DR KAREN DESALVO:
Well, hello everybody and welcome back to our afternoon sessions for the NAM annual scientific program, Women's Health from Cells to Society. We had a great set of sessions this morning and I'm really looking forward to our next panel that we have this afternoon. Our second panel for the scientific program is, addressing maternal and reproductive health in the current US landscape. Innovation to improve inequities, care and outcomes. Our moderator today is going to be Dr Laurie Zephyrin, who is senior vice president for Advancing Health Equity at the Commonwealth Fund. I would like to invite Laurie and the panelists to come on stage. Thank you.

DR LAURIE ZEPHYRIN:
Thank you. Alright, this is very exciting. After lunch, everyone's wide awake. This has just been a fantastic morning. Thank you, Dr Sal, for this area of focus. Thank you Dr DeSalvo and I just been really impressed and overwhelmed by the panels this morning. I have to find this thing. So, really, I want to start out with saying we know what to do. And I put a question mark because you would have heard Dr Johnson earlier say we need to know more and I think both can be true. We need more scientific research and we also know we have information that where we can act today. We have innovations in place where we can make a difference for people on the ground. And when I'm thinking of the perspective of communities and people who have experienced loss and families who have lost mothers because of inequitable maternal health care, we know what to do and we know that we can we can do better. And so as we think about true innovation, true innovation has to center inequities, which is why I love the focus of this panel.

We're talking about innovation to address inequities and care and outcomes as well. And we have to use our maternal health crisis as an example of the wide racial and ethnic inequities and experience treatment and outcomes. It is a systems failure. It's not an individual one as you all know. For black and indigenous people in the US, things have reached crisis proportions. It's been exacerbated during the Covid pandemic when racism was unveiled for everyone to see its impact and this has continued and we know most of these deaths are preventable. And we talked earlier about how we are exceptional in the United States in terms of our maternal health outcomes. And what, I want to just highlight about this is, you see the rate for black women to the right of this in the left graph to the right. You also see breaking out by other race and ethnicities as well. And so when we compare ourselves across race and ethnicity, even the lowest rates of maternal mortality are higher when we compare ourselves to other high income nations.

And this is bigger than maternal mortality. And what I say when I say this, I want to really highlight, my mic has come off. I want to really highlight that in comparison to our peers in the United States, things are getting worse over time. US women have the highest rate of avoidable deaths and thank you for the prior panel for highlighting some of this work. As well as we know that health care is becoming increasingly more unaffordable. So, our solutions also have to be bigger than maternal health as well. We know that when we compare ourselves to other high income countries, some of the factors that lead to better maternal health outcomes also lead to better overall health care outcomes, better coverage, more affordable coverage, comprehensive reproductive health care, including abortion care and contraception care. A diverse workforce in terms of diverse in specialty, including midwives and OB-GYN's and community health providers and doulas, as well as diversity and race and ethnicity and comprehensive postpartum care.

Pregnancy isn't the beginning and end of care. And so failed systems fail people, especially those most marginalized. And so as we think about those failed systems, we really have to understand and innovate with these systems systems in mind and pressures on these failed systems are increasing. With Dobbs, we see those states that are most likely to have the worst maternal health outcomes are also the ones that have the most abortion restrictions. So what does that mean for people on the ground living day to day? And we're going to talk more about that today. And we also have to understand that this increasing rates of maternal mortality and morbidity, limited family planning access, maternal and reproductive deserts in urban and rural communities, the uneven distribution of Medicaid expansion and postpartum extension and persistent racial and gender inequities. So today we're going to talk about that. We're going to talk about innovations that are happening. We're going to hear some of what's happening on the ground.

We're going to talk about what are some of the enablers from a policy and systems perspective, and how we can actually truly innovate with equity at its center. So I'd love to turn to our panel. I am really excited, this is a rock star panel. We have people on this panel who are leaders in health equity and health systems, innovating at the cutting edge. First, I want to introduce Dr Veronica Gillispie-Bell. I'm going to introduce each panelist before they speak. And so Dr Gillispie-Bell, I'm going to pass this to you. And so Dr Gillespie is a board certified OB-GYN and associate professor for the Ochsner Health Center in New Orleans, Louisiana. I've long followed your work and can you tell us where we stand and what we know and what we need to do?

DR VERONICA GILLISPIE-BELL:
Yes. Thank you so much for that introduction. And thank you all for allowing all of us to join you today to talk about something that is near and dear to all of our hearts. As we think about those numbers that Laurie just just revealed to us, I'm going to tell you about the deeper dive. So, I'm the medical director of our Maternal Mortality Review Committee in Louisiana. We have 36 MMRCs across the United States and what we do is actually try to recreate the life of those decedents through reviews of medical records, any other outcomes or any other data that we can find around those decedents to really determine what is leading to maternal mortality in the United States. And I think some important things to think about as we start to think about the solutions are one, the timing of the deaths. I think that a lot of people, me in particular, before I started doing this work, thought that a lot of the deaths were related to what was happening in the hospital. That is a part of it but if we look at the numbers, 53% of pregnancy related deaths occur from seven days postpartum to one year postpartum.

And if you think about, as Laurie was talking about our systems, and we think about how our systems are failing our mothers, how many of our mothers can actually get into care during that time. And if we think about the underlying causes of pregnancy related deaths and again, this is from our maternal mortality review committees, we see that mental health conditions is actually the leading cause. And we've done a lot of work in the United States about creating awareness around mental health conditions but there is definitely more to do. And so if I could sum up in just a Venn diagram, the three things that we have to work on is going to be improving our systems of care, improving clinical quality of care and addressing social determinants of health. And all of this must be done through a lens of equity or those disparities that Laurie mentioned will continue to get wider. So when we talk about improving systems of care, we mean things like bringing care to the patient instead of making the patient come to care.

We have so many innovative ways of delivering care that we need to explore that in the maternal health space. Things like telehealth, which myself and some of the panelists will share today, thinking about the ways that patients want to be centered in their care. That may be group therapy, that may be care in their home through home visiting, that may be thinking about a team of care providers that include a physician, a midwife and a doula. But thinking about systems of care in a way that are different than many of us as physicians have been trained, and many of us that have been in the health care system have been exposed to, and we have to have better collaboration among the various systems that care for pregnant individuals. And of course, we have to make sure that care is dignified and respectful. We have so many anecdotal stories of mothers and particularly black individuals, that do not enter the health care space because they are afraid of the lack of respect that they are going to receive in care.

And when we think about now the the improving the clinical quality of care, we have these cogs that work together. We have our MMRCs and that I was mentioning before that tell us the data. We have our perinatal quality collaboratives that work with our birthing facilities to implement the AIM or Alliance for Innovation on Maternal Health Patient safety bundles. And there are safety bundles that cover many of those clinical deciders and clinical conditions that we see contributing to pregnancy related deaths and to maternal mortality. And then social determinants of health. We know that about 80% of our clinical outcomes are determined by our social determinants of health. And for me, when I speak about social determinants of health in different audiences and different venues, I always describe social determinants of health like a tree. So off of each branch is going to be a different determinant of health economic stability, health and health care, the built-in environment and the reason I describe it as a tree is because it matters where your tree is planted.

I am from Louisiana, I'm from New Orleans, originally from Mississippi. I can tell you, growing up in Mississippi, if your tree was on one side of the train track, it looked very different than if it was on the other side. And so we have to think about those social determinants of health because our patients are coming into care, many of them already behind the eight ball. And again, when we think about that timing of death and we talk about 53% happening from seven days to one year postpartum, those patients are back in their social environment. And so if we're not thinking about how those determinants of health are going to impact their outcomes, we're never going to improve those outcomes. And so maternal morbidity and maternal mortality. They are both a public health crisis but there is a pathway to improvement and today we're going to share some solutions.

DR LAURIE ZEPHYRIN:
Thank you. Thank you so much, Veronica, for your important remarks and really highlighting where some of the innovations are happening within health systems and communities. Dr Alina Salganicoff, thank you so much. I have been following Alina's work for so long, and so I'm so excited to be on this panel with you today. I often look to your work to tell us what to do and and what's happening in the women's health policy space. So, Alina.

DR ALINA SALGANICOFF:
So thank thank you, Laurie. It's a it's a great honor to be here. And I really appreciate the opportunity to speak to you all today. I have to admit, like, when I was thinking about preparing my remarks for this session, I was like, I'm going to be talking about abortion and contraception and I'm not really feeling the innovation right now. I feel like kind of we've been pushed down the stairs. So, I kind of came up with a new title, which is can we use this crisis to spark equity action and innovation? Because we really need

to be really thinking outside of the box and coloring outside of the lines because we know what we've been doing has not been working. And so, I'm going to walk you through some policy issues. I'm not a clinician. I've spent the better part of my career working on health policy issues, focusing on women's health, particularly those who are marginalized, who really do not have a seat at the table and who really are facing systemic systemic racism, inequities, poverty, all of those things that we know that are part of that tree.

