 24 schools in New York City, and school based health center staff was physically here calling the patients because they knew that they had lots of these young people who were due for their birth control. And, to touch base, how are you getting it? Let you know, we're here. I think the biggest tool that we utilized and I think we would have been lost without it, was, again, the patient portal. It was critical to our success of being able to continue to connect with the young people, but at the same time, having them be able to contact back. It's not a telehealth visit, so that you have to make the appointment, you have to set the appointment, you're registered, you call in at the given time, they can text in questions all day and all night long, and they're encrypted, they're in their chart, so, you can actually have ongoing assessments and evaluations. Since most of our patients are over the age of 13, when the pandemic started, 70% were activated. At this point in time, 90% of our patients have active MyChart accounts, that we really used it as a tool for individual guidance and advice. But also, it was a very powerful tool of getting the message out and saying, we want you to be safe. We would send out blast emails saying that we're open. But, we don't want you just to come in because we're open, there are criteria. MyChart message your provider, call in, see if it's worth coming in at the risk versus benefit. We also used the MyChart portal for information. The minute the Department of Health came out with the statement about sex during COVID, that thing got spread. That went right out immediately. So, I think the ongoing use of the MyChart blasts have been really effective and very helpful in terms of keeping, at least, our established client base, connected. Then, we also have a very strong social media platform. So, we have, a website, we kept updating the website, we [inaudible 00:32:30] Twitter, Instagram, Facebook. So, we were constantly adding content around COVID. Not just around, we're open, come in, but also protecting yourself, keeping yourself safe. Our social work team put together this wonderful resource guide for how to do wellness at home for our patients. So, just things that you can use and resources remotely so that they could get the best care possible when it wasn't business as usual.

Meg Sheahan: Thank you, Anne. This actually leads so directly into the next question that I wanted to ask. I wish we had more time. We only have about seven more minutes in the Roundtable. But, I'm very curious to know how you have managed challenges, for example, limited English proficiency or technology obstacles when your services have a remote component as you were just discussing. I'll address this question first to Dr. Welsh.

Dr. Welsh: Our telehealth platform is Doxy.me, and there were some challenges when we first started to use it. Because, what it actually does is, text the patient and says, "Hey, come into my waiting room." However, many patients didn't use this option, although they signed up for it because they didn't understand and couldn't read English. So, many times, I don't think we got that. Probably about two months ago, we can text the patient in Spanish. The waiting room for this platform was in English and Spanish and whatever language you chose it to be, but just inviting them to the telehealth. It started out with a video so that they can understand what to do, what the next steps were before they even made the appointment, but just that platform itself was only English. So, we made sure that it was Spanish because the majority of our patients are. Then, we went to having our clinical assistant call the patient and have them step-by-step come into our waiting room. So, just like they did an on-site visit, our clinical assistants help the patients navigate by calling them on the telephone and saying "Hey, press this button next, press this button next, and now you'll be in the waiting room," whether they were English or Spanish, to just help with technology. No matter how old you are, no matter what language you spoke, just to help that platform because one technology is not always user friendly for anyone. So, that's what we did. We gave out cards as well and pamphlets for patients so that they knew exactly what platform we were using. Some of our providers like Doximity, a little better, as a platform, because it's less for the patients to click, and less for them to do. Well, we have a choice in the matter. You're either using Doximity, we're using Doxy.me., or they're basically coming in. Most of our staff is bilingual, and we do have interpreters to connect to the patients. We have interpreters on the computers or on your cell phone that can help interpret it during the visit as well, to help make the communication between patient and provider.

Meg Sheahan: That is so wonderful and interesting. Thank you for sharing that. Our colleagues from Morris Heights, can you add anything to this?

Tammy Gruenberg: I just want to just ditto what Dr. Welch said, that was our experience. So, we use Doxy.me, Doximity, and we also have the EMR website that we use, the Hilo app. So, in the beginning, we had some trepidation, a lot of issues. Most of our staff are also bilingual. I would say 72% of our patient clientele are Spanish speaking. So, we were able to get through that. Then, for our patients who speak other languages, or, let's say, the provider is not bilingual, then we would just do a telephonic visit. So, we're able to get through it basically the same ways that Dr. Welsh's team got through it.

