July 21, 2020

Topic areas concerning Virtual Centering (CenteringPreg) from the call with CHI:

-Recruitment for digital groups and if/how that has changed from recruiting for in person groups

Biggest change is that registrations are all being done by me with referrals/tasks from providers. We are filling groups with the Opt-in enrollment strategy where provider/midwives offer the Centering option to the patient in the first ob visit. They will send me a task to enroll the client. This may need to be adjusted as we go to a larger scale.

Moving forward: I envision that a new approach will be helpful as we attempt to expand the enrollment and open more groups (to get more patients enrolled from our Congress Clinic site and the other midwifery pods). As all of the Midwifery providers are operating under one umbrella, (rather than Congress and Birth Center) how do we designate who is going to what group.

Need to think about creating scheduling options for EDCs in English & Spanish, plus adding CParenting back on to the schedule

-Enrollment strategies- strict cohorts? open to people of any EGA?

I am still grouping the cohort by EDC, as I had done with in-person groups at Birth Center.Groups have an overlap of EDC of 4-6 weeks. For example, a patient enrolled in the OCT EDC cohort may be due between Mid-September through the end of October. The schedule has the first encounter aligning with EGA of 12-16 weeks. Then session 10 should fall at the first or second week of the month. This changed because the patients were not coming to session 9 and 10 when we met in person. No that families can join the meeting from home they are glad to join with their newborn. A lot of support is desired at that juncture.

-How/where the clinical assessment happens

We are using breakout rooms for the provider to do an assessment (conversational/verbal) without gathering any vitals unless the client happens to have a scale at home. We are using the TeleMedicine format (for billing and coding) for virtual visits. This occurs during the first 30-40 min of the two hour Zoom Session, where the midwife sees each client individually for 3 – 7 minutes (average). Our patients are generally low risk, with adjustments made for individual needs. We have been offering all of our patients a combination of in-person and telehealth appointments during quarantine March through June. With the full Centering Schedule of 10 session this means that there has been quite a bit of doubling of appointments for the centering patients.

Moving Forward: We need to adjust this somehow – reducing Centering Schedule? Replacing some of the Centering sessions with educational only and no provider assessment? Adding a way for clients to gather vitals and continue with most appointments happening virtually for centering clients?

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-How the interactive learning/community building pieces happen

Techniques demonstrated by Lynn and others at the CHI learning how to do virtual Centering calls. I have been participating in every - and all - training I can get my hands on. However I find that just like in person groups, ice breakers are the best to lubricate the crowd. Getting people to laugh and get silly will get them out of their “am I doing it right” brains and understand that they are there to have an enjoyable time. I set expectations at the beginning of the first few (3-4) calls for what it would look like in person (sitting in a circle) and invite them to imagine that everyone in this room has similar hopes and fears. Remember ARR! It still works here. It is not any easier, or any different. You do have to be comfortable with silence. You may have to call on a person a time or two.

Activities:

- We use the brainstorming activity a lot, jotting down what people shout out on a white board on the shared screen. That feels more hands on than a conversation.
- I will offer to have people send their ideas to me in chat privately (like the Popcorn Activity) Then I can present to the group so people do not feel awkward. PMD discussion and breastfeeding.
- I use the tools from Motherboard Birth for childbirth educators. I subscribe to have access to visuals and handouts, that allow me to demonstrate concepts and break up the monotony of looking at a bunch of faces on the screen.
- I use video clips on YouTube for breastfeeding and labor (Global Health Media, Nancy Mohrbacher, Penny Simkin)
- I try to remember to get people up and moving. Simple stretches or ask a brave client to demo a yoga pose or a massage technique.
- Mindful raisin with some tidbit they choose from their kitchen. “Find a morsel of food that you can eat in one bite and you can hold in your hand for a few minutes”
- The ice game for practicing a contraction has been fun when people do not have ice cubes at home, but they go find frozen strawberries or another frozen treats as a substitute.
- Lots of these ideas are available on the CHI Portal under Virtual Group Resources, because that is where I got many of them!

-How prep has changed moving from in person to virtual groups

Mostly I think it might be a little easier, you don’t have to manage logistics of a physical space. But it is a bit of a brain teaser in the management of activities – what works in the virtual format. How can I make the usual activities work in a virtual space?
If you are in your comfort zone of facilitating a group in person then in the beginning, your learning curve is going to be Zoom. You especially need to be on the same page with your co-facilitator and realize that there is this third thing that needs attention and that is running the zoom meeting. You have to manage the facilitation of the content curriculum, the client’s needs, and the zoom controls. You need to familiarize yourself with Zoom, (or your platform). Get a practice meeting a few times before you jump in with clients. You need to prep the client ahead of time on getting access to Zoom and being able to log in.
When you are doing an activity you are going to need your co-facilitator to “watch the crowd”. There is a new art to reading participants cues in this screen to screen format.

-Billing/reimbursement

We are doing the same as in person coding, Group education code and 99212 E&M Code

, with the addition of the designation of “Telehealth” encounter and attestation (telehealth is Modifier 95? I believe) Ask your billing and coding department.

-Lessons learned/best practices

Use break-out rooms to facilitate one on one conversations among the group participants. This allows for more natural conversations to occur so they can get to know each other. I have used it for triad and dyad introductions. Colorful questions where you give the pair 2 min to talk – one minute for each person to respond and then you swap partners for another question. We used breakouts for small work groups when talking about *The Family I Want to Have*, and Labor Preparation discussions.

Have fun, relax and set the tone for how you would like the dynamic to feel if you were on their end. Be transparent about your own adjustment to using the virtual platform. Don’t pretend to be an expert if you aren’t. Its ok to say, “Hmmm, let me find out”, or “That didn’t work, let me try that again.” But “Fake it ‘til you make it” has its place too. Just do your best, be prepared, and then let go and enjoy the time getting to know your clients.