And then we design whole systems to really, really starve those trees. And so let's try to think about how we can really change that. So, I'm going to talk about abortion. Where are we today? We have no federal standards and it's really up to the states. This is an up to date map and all the states that are red there are states that have abortion bans. Those that are in yellow are states that have restrictions, gestational limits before 12 weeks. Some of those that are in light blue could be changing Florida, for example. So we have a lot of huge swaths of the country, in fact, where there is no abortion access and pregnant people who seek abortion either have to travel out of state or they have to seek through telemedicine or through websites other ways they can self manage their abortions or they are forced to have a pregnancy and birth against their desire. And so this is though a point in time this map will continue to change. There's a number of bands that have been blocked and a number that are also being challenged.

And so there's a tremendous amount of activity at the state level. We also are seeing really, I have to say like, I know there aren't a lot of lawyers in this room, but this is really where things are really sitting right now in the courts and now in the federal courts as well. We have big EMTALA case about, actually there's one in Texas and recently we had a ruling from the in Idaho last Friday where they said that the clinicians really couldn't provide abortions if they are to save the health of the mother in an emergency room, even though AMTALA requires that, that is being appealed. And then, of course, the Mifepristone case and that's likely to be in this term of the Supreme Court, which really is challenging the FDA's approval of a drug that was 20 years ago and the FDA decision about how that drug can be dispensed. And so we are all really on pins and needles and a lot of the innovations and a lot of the work that's going, I think is going to hinge on that. Again, I want to emphasize, do hear a theme here.

Women of color, those in low income households and young people have been disproportionately, not uniquely but disproportionately burdened and affected by these bands. But I want to say this did not happen on June 22nd, 2022. This has been a long time coming. I think that there are many forces. Probably the day that the Roe decision was made started working to unwind this, and we are here because we have been on a long slope of abortion restrictions. And so even in the states where abortion is not banned, there are many restrictions, waiting periods, ultrasound requirements, requirements that physicians only provide the services, limits on telemedicine abortions, requirements for parental notification, pre viability gestational bans and of course, the Hyde Amendment, which limits the ability of the federal government to pay for abortions. And we have about, I think, 16,17 states now that use their own funds to pay for the abortions of Medicaid beneficiaries. So that this is not actually easy even once you get out of your state if you're seeking abortion.

And I think that as a health focused organization, really looking at what are the health implications of Roe, we're really just beginning to scratch the surface and to see that we had a meeting last, the Academy had a meeting last Friday on data. I'm part of the Standing Committee on Reproductive Health, Equity and Society but there is still very little data. I think we importantly need to center our discussion on the abortion bans, on the people who are banned from getting abortion. That needs to be where

we're focused. There has been a lot of attention, increasing attention on the implications for other clinical services. Suddenly we're thinking, oh, wow, I'm an oncologist, what happens to my patients who, you know, need chemotherapy and they're pregnant and they can't continue this pregnancy? I'm a rheumatologist. I'm an emergency room physician. What are all of these things? Before we put abortion in a separate box, now we have a recognition that abortion is part of health care. And then, of course, the broader societal, the ecosystem of health care, I think is another area where we're really, I think, trying to get a handle on what the implications are.

Everything from our discussions about addressing structural racism and racial equity in health care to training our workforce, health professional education. We had a conversation earlier, one of the comments earlier about the fact that women's health isn't mentioned in any of the medical textbooks. I can tell you abortion is probably barely a footnote there. So these are areas where, I think, we're really going to have to do a lot of work and we're going to need a lot of innovation. But there is some innovation and I did sit there and going, OK, what does innovation look like Post-Dobbs? I would say that medication abortion is an area where really, you know, when this was originally approved by the FDA, I think that there was a lot of trepidation and really was very restricted in terms of how it would be dispensed through the REMS. Now, the FDA, has reviewed all the information, the safety and effectiveness. They now permit telehealth abortions. You don't have to have an actual physician.

It can be another clinician provide the medication abortion regimen. We also are now going to soon have pharmacies dispensing Mifepristone, which was not permitted. That is an innovation and could be, I think, an important change. There's also a lot more transparency about abortion access. We have websites right now like Abortion Finder, plan C for individuals who are looking for abortions. There is information about where you can get it, how much it costs, how to get funds to help you pay for it and so all of that is out there. There's the M&A abortion line, which is staffed by clinicians that also helps people get abortion services. So that's an area. Then we also have broadening scope of practice. So advanced practice clinicians can offer services as well as a lot of state actions to really protect reproductive and abortion rights and providers. I'm going to talk really quickly about contraception because I know I'm running out of time, but I want to say that contraception is another area where we've made tremendous amount of progress with the ACA, with state laws that also go beyond the ACA, and particularly now as we're facing the headwinds of the Braidwood decision, we may lose.

Even though, the original decision didn't affect contraception, the Supreme Court may decide to reevaluate that. And so we've had a lot of progress in that way but headwinds around contraceptive coverage and the other thing that I want to focus on is the federal title ten program, which is a critically important program for women who are uninsured. And this program has been level funded for decades. It is now we have some state operated grantees who are not refusing to provide pregnancy options counseling that includes abortion. They have been disqualified from the program. And we have legal challenges now in Texas, you have to have parental consent to get contraception. So, misinformation is persistent and pervasive throughout the system when it comes to contraception but now we have the Opill, a new over-the-counter contraception and maybe we can talk a little bit later about some of the barriers and opportunities, as well as new methods with telehealth, tele contraception and pharmacists prescribing so that there's a whole host of clinicians that can help women make decisions.

So with that, I think I will.

DR LAURIE ZEPHYRIN:
Thank you so much, Alina. Next, I'd like to introduce Dr Jack Resneck, immediate past president of the American Medical Association. Jack, thank you for joining us. You probably had the longest journey here today, plane wise but, really, you've been instrumental in showing us what the physician workforce can do to tackle inequities. So, really looking forward for you to sharing more with us today.

DR JACK RESNECK:
Thanks so much for having me. It's a real honor to be here. The reason for the longest journey is that I was in Rwanda yesterday and got here via Nairobi, Dubai and a flight here this morning but I'm really excited to be here. So if I start to speak gibberish, just somebody let me know or distract in the audience in some way. So, really part of what's so great to be here is just to be up on this panel with people, some of whom I know and some of whose work I've watched for so long and that I have great respect for. Alina, I probably would never have a PowerPoint without the slides coming out of KFF and all the things that we all use from it. And I was initially going to sort of set the scene from the profession standpoint, from my AMA role, sort of what's going on both in the maternal mortality, black maternal mortality and particular space and in the post Dobbs era. But Veronica and Alina did such a great job with that, that when I saw their slides a few days ago, I sort of, retooled a little bit, and I'm going to talk a little bit more just about the context for the profession and what it's been like for the profession living through these last couple of years, and what the profession has pulled together to try to do in response to some of these challenges.

And, so I was my AMA presidency was June to June, finished a few months ago, and Dobbs dropped like a few days into my presidency. So you can never really predict what your year is going to be dominated by. That was a big piece of it but a lot of my year was framed around. What kept me up at night was not only these major government interference in access to care issues but also speaking for a profession that was extraordinarily burnt out. And that term gets used a lot, but burnout to the point of moral injury. And people talk a lot about this happening in the wake of the pandemic, people talk a lot about the administrative burdens, like prior auth that I go out there and talk about a lot. But I actually think that disinformation, which you mentioned and also this government interference, have been big drivers of burnout for physicians. So this is a stat that really bothered me. In the wake of the pandemic, only 57% of physicians would choose medicine again, that was heartbreaking for me and it speaks to an incredibly dysfunctional system that we're working in.

And yes, of course, disinformation, the amount of time that we all have to spend with our patients at every visit, undoing what they read on Facebook that morning, that they think they know about health care, and having the politicization of science driving that has really taken a toll as well. You've seen the stats on what's happening with 20 some odd states racing in the wake of Dobbs to take away physician and patients rights to make decisions together about patients health. You have even seen threats of violence and actual violence against physicians, whether it's in the abortion space. This is an example from Boston of a hospital where there were literally neo-Nazis protesting in front of the hospital against specific physicians doing health equity work.