Meg Sheahan: Right. Thank you. Navigation. Anne, we have about four more minutes, three more minutes, can you add anything to how your agency managed challenges when the services had a remote component?

Dr. Anne Nucci-Sack: I'm back on audio. We have limited experience. So actually, I'm learning from my colleagues over at Morris Heights and Sun River. But, our experience has been that most of our patients do indeed speak English, and if there's a question about somebody who has a different language need, what we would do was, we'd convert it to a telephonic encounter, and we could always patch in our interpreter services. So, it's slow, but at least there was a way to work around it. We have not set up the telehealth platform where we've had that experience yet. So, I have to defer to my colleagues.

Meg Sheahan: Great, thank you. Thank you all so much in this Roundtable, for all of this great information and sharing your expertise. I'd like to move on to the next slide, so that we can get any questions from our participants. Participants, what questions do you have for our presenters, please use the chat to type in your questions and we will do our best to moderate.

Tammy Gruenberg: I just want to add, while the participants are asking questions, that we had a fantastic clinical informatics team as well. We will call them at night and we have their cell numbers and any issues that we came up with, they were very helpful. In particular, the Head of the CI team was just really terrific. So, it was important to have the support as well, when we had this steep climb of, how do we do telehealth? We were just thrown in there. So, I just want to just add that, it really was a team effort, including our CI team.

Ebony Copeland: Yeah, this is Copeland from Morris Heights as well. I will say that, the organization as a whole from a provider and CI standpoint, really tried their best to meet whatever needs. Because, we started with just Hilo and then we were, okay, we're having these challenges, we're missing people. So then, we got to the docs where we can send them out the link. Taking in age and difficulty and how they are able to manage the system. So, there was a lot of different iterations to get to the methods we use to make sure that we're trying to reach as many people over this time period. But, I think both the providers and the CI staff really worked hard to try to capture as many people as we could... Not just family planning, but just as an organization.

Meg Sheahan: Absolutely. A team effort. Thank you for sharing that because it is true. As my agency has transitioned, we could not do it without the team effort. So, thank you for mentioning that. Participants, again, if you have questions, please chat them into your chat box. While we're waiting for those questions to roll in, I actually have a couple of questions that I'd like to ask. One thing that I would like to actually hear more about, because, in the beginning, there was great concern about PPEs, and will we have enough and how do we provide good stewardship to them in order to maintain an adequate supply for safety? So, my question that I'd like to hear more about from each of the speakers is, can you describe how you optimize and manage your PPEs, when you're providing family planning services, as an agency and within your unit? Perhaps with that, we can start with Dr. Welsh again.

Dr. Welsh: No problem. In the beginning of this pandemic, I will go on record and say that, I don't think we really had PPE. We weren't using it at the Health Center. I had to write an email to my CMO and say, this is not acceptable, especially for our prenatal patients. The following week, all staff had PPE. I don't think it was just my email alone, but it was something that I was really concerned about. Our PPE was meant to be reused. We were offered N95s, we were given gowns, gloves were running low. So, all of those things. We had a room where you hung your PPE overnight, and it was reused. We still continue in that trend where unless it's soiled, we do get a new PPE on a weekly basis. They have since added, like I said, goggles that we are to wear during patient care. All patients are expected to use PPE and we offer masks at the front before they walk in as well as our front desk staff. So, we are not in short of PPE. I think, gloves, probably, a little bit more than masks. We are making sure to sanitize everything after each patient contact, and if there is a patient that is a PUI that came in with symptoms, we close down that room for at least an hour before it can be reused. We have our urgent care centers in some of our health centers to help mitigate those that are coming in with symptoms. So, they're being tested outside in their car, so that they don't have to walk into the Health Center, which wasn't the case in the beginning of the pandemic. So, we really have changed things, maybe 180 degrees, to help with the PPE and help with making sure patients are separate, especially those with symptoms. We're asking at the front all of the important questions. Have you been exposed? Have you been tested? Have you been outside of the tri-state area? We're doing that on the phone as well before they even make their appointment?