JACK RESNECK JR:
We have had threats against transgender care at several hospitals and clinics around the country. So it's been a tough time for the profession in the midst of everything else that they're dealing with. A lot of people may not know how the AMA works, but we actually have a House of delegates. There's 700 or so

delegates in that house. It's made up of physicians from every state, every specialty rural, urban areas, small practices, giant health care systems, the entire political spectrum. I know because they all emailed me all the time, furious with our decisions. And we actually have evidence-based, science based debate the vast majority of the time. And those have been our North Star. And so when we are a nonpartisan organization, but when we come and take positions on things like abortion or gender affirming care, it is not because Jack Resneck is all of a sudden decided that's what he thinks the AMA should be for. It's because this group of people from all over the country, again, the entire political spectrum have come together in the wake of what we're seeing and said, hey, for example, in the case of abortion, a whole raft of policies passed over the last decade and a bunch more in the last couple of years, and I'm not gonna go through them 'cause I don't have time.

But I'm happy to hand out my slides about things like recognizing health care, including abortion and contraception, specifically as a human right etc. And why is that policy important? It's important because it doesn't happen in a vacuum, but it allows the organization to then go out and execute on and act on that policy. So I don't usually have this many pictures of myself in a PowerPoint. This could be considered an incredibly narcissistic but the reason to put it in there is to say that allows us to get out on the road and talk to the public about why the profession coming from science and evidence as our North stars think that, for example, it's incredibly reckless and dangerous to allow politicians to insert themselves in exam rooms in these most personal decisions that patients and doctors make together. So that's why we do this. This is an op-ed in the New York Times in the wake of trying to influence the Supreme Court around the mifepristone decision. I'll go anywhere. Anybody will listen to me to talk about these issues, whether it's abortion, gender affirming care or health equity work.

Traditionally, we fight in legislatures about these things, but it's been a rough couple of years on that front. So then we turn to courts. It's kind of been a rough couple of years on that front too. But we keep fighting. And so whether that's in small district courts or state courts or whether it's in the Supreme Court, whether it's these big abortion cases like Dobbs, the trap cases in the years leading up to it, whether it's about showing up in Indiana to defend Caitlin Bernard when the state attorney general came after her inappropriately. And we do this across the spectrum briefing in the Arkansas case challenging the state's ban on transgender treatments. This is actually important for women's health. You probably know about this other case going against the preventive care aspects, mandating no cost preventive care and ACA plans. When you think about breast cancer screening, domestic partner violence screening, all the things that are included in that and the enormous impact on women's health.

Not a great outcome on that case either. The ability to do comprehensive, race conscious admissions in higher education and medical schools briefing in that case as well. We've also been thinking a lot about health equity at AMA. We have 176 year history, so any organization with that much history has actually done a lot of harms in this space. And so we spend a lot of time at the beginning actually reckoning with those harms to try to rebuild trust with communities that have been harmed. This is a statute of J Marion Sims. You've probably heard of being taken down outside of Central Park in New York. He's actually an early president of the AMA, did a lot of experimentation on black bodies in the GYN space without anesthesia, incredibly racist experiments. So we have been doing a lot of that work just to deal with our own history and rebuild trust. And I probably should just pause here and even say that when I enter a conversation about health equity, especially on a stage like this, I do need to pause and just recognize that there's a lot of lived experience and expertise, both on this stage and in this room that I

don't bring to this conversation, but that I still think it's important for me as a cisgendered white, middle aged white guy to talk about.

So we've been doing this on all fronts. We have a new center for health equity led by Aletha Maybank. It has over 50 employees now, but when we created it, the long term goal obviously was to think about, hey, wouldn't it be nice someday when your zip code or your race, or your LGBTQ status, or your American Indian status or your disability didn't affect your health outcomes? But in the medium term, we felt like it would be successful when it wasn't a siloed thing at AMA. And we didn't expect those 50 people to do all this work. But it actually affected every business unit. And what I'm seeing so far has been pretty exciting on that front. So this is our chronic disease unit going out to actually show up in black women communities. This is a partnership with essence about hypertension and black women work to really change medical education and put out medical education that addresses these issues, thinking a whole lot about the pathway to medical school and to specialties so that we have a workforce that actually resembles the patients that we take care of.

When we think about innovation, actually making sure that we build innovation that doesn't submit existing inequities, whether it's digital health or AI, but that we start with that lens so that we get rid of them. And then the last thing I wanna talk about is sort of just what this equity work looks like in the maternal health sphere. This is a long list that I'm not gonna read, but it's about just numerous. There's a KFF slide. There you go. Alright. Fortunately, I didn't steal it without KFF credit. There's the little symbol there at the bottom. So we're all good. So for example, things like in our advocacy unit working with states to make sure that they take advantage of what we got in the rescue plan federally that now allows states to extend postpartum coverage and Medicaid and Chip from two months to 12 months. Think about how important that is with the slide that we saw earlier, about how many of those postpartum deaths, whether it's due to postpartum depression or a number of other issues that come up in that period when people actually can lose their Medicaid coverage and a long list of things that I hope that we will get to talk about in the discussion.

So with that, I'll just close and say, these are really hard times. And there was a period in the middle of my year when people started talking about my lectures as the angry Jack lectures, but I have reached a point of actual hopefulness in these difficult times, and tried to sort of end my year with that. And one of the most fun parts of the job is actually getting to travel the country and interact with great innovators like the folks on this stage, and actually frontline physicians and other health care workers in states across this country. We're the ones doing the hard work to advance the health of the nation. So with that, I will pass things on.

LAURIE:
Thank you. Thank you, Jack. And we'll get to dive a little more deeply in the Q&A. Dr Neel Shah, how are you?

DR NEEL SHAH:
Alright. Good to see you, Laurie.

LAURIE:
Good to see you. Neil and I go way back. Dr Neel Shah, chief medical officer of Maven Clinic. I've known Neil for a long time, and it's really been an important voice in this space. And so really excited to hear your perspective about technology as a vehicle for trustworthy care and equity.

DR NEEL SHAH:
Thank you Laurie. It's really an honor to be here. I'm looking out over the audience and I see a lot of colleagues and friends and mentors. So it's a deep honor to address this audience. I'm an academic physician, and most of my career is one of many people on the stage and in the audience who have been surfacing the maternal health crisis in the United States. I was gonna say, but I'm gonna say, and two years ago, I had a midlife crisis and some pandemic ennui, and I took a leave of absence from my university, ultimately gave up my academic appointment and gave all my grants away to help build a technology company of all things. That technology company, it's called Maven Clinic is now the biggest virtual clinic for women's and family health in the world. We cover 17 million lives and 175 countries which is now both my disclosure of positionality and my kind of vantage and aperture for understanding some of these issues. Now, technology is one of those words that means everything and nothing.

So when I use it and I talk about digital health specifically, I'm not talking about zooming to have a medical visit necessarily. I'm talking about actually something that's fundamental to what everyone on this panel is talking about which is information and how it gets deployed, how it gets accessed, whom it's deployed to, why, when, where? So that's what I want to talk about. And just very quickly, there are very few moments in one's life where you have a cinematic kind of worldview shift. Mine was definitely March 2020. I was on call on my labor and delivery unit. And you know, we didn't have any beds available. Testing wasn't there. It took six hours to get a test. The last person that we'd wanna bring into the hospital was a pregnant person unless you had to. And there was a scared pregnant woman from Chelsea, Massachusetts, who called me with shortness of breath. And according to my triaging algorithm, she wasn't sick enough to come into the hospital. So I gave her the advice that we were supposed to give her which was to self-isolate at home.

And she was like, I can't because I have other young kids. And she also drove a bus for a living, and I knew what social determinants of health were, but I did not understand to this degree. I mean, I still don't know what happened to her. But at that moment I was like, health is not produced in the four walls of my hospital. It's produced in people's homes and in their communities and even in their workplaces. And so that really changed my aperture from trying to optimize what was happening in labor and delivery rooms like this, to thinking about this broader sphere. Now, again, like maybe a disclosure here, an app is not going to fix structural racism. You can't deliver a baby through a screen, but I do want it as a provocation for discussion. Share a little bit about how I think digital health can be deployed to attend to some of these other things that we know to be very important. And I'll say also that I think that digital health has as much potential to impact people's well-being as drugs and devices, but doesn't often get subject to the same scrutiny.

You know, disinformation, to Jack's point, is probably the existential issue for this institution and every health care institution with severe consequences, potentially for women's health. So a little bit about that. The first step to understand people's social needs is to ask them about it. The gold standard currently to do that is a 17-question survey which is very hard to administer. I don't have a waiting room at Maven Clinic. Everything is digital. People can put their phone away at any point. So we created a three question version, published it in the American Journal of Obstetrics and Gynecology, and showed it had similar sensitivity and specificity as to prepare survey. And we asked about people's material needs. So we also asked them if they feel lonely or isolated and if they're safe. And what's interesting is that in a commercial population and a publicly insured population, about two-thirds of people screened positive, and of them, 80% have a clinical risk that would qualify them for a high risk case management.

And about half of the people with a social need, what they flag yes for is feeling lonely in 2023. The formal definition of which is talking to someone that you believe cares about you less than five times a week. We also found that people really wanna tell us these things can be stigmatizing. And so often, that's a reason to hesitate. But not only do they wanna tell us, but they may even be more willing to tell us in a digital paradigm than they are in front of a white coat which we found kind of fascinating which sort of led to this thought at Maven, which was like, to be more trustworthy, we have to be competent. And Veronica laid out all the statistics. We're not competent when it comes to maternal health. Compared to the last generation, moms today are 50% more likely to die in childbirth, even though we intervene 500% more. To be trustworthy, we also have to readily be available for people. Actually, I think that's what the brick and mortar system struggles with showing up for people when we need and expect them to.

If I were to tell the doctors that my health system in Boston to text their patients, they'd probably quit. And it's not because they don't care to communicate, it's because nothing about their day enables them to do that. But when you create a platform that does enable that kind of communication, people engage differently. And of course, we have to be able to affirm people along the way. So this is not epidemiologic data. This is just product analytics. But what it shows is the way that Maven works is we create access to 30 different types of health providers within 30 minutes, any time of day anywhere in the world. And you would think that would be the ultimate example of moral hazard. But it turns out people utilize that kind of access very rationally. And what this shows is the mix of specialists that people choose to access shifts over the course of their journey in very rational ways, use a lactation consultant and a sleep coach and the postpartum period and use... Actually, mental health is very stable across the entire thing.

It goes up a little bit postpartum. The other thing that we found is a person also is not gonna fix health care, a system is gonna fix health care, right? Because a bad system beats a good person every time. So we took basically the Cochrane review on doulas, which is continuous access to care and support. And we replicated it virtually with very similar results and put it through peer review. Maybe the one other sort of thing I'll put out there is when geography isn't a constraint to how you construct a provider network, you can change who provides services. So we're able to increase the concentration of providers of color on a digital platform by an order of magnitude over the US baseline. There is a paper in the proclamation of the National Academies of Sciences, actually, by Rachel Hardeman and our colleagues at University of Minnesota and Harvard Business School that shows that concordant care, when a black pediatrician takes care of a black family, it has 2X impact on mortality.

That's a 2 million patients in a claims based study. And so again, we're replicating these results at very, very large scale. That we see is when we are able to match people to group of people is a monolith obviously. But sharing lived experience matters quantitatively. What we see is our black members engage with all of our provider types, particularly our doulas, twice as much. And I'd be lying if I told you that we have parity and outcomes for NIC utilization and C-sections. But we are seeing parity when it comes to mental health management and acute care utilization which I think is directionally correct. So maybe I'll just leave off with actually something that Paula Johnson said this morning, which is like we need an ecosystem approach here. And I'm no longer academic, only I'm more academic adjacent. But I love this quote from Loretta Ross, which is not written down as far as I know. It's something she just said once on the phone which is, "When the world's a mess, just grab a broom and clean where you are." (APPLAUSE)

LAURIE:
Thank you. Thank you so much, Neel. Next, I wanna introduce our last speaker, Dr Melissa Simon. Once identified as a trailblazer for health equity. Your clinician scientist, George H Gardner, professor for clinical guy and vice chair for research department of Ob-Gyn at Northwestern University. Melissa.

DR MELISSA SIMON:
thank you. Thank you so much for having me here. Thank you. Well, it's hard to follow this esteemed panel, but I'm gonna give a little twist. And that's why I chose not to have slides. So mi Familia knew what was happening when my great grandmother, Abuela, passed away during childbirth a long time ago. And they knew the answer as to why, but they deferred culturally and out of respect to the doctors. And then fast forward when I went to the University of Chicago, sight unseen, first in my family to go to college from Detroit, you know, it was community who lifted me, community got me through those gray days and those gray buildings filled with gargoyles everywhere, very intimidating. But I found it and led the Latino Students Association, and that was founded by all that love from community and all that partnership. So community was really essential to moving me towards health care and science. And then in the Department of Public Health as an epidemiologist during the mid 90s when there was a rash of heat deaths, the community knew why black elders were dying at a disproportionate rate than the white elders.

We didn't have to do all that fancy epidemiology door to door studies, all that innovation, all that stuff because the community knew the answer. But we had to collect the data. But what I learned there, and what I keep to this day, is the community's voice is with the data and we bring that data and we respect that data to the table, and we allow those data to speak on behalf of the community. And that's how we get the community voice into a lot of the innovation and research that I've had the privilege to have over the last 18 years with NIH across eight centers and institutes with funding. That's all co-created work with community. And that is what pushes the innovation and what I do. And so when I hear the word innovation on this panel, I don't always hear community. And throughout the whole thing we say, oh, innovative research, we're gonna build a new institute, we're gonna do this and that and the other and we're gonna go into that bold, bright, brilliant frontier of innovation but if we don't have community along with us, then that innovation is not gonna happen on the ground and the community will tell you that.

So the next few minutes, I'm just gonna bring my communities with me to this panel right here and kind of tell, tell y'all what I've learned and help to share. And perhaps that will help push the innovation that is happening and so important especially in this day and age, with the overturning of Roe and all this assault, full throttle assault on women's health. So trust, we've heard it. We just heard it from Dr Shah. One of the studies from the improve initiative through NIH that I'm funded with is optimize. It's about trying to co-create a new vision for the model of prenatal care that most women in this country get, and it's one on one perinatal care. So why does that first visit in perinatal care need to have about 45 minutes of just a bucket of information and a litany of things that you have to do or don't do, blah, blah, blah, blah, blah. That's all you hear in that first 30, 45 minutes. And if you've ever been a patient, I have four teenagers, so I've been a patient a few times and they're all taller than I am.

It's pretty cool. But if you've been a patient and you just hear all that stuff, no matter what level of health literacy or education or training that you have, you don't listen. You really don't listen. And you may not trust that person or institution that you're forced to go to because it's the only clinic in the area that you

live in. And so why can't we dial it back? We have nine months of pregnancy care, right, more or less. But why can't there just be a first visit to build trust? Why can't there, why not? When I started this question with multiple clinics across Chicago, people were like, but that's not the template and that's not what we're getting billed from. Well, what's your fears about this pregnancy? What can we do to help support you? What's your hopes and dreams? Does anyone do that in this room with their patients, right. Pause. Have another visit two weeks later or a week later to deal with the rest of the stuff because we know that health care and health is not in those is not created by being in that clinic.

It's all out in the community, right? So that's what we're doing in that study. And then, you know, really the education, health, literacy, numeracy, all of those things are really critical. And checklists are another way of doing it. Another improved study that we have is around checklists and not just a checklist like a problem list on the electronic health record, but one that you physically give to the patient and his or her, or their loved one or caregiver and literally there are boxes on that piece of paper. And no matter what the information is next to the box, if that box isn't checked by golly, your patient, regardless of their level of literacy, the language they speak, any kind of numeracy, they're gonna say, hey doc, why isn't that box checked? Community helped create that. This wasn't my scientific. All these fancy Yale UChicago degrees. This community is is understanding. This is co-creation. This is how you innovate, right. And then you can merge technology and all that stuff with it.

We work with public libraries around building trust because librarians and libraries are some of the safest spaces and most trusted professionals in our country. Think about that. Why does health care need to be right in the clinic, or in Walgreens or CVS or other places? Why can't it be in a library, right. And then other things. Learning how to unlearn. My community partners day in and day out will tell me, girl, that's not how it is. You have to unlearn that stuff you learned in school, right? We don't learn how to unlearn in medical school for sure. And there's always new guidelines, recommendations, ways of doing things, biases, unlearning our biases. All of those things are really critical. And they always tell me about making sure we don't leave anyone behind. But recently in the news and over this last year, we heard about Facebook as an example with algorithms and AI. And Facebook actually had an algorithm that was blocking words like period and menses around the world. And the reason was, well, some cultures and some countries don't wanna talk about periods or menstruation.

Imagine the impact. We already know that women and girls are in a different class and treated very differently in most parts of this planet. But imagine when you have an algorithm on a platform that is so used day in and day out, and in places and spaces where people, especially girls and women don't have access to an education or higher education or they can't read, right. So how are they gonna get accurate, factual information about their health and periods and menstruation, right. Something that happens for a good chunk of our lives, right. So that is being fixed. Alright. But those are the things that AI if it's not partnered with community and we're not really looking under John Lewis's hood of the car could actually be super detrimental to health.