Meg Sheahan: Great. Thank you. Our colleagues from Morris Heights. Can you describe how you optimize and manage PPE use in the midst of this?

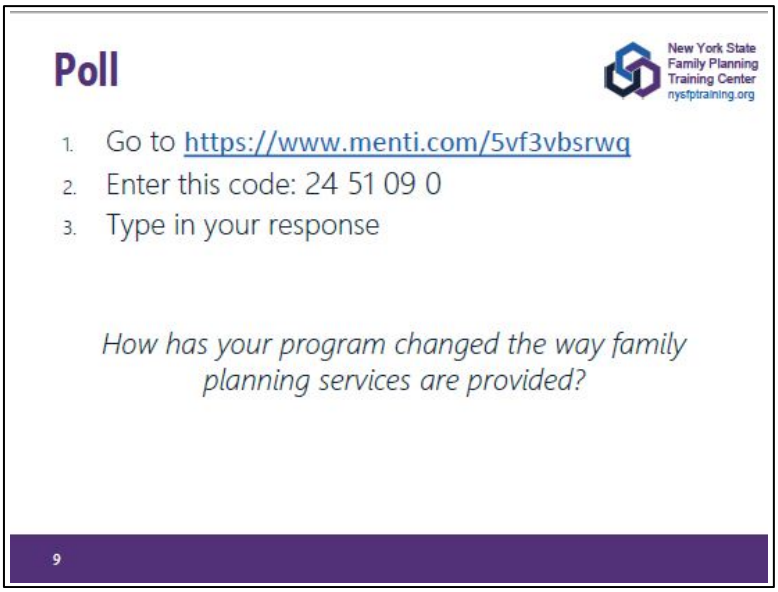
Tammy Gruenberg: I think, again, much in the same way as Dr. Welsh's [inaudible 00:44:05], seems like we have a very similar experience, although we are in a very urban setting. But, in addition to the disposable mask, we were initially allowed to have the cloth mask, and we could use those. In fact, the organization, I think, bought some cloth masks for us which then we weren't allowed to use later because wasn't recommended. So, we had the same issues. Then, personally, I was able to acquire, through colleagues in different organizations... Specifically the Christian Medical Dental Association was able to give me 1000 patient masks and 1000 PPEs that they were able to give to us and they gave to us at the Women's Health Center. So, that was amazing. So, we were able to acquire that out of the goodness of their hearts, because we told them that it's just... As Dr. Welsh said, it was just unacceptable what was going on. We had a few colleagues who had COVID and had to be out, so we were scared. It wasn't safe from the beginning, but it did get better. I think now we're at a good place.

Ebony Copeland: Yeah, I agree with Tammy. We always... Not always, I think, post-Ebola, we've always had some PPE on site. So, we never were operating with zero, right. But, it wasn't a lot, right. We definitely didn't have access. In the beginning, when there was conflicting guidelines, who should be using what and what we should be using, there was issues with that. Then, I think there was also challenges with distribution, it was kind of centralized so that was limiting our access to it. When we needed it, it might have been in a big building, but not at the sites when we needed it, because we were trying to ration. But, I think, over time, it's not really been an issue, we don't really have much of a shortage of anything. As of now, we're not rationing anything, which is great.