SPEAKER:
Right. And those are the things that we can change. And then finally, my community would always say, use your voice, right. It's so powerful, especially when you have power positioning platform as a physician or a national academy of medicine. Use the collective voice. And as Dr Resnick said, the AMA is such a powerful force. And the way that they got out when the overturning of Roe happened was so powerful in terms of a hard stop on no government interference in the exam room. You know, that's

important. Hard stop. If I'm an emergency medicine physician or I'm an OB gyn, whatever it is, and I am faced with life or death of a person right in front of me, and I feel that there is a legislator or a lawyer or something sitting on my shoulder and not allowing me to give the right standard of care that's evidence-based to my patient in order to save their life, that's a problem. And so community would say, absolutely no. That's it. We need us, the physicians and the clinicians and all the advocates right now to say hard stop.

No government interference in our health care exams and in decision making. Really critical. Thank you.

LAURIE C ZEPHYRIN:
Thank you so much. Powerful. Thank you. And so what you've heard is innovation from what health systems are doing on the policy side, what clinicians are doing, technology and community. And what we've talked about is really how to center community to really address inequities. You know, I've had questions around when we think about innovation, when we think of of implementing change from the top down from policy and systems. And what you've also mentioned from the bottom up as well, sometimes I often feel and hear that what's old is new again, right? Some of the things that we say are innovations around, let's say community birthing centers as innovation, community led models of care. And so we'd love your insights on the panel in terms of how can we truly innovate in terms of what's old, what are the challenges to really implementing what we already know works? And then how does that come into connection with something new and shiny that's also important? How does that come in connection but not replace the innovation of what we already know needs to be moved forward?

We'll love to start with.

VERONICA GILLISPIE-BELL:
OK, sure. I'll talk about it from the perspective of of health care systems. When you one of the slides that I showed was the Cogs and how the masks work with the perinatal quality collaboratives to implement Aim bundles, I think it's really important to have perinatal quality collaboratives because we use improvement science to implement what's old. So there's data that shows it takes about 17 years to go from translational research to something being practiced at the bedside. If you use improvement science, it goes to three. It's not about always knowing, especially as providers. And when I say providers, all providers, physicians, nurses, midwives, doulas, it's not always about knowing what to do, but it's understanding how to do it. How do you change your workflow? How do you change your systems? How do you change your processes and your structures to improve those outcomes? And so really, perinatal quality collaboratives across the country have really been instrumental in implementing those Aim bundles on the health care system side.

But to your point, Melissa, one of the things from our Perinatal Quality Collaborative here in Louisiana is not just those best practices, just those clinical practices, but for us, we believe there's four drivers for implementing those bundles. Yes, the clinical practices, but also making sure we have effective peer teamwork. We have engaged perinatal leadership, but we also have patient partnership. And so for each of our initiatives, we have patient partners as part of designing how we do the implementation. And we also encourage and have our hospitals to have patients as part of their improvement team. Latasha Rouse who is a patient partner that I was introduced to early in my improvement work says nothing for us without us. We cannot design solutions for patients if we don't have them at the table, helping to tell us what they need.

LAURIE C ZEPHYRIN:
Thank you. And from the policy perspective, Alina, what are your thoughts?

ALINA SALGANICOFF:
From a policy perspective, I think the issue around implementation in policy is something I have been thinking about tremendously. I mean, I think we have so many great, I mean, I live in California. There's like not a reproductive rights positive policy that hasn't been passed by our legislature. They're like desperate for more. But still, we have places where there are contraceptive deserts. There are places where you still can't get an abortion, counties in in California. And so I think that there is, I think, a lot more intentionality and thinking about what are the resources that we need to develop that. And I think that you have coalitions coming together with state policymakers and state government. We heard earlier about the maternal mortality work that's been done out of California. And that was because Stanford came to the table, the state health department, there was an investment. I mean, these are the types of things that I think we need many actors coming through. And I do think just generally I was thinking about your your point about listening to communities.

I think that in the field around contraception. And I wanted to make that point too, that now there is a greater acceptance that our contraceptive counseling needs to be person-centered and that we really need to listen to what people want. What is the best contraception for them, not necessarily what is going to be the most effective method. And that's how we've been doing that. And now the Office of Population Affairs is updating their guidelines. Their focus is on equity and centering the care, the counseling around the patient. That's what makes quality. So we're realigning, I think, getting many stakeholders to the table and realignment.

LAURIE C ZEPHYRIN:
It makes a lot of sense in terms of the multi-stakeholder coalition. Right. Kind of breaking out of our silos to really advance that change. You also mentioned something about funding which I wanna get back to that after Jack, I want to hear Jack thoughts.

JACK RESNECK, JR:
When you first asked the question, I was thinking sort of about long standing things that took us forever to implement. You know, aspirin after MRI and how many years it took until we started measuring and publicly reporting. But I transitioned a little bit to thinking about even just sort of recent digital health stuff and AI stuff and some things that we know work that don't go anywhere, and some things that do go places and don't work. And I think one of the observations I've had is that in addition to the fact that we don't have systems to support implementation sometimes, or that there's not a payment model, or there are little things that get in the way that we blame. At the end of the day, it probably matters most. Do you have frontline people engaged early in the development process as one of the... So when I think of frontline people, I'm thinking both of patients and communities and physicians or whoever the end users are gonna be, and we are seeing so many examples of this, particularly in the digital health space.

And those folks bring a very different lens to the development process than all the funders and all the money that's sitting on the sidelines so eager to go into the digital health space or sometimes the entrepreneurs. We have some great physician entrepreneurs, but some of the entrepreneurs who are dreaming up the ideas. And so questions don't get asked early, right? Does this work not will it sell? Does this actually even validly do what it says it's going to do? And we have way too many examples in this space of things that get implemented even with good intentions that don't. The people know the story

of the Optum health. Sorry if there's some executive here from United Health Care. I have sort of beat up on health insurers for a living, but so well-intentioned, we're gonna design an AI tool that's gonna comb through billions of data points from all the data that we have at Optum and identify patients with our insurance products with chronic disease who are likely to kind of fall off a cliff in the next year and need hospitalization.

We're gonna put extra resources out for those people to help avoid that happening and see if we can keep them out of the hospital. Great. Good intention. So they weren't thinking from an equity lens when they started the project. So it went into use. It was being used and moving resources around. And some young person had an idea. It was like, you know, this whole tool learned on using as a proxy for health care needs, previous health care usage and what things affect usage will access and insurance, among others. So if you feed, they did a test. If you feed all the same data into that thing, that AI tool, but just change one thing, the patient's race, it will take all the resources from the black patient and divert it to the white patient, right. Again, well-intentioned. So I think these early questions about does it work, does it actually, and having the right people at the table to ask those questions, does it work in my venue? And it's not some brittle thing that was created somewhere else that's gonna break.

And does it actually affect something that matters? Just sorry to go on. So long. But that's the other thing. Like, we've got a lot of digital tools out there to make it easier for people to get antibiotics they don't need for their sniffles or very quickly get Viagra online. We don't have as many digital tools yet, and we're starting to get them thanks to wonderful innovators around maternal health, around mental health, around diabetes, around hypertension, where the gaps as a country and our patient care really are. So not sure it was an answer to your question.

LAURIE C ZEPHYRIN:
Thank you. Thank you. And, Neil, just just a little twist. Since you're in the technology space, given all the tools that Jack you've just mentioned, whether it's the app for self management etc, how do you see connecting that to communities? And also as a user, how are communities going to know which one to choose 'cause there's so many out there now. There's something for menopause, something for maternal health, something for postpartum health, something for mental health. Like I know those are two big questions, but like from the user standpoint too, like how is that, how are people supposed to be able to choose which innovations can work for them?

JACK RESNECK, JR:
And we call it drowning in a sea of point solutions. But I'm gonna actually answer this from two lenses. One is the innovation itself, and the other is the innovation cycle. So like look at Maven clinic, we're not splitting the atom. We're finding people who need more care and support and we're giving it to them. And then we're measuring that that helps. And then it turns out there's a good business case for that because it makes the sales cycle more efficient. And it turns out people wanna buy things at work. So in terms of like old things being new again, in terms of the broader innovation cycle, there's sort of two pieces of it. I think one is certainly how we think about funding, and this is a little bit of a provocative thought, but I think the health care delivery system might actually be undercapitalized. A lot of the funding goes towards the biotechnology side, and that's how you get like an mRNA vaccine in nine months and then really struggle to deploy it. I would say, in terms of the community aspect of it and old things being new again, I feel like we're here to talk about women's health, maternal health, reproductive health.

And I think that the moment that we're in now is very much like the HIV Aids crisis in the late 1980s where there was a community group, Act Up, probably the most successful social movement in my lifetime that compelled the medical establishment. And at the time, there was a community of people. It was very disenfranchised getting leftover chemotherapy that was horrible and didn't work. And they not only got (UNKNOWN) and dropped mortality by 70%, but they make it so that there's community advisory boards on every research initiative to this day. And what I see is that same community energy across the country compelling dedicated caucus in Congress that it will be part of the panel at the end of the day, a platform in the white House and all this transformative change.

LAURIE C ZEPHYRIN:
Thank you. Thank you for highlighting the importance of community advisory groups. We're gonna turn to Melissa. But I do wanna you to talk about MMRCs after this. So community. We keep saying community. Who is community? Who are community? Who are we talking about? And when I talk about bottom up innovation, the reason why I mention that is there are people out there on the ground doing the work for cents on a dollar, right, and making change. And to me, that's innovation. And so when I think about resources and funding, that's what we need to fund as well. So who is community and from your perspective, what have you seen in terms of bottom up change which I think is also driving this coalition of conversation around this important issue today? I mean, mind you, disparities in maternal health have been around for over a century. And that's why I went into OBGYN because not a century old, but because this is a field I wanted to change. And so now we're having these conversations, community.

MELISSA A SIMON:
So communities, it's all of us, right. But the thing is, is all of us traditionally in academics and medicine and health care delivery and science has been that us has been kind of framed in a very limited way. And so, especially when you think about who's trees are growing and flourishing and whose trees aren't, and that could just be within a mile of each other or a block over, like in Chicago, for example. So community is all of us. And it's especially with respect to who you're delivering health care to or trying to get to participate in research or the topic of what you're studying is impacting them. It's really about the who, right, trying to frame that. And it's not who necessarily the same who every time, right. It really depends on what you are, what condition or whatever you're talking about. In this case, a really good example that communities spoke up for with respect to the overturning of Roe was primary care is gonna be decimated in many areas in this country where there is no other care provider than a Planned Parenthood or some kind of a family planning clinic because family planning clinics and Planned Parenthood don't just give abortions, and they don't just give out birth control.

They do primary care for people who are predominantly female or who identify as female. And it's really important to understand that, right. And community was pushing that. But nobody, the health care providers didn't really band and go, whoa, primary care deserts, right? And that this is gonna worsen it, right. And on top of that, we have the maternity care deserts. So I think those are opportunities for like examples for that. Does that answer your question?

LAURIE C ZEPHYRIN:
It does totally. We are going to turn to audience questions in a minute. So start lining up. Veronica, just in terms of the MMRCs and community, you know, I'd love for you to just talk a little bit about that because

I think there's a power in that to not only hold our systems accountable, but also to give community voice and to truly impact what we're seeing.

VERONICA GILLISPIE-BELL:
Yes. So MMRCs are so crucial I think, to understanding our data. Our MMRC in particular is 50% clinical, 50% non clinical. So this is not a bunch of doctors in a room looking at medical records figuring out what happened. We have doulas, we have midwives, we have domestic violence specialists, we have addiction specialists, we have a patient who has a friend that experienced maternal mortality. And what we do is we have case abstractors that will create a case for us that it has medical records, but it also has obituaries. It has coroner's reports. It has for us, we create geospatial information as well. What is the (UNKNOWN) score of the patient? We use parishes in Louisiana instead of counties. Let me just clarify that. But what is the the Alice score in that parish compared to the rest of Louisiana compared to the rest of the United States? How many OBGYNs per capita are per 10,000 in that parish? So we're looking at a full picture. And actually going into this next year, we're starting to do informant interviews where we have someone that is trained in trauma-informed care that is going, that is interviewing the family of the decedent because there is a lot of data that we don't get because nobody's gonna write down in a medical record I am racist, or I use bias in the way I provided care for that patient, but the family knows.

And so we use all of this to recreate the decedent's life and to understand what was happening, what was driving that maternal mortality and what can we do, what recommendations can we make to change those outcomes? And when we make those recommendations, you know, there are recommendations for health systems, there are recommendations for providers, but there are also recommendations for policy makers, for public health professionals, for community itself for a lot of the things that we've already mentioned here. But I'm very, very proud of the work that we do as MMRCs and the individuals that are a part of that process.

LAURIE C ZEPHYRIN:
And for states that may choose to opt out, it seems like there's...

VERONICA GILLISPIE-BELL:
Idaho, Idaho.

LAURIE C ZEPHYRIN:
And there's a lot of information we won't get which further will fracture outcomes.

VERONICA GILLISPIE-BELL:
It is. And we have to think about the systems that are in place and what those systems are designed to do. I firmly believe a system is gonna produce what a system is gonna produce, right. Dunkin donuts is not gonna make anything but (UNKNOWN) they'll make more things, but donuts. But that's what they're designed to make, that's what they're gonna make. And I think there are some systems that can have some negative impacts. Even on that review process, we do know of a state who they legislatively controlled their MMRC. And when the data came out, the legislators were not very proud of the data. So then they made it so that the report could not be released. And so we do have to think about that. Who is gonna have power over these MMRCs funding and all of those things, as well.

JACK RESNECK, JR:
As if those legislators wanna do something to fix the underlying problems so that the next year those numbers might look a little better.

VERONICA GILLISPIE-BELL:
Exactly.

LAURIE C ZEPHYRIN:
And that's really critical when we're talking about innovation. If we don't have the information, then we can't know where to direct the resources. Amazing. I see people lined up and then there might be people on the phone virtually as well. So I'm gonna go left right, left, right. So I can't see your name. So please state it and ask your question with a question mark on it.

BROWNSYNE TUCKER EDMONDS:
Thank you. First, thank you. This has been fantastic. Thank you all for sharing your expertise and just bringing voice to this really important set of questions. My name is Brownsyne Tucker Edmonds. I'm a professor of obstetrics and gynecology at Indiana University School of Medicine. And my question actually came to mind, Elena, when you were sharing your comments, sort of post Dobbs related. And obviously I live in Indiana, so we are sort of in the thick of it. One of the challenges that's come up, I guess, connected to this larger conversation about innovation and data and community has to do with sort of a lot of the fear and what we sort of suspect will be sort of downstream implications for patients sharing or reporting any kind of data about pregnancy and tension, pregnancy losses, different types of events, how miscarriages are might be used against patients. So in this moment where there's a lot of heightened fear and we need high quality data more than ever, I was wondering if you all might be able to share either strategies or discussions that you might be privy to.

One thing that's come up in, like by analogy to the behavioral health realm, is that there might be sort of protections that could come out around sort of reproduction related data sharing and things along those lines. But the challenge there is that it's very difficult to actually do like health services and outcomes related research in that realm because of those protections, though, they were placed with good intentions. So I'm just wondering if you have thoughts or things we could consider about navigating that tension around sort of privacy, fear and the need for high quality data?

LAURIE C ZEPHYRIN:
Thank you. I see Jack and Alina.

ALINA SALGANICOFF:
On Thursday, NAM sponsored a whole workshop on this particular issue. I would say that yes, yes, yes, you are absolutely right. This is where I mean, we're in a situation where clinicians are afraid they're gonna be criminalized. And actually, even though the states say they don't have laws that criminalize women, they do. And particularly, women of color are the ones who are the most targeted. We know that that was happening before Dobbs. And so I think that there is really a very intentional effort right now to start to think about how we get this data. The Guttmacher Institute and the society for Family Planning is trying to track what's happening with abortion. But we also know that there are a lot of people getting self-managed abortions. It's kind of a data vacuum in that regard, but I think that we are all gonna have to put on our thinking caps and think about what are the issues that we really need to understand better around maternal outcomes, around mental health, around emergency care.

All of those issues are things that, as I tell people, it's like, it's time to like stay in your lane where you have expertise, but go bigger, go broader. Now think about the fact that you have a population now they're not going to be getting, they're gonna be forced to have children they don't want or can't afford or for medical reasons, they can't get abortions and they could be dying. I mean, we've all read the papers, we all see what's happening. And so I think we are in a moment where it's really pushing innovation. The field around abortion is being pushed. And I think that now we're hearing other fields as well. There was a whole series on cancer treatment, oncology that NAM sponsored as well as it relates to Dobbs. So there's more work to be done.