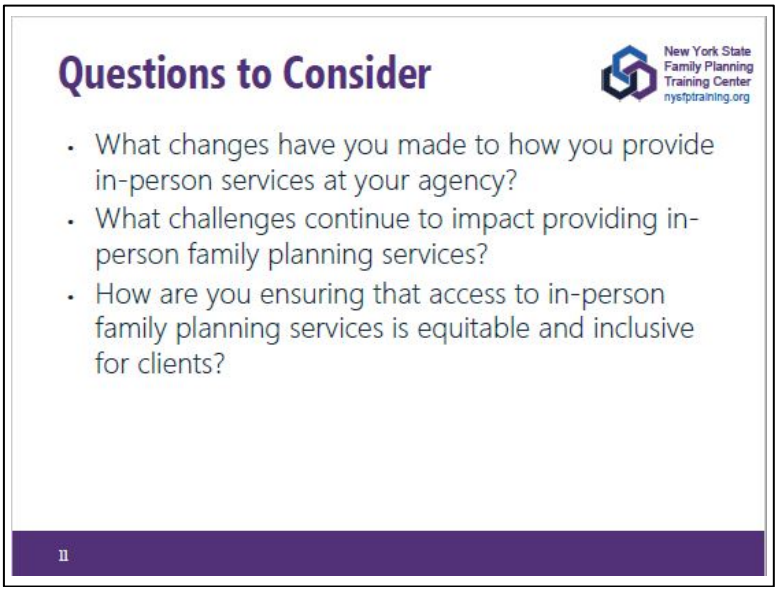
Meg Sheahan: That is wonderful, and so reassuring to hear. Okay, let's move on. Actually, I'd like to hear a little bit from Anne. We've got a few minutes on this. Let's hear from Anne about how PPEs were optimized and managed at your site.

Dr. Anne Nucci-Sack: Okay, I'm back on. Can you hear me? Yes, the PPEs, at the beginning, it was... We didn't have a lot, but we had enough. We always had adequate supply, but we had parsimonious use of it. So, if a patient were to come in and have some COVID-like symptoms, we put them automatically into... We had redesigned our clinic flow, so we had isolation rooms that were set up in one quarter very close to the door, so they wouldn't have to go throughout the entire clinic. The young person would be put into the room, and then we would call in and do a phone visit with them and get the whole history. Then, what we would do is, understand everything we needed. So, if they wanted birth control pills while they were there, along with being evaluated for their COVID symptoms, at that time, we didn't have COVID testing. That was only for higher order levels of illness. But, we would get all the information and anything the young person needs, we would gather it up and then put on PPE only once, when you go in, you do the face-to-face with the patient, give them the supplies they need, anything else that needed to be done, we would have other staff come into the isolation room and do... We just tried to minimize the amount of times you had to change your PPE. So you go in, then you have to come out and get some supplies, go back in, you have to re-suit up again. So, I think it was just more, a very conscious use of the PPE, and, of course, at the beginning, there's just nothing more brilliant to add. People were very good about... Actually, many of the staff made masks for each other at the very beginning when it was okay to wear any kind of cloth mask. But, if the young people came in, we gave them masks if they didn't have one, and they would come in and... They needed a mask, and so we gave it to them. We weren't going to tell them to go away because they're not wearing a mask.

Meg Sheahan: Absolutely. It's so nice through your stories through this time of shortage and wondering how to be good stewards to hear these stories about the generosity of our colleagues and other agencies and people making masks. That is very nice. I think, for now... I have so many more questions that I'd like to ask you all, but we're going to move on with a poll.



Caitlin Hungate: Okay, so we are going to use Menti, everyone. So, if you can, please go to www.menti.com and we'll put that in the chat for you all, and enter code 2451090. You'll see the instructions will show up in just a second again. We'll put it in the notes... In the chat, excuse me. We want to hear how your program has changed the way family planning services are provided. So, if you, again, go to www.menti.com and then you'll enter passcode to 2451090. You'll see on your screen the opportunity to add some responses. If you can try to be succinct in your answer, and make sure to hit Enter or Return, and in a second, we'll start to see results pop up on the screen. Again, once again, the code is 2451090. Wonderful. So, someone wrote in that they continue to provide telehealth services and that this was done pre-COVID. Education team working remotely, excellent. Collaborative innovation, inclusion via digital, excellent. Curbside pickup, wow, that's incredible. Thank you. Sending prescriptions to pharmacies much more than before, absolutely. More pill pickups, more telehealth, probably. What else? Please make sure to... It's so wonderful to see these ideas come in, so we'll take another minute or so and hopefully get to see a few more ideas come in about how you've changed your family planning program. Continuing to offer telehealth, more mix of telehealth and in-person. Wow, look at this, we've become more accessible. Lots of ideas coming in. Same-day visits, I saw that. Thank you, Rachel for scrolling down. Walk-ins change to same-day appointments, that's excellent. Mailable [inaudible 00:51:57] kits offering telehealth. Something about Health Education team. Wow, it's a lot of change and innovation and adaptation to how family planning has changed. Thank you all so much for weighing in. It looks like more so coming in. So, we're seeing a lot of themes of mix of telehealth and curbside and really just the flexibility of you and your teams and we are so thankful. So Rachel, if you would like to close the Menti poll, and we'll go back to our slide deck. I'll turn it over to Meg to give us some instructions on the virtual breakout room.



Meg Sheahan: Just waiting one more second to move over on to the next slide. We can take a minute to look at what some of our peers have typed into the Menti poll in the meantime. Well, I'm going to explain the instructions anyway, while we're waiting for the next slide to come up. So, now we're going to break out into our smaller groups to continue this conversation. You don't have to click on or do anything in order to get into your breakout room. We'll all be placed there automatically, and we'll have a couple minutes, about 15 minutes, to talk and learn from each other about the journey that we've been on. Then, we will be placed back into our larger group again, and we'll have a little bit of time to report back what we discussed and what we learned. So, let's go. We'll see you in our breakout rooms.

Caitlin Hungate: Hi, everyone. Thank you so much, and welcome back to our big group. We're going to now do a bit of a report out and share some insights that you discussed in your breakout room. I'm curious for Meg, who is the reporter outer in your group?

Meg Sheahan: Ken very generously volunteered Olivia.

Caitlin Hungate: Oh, Olivia. Olivia, thank you. Can you share, what was one to two strategies your group talked about for ensuring safe in-person services? Sorry about that.

Olivia: Yeah. Can you hear me all right?

Caitlin Hungate: Yes, thank you.

Olivia: Good. We took... Sorry, I did not take notes. So, we talked about how where Ken and I work, we no longer do in-person, we call people just to give that safety factor of not a lot of people going in. Then, we also talked about how innovative all of the strategies people are coming up with and how it really makes you think about how you're going to be able to talk to your audience, and how are you going to keep them captivated with everything.

Caitlin Hungate: Thank you so much. How about Lisa, who is the reporter outer from your group?

Lisa: Martha graciously agreed to be our reporter outer.

Caitlin Hungate: Great, Martha. Where's Martha? Oh, there she is.

Martha: I have no face. Sorry, I'm without a camera today. So, our group had lots to talk about the first question, the strategies that we're using for the safe in-person visits. For the most part, all of our places of sex are open, although some of the programs have closed. Some sites are now having patients go to other sites, where the staffing and where the resources are available, following the CDC protocols for safety, of course. Then, the other piece that I think is universal is folks increasing their use of telehealth service, which for some of us is brand new and for others, they were started ahead and had a headstart really incorporating it more into their activities. The other piece really is, increasing the outreach, which is talking to the patients and ensuring that it'll be safe and in-person before they get there. As far as equitable access, that's something that everyone is clearly interested in. I think one of the most interesting things that was mentioned was the use of iPads that the hospital... I'm sorry, sponsor organization provided to one of our group members so that patients would be able to see the face of a translator both for spoken languages, as well as for sign language [inaudible 00:56:49] for their patients that's going to continue beyond COVID. So, that was an exciting innovation.

Caitlin Hungate: Thank you so much, Martha, and Lisa, for that reporter outer. How about Katie, who was the person in your group that is the reporter outer?

Katie Quimby: That would be me.

Caitlin Hungate: Oh, fantastic.

Katie Quimby: I will share some of what we talked about. Yeah, we focused on other strategies that were not already shared by our panelists. Some of the other things that were talked about in terms of strategies for ensuring safe in-person services were, waiting room. So, using the car as a waiting space, and also having separate waiting areas for various patients, based on the services they're seeking. Talked about pre-visit planning as a strategy for screening patients, as well as identifying potential barriers that they might be facing to come in for their visit that day. And, if they're not able, coming up with other strategies that can continue to meet their needs without them coming on-site, if that's something that has come up last minute. Also, as a