JACK RESNECK, JR:
I'm so glad that you brought up this tension, because yes, it's true, we need the data, but think about the importance of the Texas data around what how things change with patients who had premature rupture of membranes of non-viable pregnancies and the choices they could make at one point versus another point and the morbidity afterwards. Think about all the people accusing us of making up the stories with...

SPEAKER:
Disinformation about patients with ectopics or complex miscarriages being packaged up and sent thousands of miles by ambulances. And on the other hand, think about how terrified physicians are and their patients and the friends who help those patients seek care of being criminalized. For example, when they cross state lines and come from Texas to California and get care. And so, for example, the Cures Act, which we were incredibly supportive of to help open up access to electronic health records across health systems and for data use. But unfortunately, when HHS created the rules, there are very limited exceptions for sharing all that data. So, if you're an abortion provider in California now, every nurse, doctor, and anybody else back in Texas can see all your notes and you are a data blocker with multi hundred thousand dollar penalties if you don't share them. So, we've been pushing really, really hard on HHS to change that. The other example is all these apps right? So, the new rules are that if we don't, if you click OK and didn't read the four-point font on your new app that asks for one of our health systems to release all your health history on your pregnancy tracker app or your period, whatever else, that they are not HIPAA covered entities.

Those apps can sell those data now to your employer or your insurers. Just... because you brought up the apps. I mean, it's not just the period trackers, which got a lot of the press. Everything. Just to be clear, every single tech-enabled consumer platform that all of us use to live our daily lives or the same algorithms that suggest which movie, you should stream, or the same ones that know that you just bought a pregnancy test (INAUDIBLE). That the privacy issue is huge. It is huge. It is huge. We should have another session on the privacy issue. And to make things worse, I'm a resident of Florida, although I'm Nancy Ream, Columbia University, and I guess this is a question for angry Jack (LAUGHS) who made, has to come back For angry Jack. I know, I know. As a resident of Florida, I appreciate your comments about the AMA trying to keep legislators out of the exam room. But in Florida, where we have a surgeon general who is so promoting anti-science and belongs to some of these doctors on the front lines, it is really so devastating the amount of damage that's already done.

I mean I know we can do one thing, we can vote, I know that. But in the meantime, while you're on CNN, the AMA, he's on Fox News. And there is. So, I can't tell you the number of patients who are taking all this disinformation in. And what would be your comments about strategies for. Yeah, so I have come to

Florida and done local talk radio. And so, just so you know, not just CNN, which is fascinating and fun. So, we have had to play a much more sophisticated game, I think, whether it's organized medicine or the public health community or anybody else, early in this, they the folks who were pressing, pushing disinformation were so much more sophisticated. There's a really cool researcher at Stanford who does these great data maps and like, we're off on one corner and all these other groups are connected, spreading this information. And you bring up the point of when it's a physician who's part of the problem, all the more distressing to the rest of us. So, we have spoken up, for example, for state medical boards, although yours may not be interested in doing it (LAUGHING), and medical certifying bodies, retaining the right which some states are trying to take away.

And again, we're not talking about free speech. We're not talking about. The doctors love having differences of opinion. But when somebody is actually doing harm and we know, like with the Dirty Dozen, a very small number of people can do tremendous harm. We have pushed for capacity to be able to have social media companies work with us, to adjust how people understand expertise, and also adjust licenses and certifications for those (INAUDIBLE). I feel like I got to get on this one really quickly just because like. (CROSSTALK) Joe Oladipo is someone I really looked up to in medical school. He has an MD and a PhD. There's people here who taught him. And we live in a world that's very weird right now. But disinformation is different from misinformation in that it's used for politics or power or profit. And there's nothing that Google can do when not only a physician but an elected official is purveying disinformation. It's a very complicated issue. But as a call to action for this body, one of the things that I think is very important is to come at it from a point of humility, because I think one of the reasons why we're a peripheral node is because many times the people who are consuming this information don't feel affirmed by, in fact, Maven clinic.

One of the reasons we exist is because we're filling in that gap and we're trying to be an honest broker along the way. But I think that it's not. Remember when we used to worry about people going on Google or WebMD? Now we wish they were on Google or WebMD (LAUGHING). My patient population, most of them their primary source of information is TikTok. And rather than kind of lament and being like, well, "Oh my gosh, we need more education in our country or whatever the case might be." I think that there is an opportunity for us to think about what is absent and also what's happening within the House of Medicine to be very frank, when it comes to who's purveying disinformation. It's OK. Sorry, I lost count. OK. Thank you. So, Les Benet, UCSF and I'm really glad that June came because Doctor Resnick is my dermatologist and I'm still trying to get an appointment, so... (LAUGHING). But I have now been outed as the workforce problem (LAUGHING). But, Jack there's an impression that the AMA has restrictions against other health professions in a lot of areas in terms of plan B and other things.

Could you address what the AMA position is in terms of dealing with these issues? And just for time, I'm going to do two questions at once. So, yeah. Hey y'all, it's Joia (UNKNOWN) Perry Founder and president of, National Birth Equity Collaborative. I could talk to you all about all of this, but I had a specific question about power right, because I was thinking the innovation is actually having the power to be in the patients and the people who are most impacted because we usually think of innovation as being technology. And to your point of what's old is new, how do you think about power to the patients? The people who are the most impacted is actually being the innovation. Thank perfect. So, Jack that answer the question about. OK, I'll be very brief 'cause everyone dominated the Q&A a little bit here. The short answer of scope of practice in AMA is we are not like a big protective union body who is trying to protect

our finances or anything else. This is really about finding the best way to get access and quality care for as many people as possible.

I work at UCSF with fantastic NPs and PAs. We don't want to live without them, and I occasionally see patients who've seen somebody who didn't even recognize there wasn't enough transparency to know they weren't a physician holding out a shingle, practicing as a dermatologist, a neurologist, an endocrinologist who never had any education in that space. So, when we get into these battles around state laws, it really is around that, around making sure there's transparency. And that we do great team-based care so that we can improve access and quality. Thank you. And then this question about power and innovation. Melissa, then Veronica, then anyone else. I think power and money are inextricably linked in many ways, especially when it comes to innovation that needs research dollars or funding along with it. And usually, for the most part, most large grants that push technology are underpinned by large academic usual suspects institutions. And so, that shift is starting to happen, with more HBCUs and minority-serving institutions getting into the mix with a large research portfolio and some of these larger grants, especially with NIH funding, design shifting, which is really good.

But now we see also a major initiative that was just funded, the grantees were announced through NIH of community organizations, actually leading a lot of different projects across the United States, focus on different social and economic determinants of health and community level health needs. So, those are really good examples. But Corey obviously is another good example. So, shifting that is really important in my institution, and in others there's groups like we call them community scientists. I don't use the word citizen. Some people call it citizen scientists, but I bring people from our communities across Chicago and our catchment area into our cancer center bench, science labs. So, the most basic T0T1 science labs to talk about what is the relevance of this science to us. And it really flips that dynamic right there. So, there's different ways of shifting power besides just money. And I was gonna say very similar. I think we're seeing more innovation of who is at the table and the collaborators.

A very similar NIH grant that I'm a part of is bringing Ochsner and Tulane, RH impact and some other community-based organizations so that we are bringing more power to the people or more having their voice as part of the power. And I think just other unique collaborations. Ochsner has a collaboration with Xavier as an HBCU, and I think that has also created power in a place where there had not been power before. And so, just seeing more of those type of collaborations being supported, I think we're starting to see the landscape change. Thank you. And we have a question from someone who's participating virtually. It's not on. I'm sure. I hope I can count properly (LAUGHING). Now, do you want me to read it? I can. Do you want me to read the question? We'll just mix it up a little bit. OK. Alright. Thank you to the outstanding speakers. Patient-provider concordance has been associated with reduced infant mortality. Do we know enough to recommend this as a strategy to reduce maternal and perinatal morbidity and mortality?

So, patient-provider concordance. Thank you, Veronica. I was just going to say as much as I 100% agree with that. And as much as I think we would all like to advocate that, we still are in a position where only 5% of active physicians identify as black, 6% as as Hispanic. And if we look at our resident class, it's the same. So, if we did that, I think the solution is making sure we are fostering our elementary-age children and having exposure to these careers and creating a pathway so that we can create a diverse workforce so that we can see that when patients walk into a room, they see a provider that looks like them. Absolutely. To add to that, I think what we see in our data because we don't, we're able to increase the

representation from the national sample. And we did it based on that very research. And what we see is, again, no group of people is a monolith. So, people select their clinician for a variety of reasons. And by the way, we match people on the basis of personal identity across many dimensions, including sexual orientation, geography as part of your identity.