pre-visit planning as a way to keep patients engaged in services. And, cleaning and sanitizing, to an increased degree came up, as well as staggering appointment scheduling, so the patients are not coming in, the groups at the same time. In terms of some of the challenges, I think the main themes were around continued fear that patients have coming on-site. So, trying to do as much as possible around preemptively explaining. I think, Olivia just mentioned this, too, around what sanitizing will be happening and masks and some of the precautions that are going to be taking place on-site to address some of that fear, which still seems like it's the number one concern that prevents patients from seeking services. We didn't get a ton of time to talk about the last question. The main strategy that did come up was just ensuring access to phone services as one strategy for addressing equitable access given the number of challenges that have come up around cell phone reception and internet connection. Just making sure that there's a fallback plan of phone access to this.

Caitlin Hungate: Thanks, Katie. Jennifer, how about your group, who was the reporter outer from your group? Dr. Welsh.

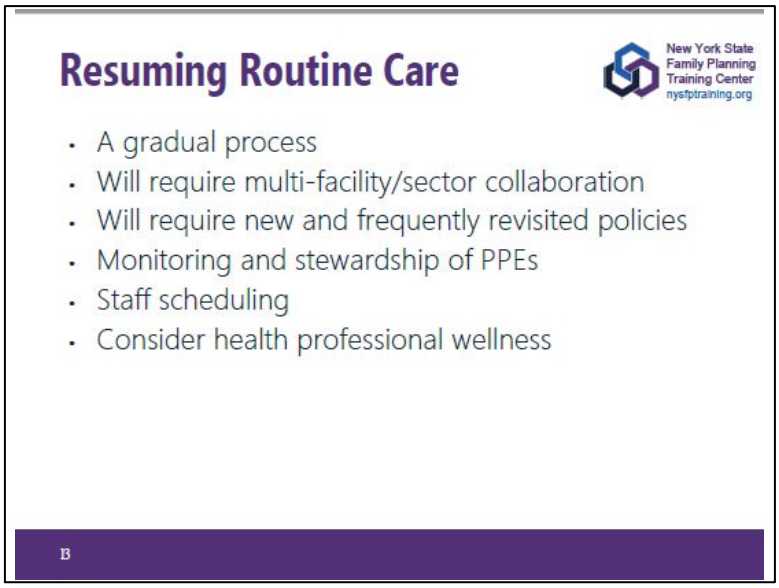
Dr. Welsh: Sorry, our group really focused on the challenges of telehealth because that's what we focused on as a strategy to continue family planning services. It was said that adolescents really want to be in-person. They tie their family planning appointments with other issues. Depression is also a concern. Privacy was a concern as to why some providers and/or patients didn't utilize telehealth as much as people expected them to. Training via telehealth has also increased. So, in family planning and trying to get the word out, the training aspect which used to happen in-person is now going via the telehealth route. So, we were discussing more of the challenges that's associated with that and why some folks may not be utilizing it as often.

Caitlin Hungate: Thanks, Dr. Welsh. Were you able to get to the equitable access at all, or, did we did your group focus mostly on those challenges and changes?

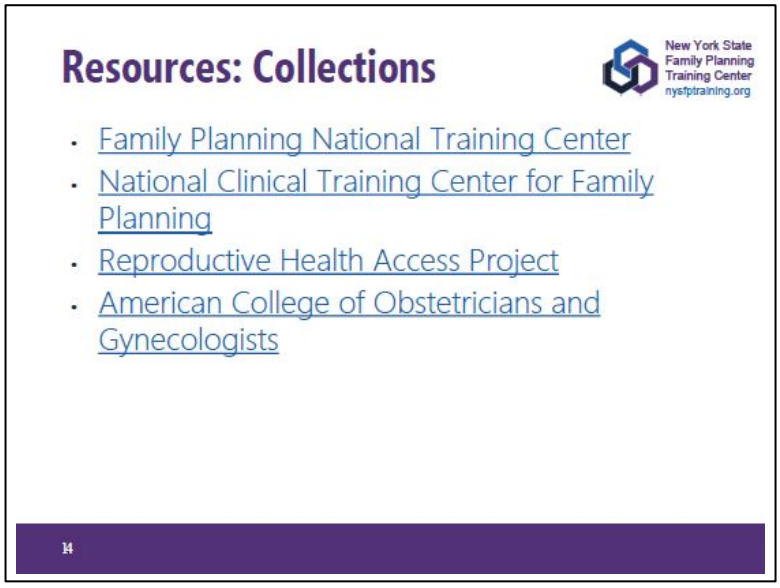
Dr. Welsh: That's what we focused on.

Caitlin Hungate: Okay. Perfect. Thank you so much, Dr. Welsh. Last but not least, our speaker outer, our reporter outer for our small group is Julie Westberg. Would you be able to come off mute and share with our group talked about?

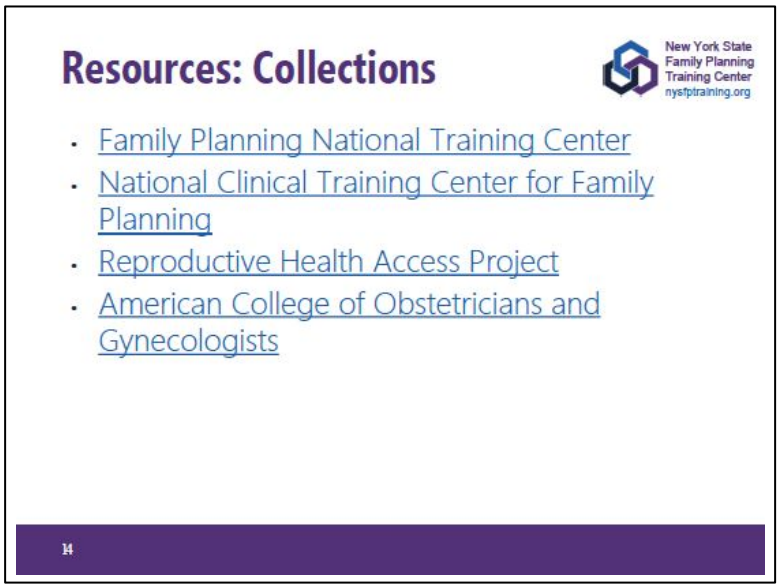
Julie Westberg: Absolutely, there's an advantage in going last, which is everyone pretty much said everything that was on our sheets here. But, as everyone was talking, there's a challenge that actually came to mind, I know, for us here in our Medical Center, which is quarantining and staffing. That's really new, and it actually has been quite challenging at times. We've had more than one staff person come into close contact with someone who is tested positive, they have to go quarantine, they have to get their test. We've had a couple people that, once the hospitals and primary providers open back up again, there's medical procedures and things, you have to get a COVID test, you have to quarantine until you find out about that COVID test. So, that's actually been... And, I, myself, admin side, I can work from home, but I've been quarantined twice and working at home is great, but I need to be here to do things. So, that's been challenging, too. So, I think that's certainly something new and that will be ongoing, I'm quite sure. But, everything else, everyone else said, I think, all the other points that we discussed.