And so, other things being equal, people prefer to meet with people that they think they share a lived experience with. But it's not the only reason. And they'll select on convenience much more quickly. And we see that very clearly in our data. That being said, the way that I think about it and not that this is the entire thing, but again, I don't have a waiting room and I earn the opportunity to try and support somebody's health by engaging them in the right way. And so, I think at least from that dimension, it's very clear that this is a directionally good idea. If that was the spirit of the question. But to Veronica's point, there's a lot of work that we have to do to make sure we have an adequately diverse workforce. And there are so many benefits to diversifying our workforce beyond just race-concordant care, which is obviously a piece, but just I so deeply believe that if you train alongside people with diverse lived experiences, you will be less likely to be biased in the care that you provide and more likely to be actively anti-racist in the care that you ultimately provide.

So, just the list of downstream benefits of that are... So. I think just to add to that, too, I think it's along those lines, too, of diversifying the workforce. I as an obstetrician, I'm not the only provider that can deliver a baby. We have to create a more collaborative care model that integrates midwives. Because we do have midwives of color, we have doulas that also, more doulas that look like the patients that we're talking about. So, creating that collaborative care model will at least have patients to have a provider that looks like them, any provider that looks like them. And if we think of the source of the inequities in terms of not receiving quality care, not being listened to, being discriminated against, that's everyone's problem, not just the provider of color as well. OK. So, we have the three minutes. And so, what I would like to do is there are three people with remaining questions. You can ask your questions, and then we'll close out the panel with those questions, please.

(UNKNOWN) I'm an RWJ Health Policy fellow and a licensed psychologist. So, my question is based on the last panel where there was a discussion about the resilience of African-American girls and your 80% of the issue being a mental health issue. Well, we know that African-American girls may not feel safe to say how they're really feeling, and there's a strong woman mantra going on. But you also may be introduced to other systems that you don't trust, like the criminal justice system, by sharing your mental health status. So, even if you answer on the app, what's the innovation around addressing the mental health issues that are driving some of the infant mortality? Innovation around addressing... Mental health issues. Thank you. Hi, I'm Shelley McGuire, University of Idaho. Humbled to be the first member from Idaho, which has been brought up a few times today. Idaho (AUDIENCE APPLAUSE). But my question has to do with, I was really shocked, actually. I'm a maternal-infant nutritionist. I was really surprised at how much maternal mortalities happening after birth.

And then Doctor Shaw's data to show that the number one requested information after birth is lactation consultants and sleep. And then this morning we heard from Doctor (UNKNOWN) about the need for deep rest and not being stressed. And I really think that we have a serious problem around helping women breastfeed and feed their babies. And I'm wondering if anybody up there has a solution. And with that, I'll sit down. Thank you for bringing that together. Thank you. I'm (UNKNOWN). I'm an OBYGN and bioethicist at UNC and your outgoing Greenwall fellow in bioethics. My question is about kinds of

data. So, this morning we heard a lot about sort of the "hard data" and science. Right. And how it has always been men's health and male diseases by male scientists that have been overfunded. This afternoon, we're hearing a lot about the power of the narrative, whether it's the individual patient or the community, and how this is the kind of data we need to leverage to improve women's health. So, I'm just reflecting on sort of the dichotomy of 'hard' versus softer data.

And why is it that as an academy, as a system, as an infrastructure of science, that we're just now broadening our doors to the definitions of data and what that means for the inequities between men and women? Thank you. Thank you for your question. So, let us start with mental health. I mean, we heard this morning about the resilience of African-American girls. But there may not be trust in terms of actually sharing how they feel and this sort of strong woman complex. So, how do we actually get true information on these apps? How can we actually address mental health in a meaningful way? I do think that's a challenge. I can tell you one of the things we want done with our perinatal quality collaborative, in terms of maternal mental health, we realize the data shows there are a lot of postpartum patients that don't come to their postpartum visit. Quite honestly, we've not created a lot of value around the postpartum visit, so I can understand why they don't. But those same individuals will go to their newborn visits.

So, we created a pilot with pediatric practices doing caregiver perinatal depression screening for caregivers at, when they come in for the newborn visit. And we did see a discrepancy in the, we used the Edinburgh Postnatal Depression Scale as the test. And we did see a discrepancy amongst our black patients in the number of positive screens compared to what we expected from what's in the literature. So, what we did is we used our patient partner, we use our patient partner to help our teams design how they are asking the questions, because there was a lot of concern and mistrust of, OK, if I answer this question and they find out I'm depressed, is somebody gonna take my baby? And so, we had to go over what that scripting looked like and explaining why we were asking the questions. And we did see more positive results after that. And so again, I think it's back to what we talked about designing things for patients where the patients have input. Thank you, thank you. And then addressing the lactation, lactation consultants, and sleep as primary areas in addition to others.

Yeah I mean I totally agree with you that nutrition and feeding babies is really important, but I also don't wanna just push breastfeeding 'cause there are some people who can't or chest feeding. So, I wanna be clear on that. But yes, optimizing nutrition. I think one really important thing, though, that we encountered in the pandemic, and there's a current consensus study going on right here at Nam, is what happened with infant formula, right? During the pandemic. We've kind of forgotten about that. Oh yeah... We had no infant formula for a little while, folks, and there's a lot of ramifications around that. So, part of emergency preparedness actually does need to innovate with respect to nutrition and not just for infant formula but for other things. Right. What if maybe it is breastfeeding supplies, right? Availability. Maybe it is about the people who live in food deserts. And then the pandemic happens and there's even less food available. Right. So, I think things like nutrition are an important part to think about and innovate, especially with emergency preparedness.

So... Can I just add one more thing about the breastfeeding please? part of the work of the IOM Committee on Preventive Services for women was actually to include breastfeeding counseling and lactation support and supplies as part of preventive care. And so, that has been, it was an important advance insurance is supposed to cover it. But we've really run into, I think, a lot of walls in terms of

implementation, in terms of having plans cover it in terms of certification and who's certified. And so, I think that this is kind of the are an example I think of where you can have a policy, but then thinking about we really need to do some hard work thinking about how do we implement this and remove the remaining roadblocks because the policy is there, it should be paid for, it should be covered. I mean, I know it isn't always, but that the scaffolding is there for that. I'll be brief because I know we're running out of time home visiting. Home, visiting, home visitors, all those other countries that you should have home visiting program (CROSSTALK) ...that works.

Exactly. And so, we've talked about a lot today, and I hope you've heard a lot about solutions and things we know can work and we can implement today if we have the political will, the financing, the policies in place. I think I'd like to really bring up the importance of centering communities in innovation. And to the question about data is it hard science or is it soft science or hard data or soft data? I mean, I think it's both. So, why don't we go across the line and we'd love to hear your thoughts on that. And how can Nam really think about both? I think the first thing I would say is who decided? Who made that decision, that that was hard data and that the lived expertise, I'm gonna say lived expertise and not lived experience is soft data? Who made that decision? I'll just leave you with that (LAUGHING). I don't know. I would say that we are at a point right now, I think, around particularly around abortion data. Really thinking about, we getting the quantitative data is gonna be hard.

Also the qualitative data really having high-quality research and recognizing that we can have really high-quality research that can use qualitative data and tell the stories that we know that we all need to hear as the larger health care community, and certainly our policymakers need to hear that as well. And so, kind of really elevating that type of work, because the. It's really gonna be a whole of field effort. A 10-second answer to Kavita's question is, yes, we've got to have both. Abortion is the perfect example, right? I think even pre-Dobbs, the Turnaway study, the benefits of having some hard data around economic and health and intimate partner violence outcomes. I think about Dan Grossman's the qualitative work in this last year about people's stories getting turned away in the post-Dobbs era, and how we just have to keep funding both types of work. I have a very strong take on this, which is that we live in weird times such that there's only three private companies in the world that are that have the ability to consume the amount of data that we have, right?

That such that LLMs depend on massive, massive reams of data. We live in times where there's so much quantitative ability to create data that you don't even need a hypothesis to have ChatGPT spit out a directionally correct answer, right? What we need qualitative information for is to make sure that we're actually being hypothesis-driven and answering the right questions. And then just finally another take on this. It's not just the data. Are we asking, do we have the right metrics for evaluating what it is like in terms of women's health, gendered things, promotion things, all this stuff? Like you, we might not be even asking the right questions to begin with, to collect metrics to hit some kind of benchmark. Thank you. Well, if it wasn't clear before innovation that centers equity is key to really addressing this maternal health crisis, I think we have a lot of information resources where we can act now while we continue to learn. I wanna thank Veronica, Elena, Jack, Neil, and Melissa for the incredible work you're doing.

Thank you all for listening (AUDIENCE APPLAUSE).