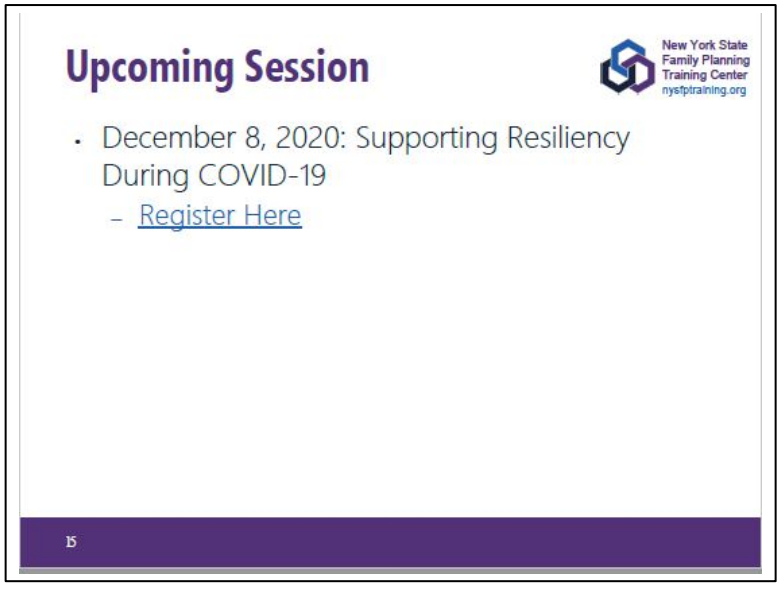
Caitlin Hungate: Absolutely. Thank you, Julie. There is benefits to going last Tuesday, as you say. So, we want to thank you, everyone, for your time in the breakout room and the small group discussions to really dig into some of the challenges and strategies. When we think about what resuming routine care looks like... My colleague, Rachel, if you can advance to the next slide, please. So, routine care, what is that, right, in COVID? I think COVID appends whatever routine we had pre-COVID. It's going to be a gradual process, it will ebb and flow. I just want to also take stock and celebrate you all and all that you have accomplished and strategized from the workflow redesign to the stewardship of PPEs and the ways you had to save and reuse. Julie was talking about the quarantining with staff. The level of challenges and strategies that everyone has rose to the challenge to find a way to ensure access to care to access to services, and still do the submits to COVID-19, it's amazing, and I hope that each of you can take a moment to pat your shoulder, celebrate or give yourself a hug to celebrate the challenges in resuming and ensuring access to care. The last eight months have been chaotic and stressful, and what the winter and 2020 looks like. Flu and COVID, I know many agencies are probably concerned about that. So, we just really wanted to celebrate and look at all that you have done and what resuming routine care looks like. So, some of those staff scheduling and strategies will continue. So, I'll turn it over to my colleague, Meg, to share some resources before we close out.



Meg Sheahan: Thank you. So, I'm not sure about you all but when my head is down and I am working in the trenches, I often don't take time to come up for air and find resources that can help me answer my questions and structure my work. So, we really wanted to provide some very useful resources to help you not reinvent the wheel. This slide contains links to collections of resources. And, within these links, and within these collections, you will find social media toolkits, information on how to achieve health equity during the pandemic, clinical best practices, information on billing and coding and so much more. So, we hope that you will check them out. Next slide.



Caitlin Hungate: In our final session in our, Adapting to COVID series, is on December 8th, and the focus is on supporting resiliency during COVID. So, we will center the conversation in our last session around this notion of collective trauma to identify opportunities for building resilience and support. Like I said, especially as we head into the winter months with flu and COVID cases rising in New York and across the country, and particularly across New York hotspots, as the numbers are not what they were in the spring, but communities are seeing hotspots in their service areas, we want family planning providers and staff to leave our next session, feeling seen, feeling supported, and having strategies to support themselves and their teams and clients in the months ahead. We heard from you earlier that managing staff and client anxieties was a challenge, so we really want to center the conversation so that you can walk away feeling seen and supported and have strategies. Our final session will also include another virtual Roundtable, and breakout rooms for smaller group discussions, and we hope you'll join us in our last session in the series. Thank you so much for your time. I'll turn it over to my colleague Katie for any closeout or final wrap-up.



Katie Quimby: Great. Thanks, Caitlin. Yep, just as we wrap up in the last couple minutes here, we chatted out the link to the evaluation, so please take two minutes and share your thoughts on today's session. We have been using these evaluation results to inform each of the four sessions and so we would love to get your thoughts as we are putting our wrapping thoughts on preparing for the December session that Caitlin mentioned. We will put the registration link for the December 8 session in the chat so that you can sign up for that now as well as that will be in the newsletter that goes out next week, if you miss it today. We will be posting a recording of today's webinar on nysfptraining.org in the next few days. You will be able to find the slides there along with the recording in the next few days, and you already have the slides in your email from pre-registered. Thank you so much for joining us, and a hearty thanks to our panelists. We will see and speak with you all again on December 8, and have a wonderful day until then.

Camille Robinson: Thank you.

Caitlin Hungate: Thank you, everyone.

Ebony Copeland: Thank you.

Meg Sheahan: Thank you. Stay safe.