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Proem

Maternal mortality rates in the United States are low. That statement needs a bit of unpacking. What’s a maternal mortality? What’s a rate? Low compared to what or for whom? A **Pregnancy-related mortality**, death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Physiological means relating to the way the body functions, like blood pressure. Pregnancy-related death is used by the Centers for Disease Control and Prevention (CDC) to report U.S. trends. The CDC typically reports this measure as a ratio per 100,000 live births.

- The most recent U.S. maternal mortality rate of 17.4 per 100,000 pregnancies represented approximately 660 maternal deaths in 2018. Is this a low number 17.4 per 100,000? It ranks last overall among industrialized countries. New Zealand is lowest at 1.7, the United Kingdom is 6.5, and Canada 8.6 per 100,000.
- The maternal death rate for Black women (37.1 per 100,000 pregnancies) is 2.5 times the ratio for white women (14.7) and three times the ratio for Hispanic women (11.8).



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- A Black mother with a college education is at 60 percent greater risk for a maternal death than a white or Hispanic woman with less than a high school education.

Why is this? Aren't we the best? I guess not. On a call about computerized decision support, I heard Dr. Julia Skapik, Medical Director for the National Association of Community Health Centers, say that primary care physicians had great difficulty obtaining information about pregnancy and hospital births from electronic health records. I stopped in my tracks. How could this be? Almost four million births occur every year. It's not a rare disease. It's predictably everywhere, all the time. Obtaining information about pregnancy and delivery is a problem that should have been solved long ago. I'm also on the PCORI Board of Governors. PCORI's legislative mandate requires that PCORI fund research into [maternal mortality and morbidity](#). Morbidity is illness. I'm curious. I need to learn more. Dr. Skapik suggested I meet Dr. Lisa Masinter and Dr. Michele Whitt.

### Introducing Drs. Whitt and Masinter 04:58

Dr. Michele Whitt is an OB/GYN physician specializing in healthcare information systems and technology with [OCHIN](#), the Oregon Community Health Information Network. OCHIN is a national nonprofit health I.T. organization with two decades of experience transforming health care delivery to advance health equity through technology, data insights, and expertise. Dr. Lisa Masinter is also an OB/GYN physician working with [Alliance Chicago](#), advancing community health through collaboration, technology, and research. You hear both speak about Federally Qualified Health Centers FQHCs. Federally Qualified Health Centers are community-based health care providers that receive federal funds to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. Federally Qualified Health Centers FQHCs may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing.

**Health Hats:** Thank you for taking the time. I'm so curious. Michele, do you want to start?

**Michele Whitt:** I don't have much to say about myself. I could do my little spiel of I'm Michele Whitt, a clinical informaticist for OCHIN. I am a clinical informaticist. I'm also an OB-GYN by training. I take care of patients, and I don't know what else I need to say about myself? Is that enough?

**Health Hats:** What do you do for fun?

**Michele Whitt:** Not much right now. It's the pandemic, but typically I do enjoy traveling. I read quite a bit, and I do many activities that are more family-oriented around my kids.

**Lisa Masinter:** I also am clinically trained as an OB-GYN and am not trained at all at informatics. I always like to make that very clear when I'm in any conversation around data and informatics. That being said, I do have some training in health services research and public health. I definitely speak public health and research to the extent that the data are presented to understand someone with my informatics training.



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And Michele works for OCHIN. I work for Alliance Chicago; thankfully, there's no acronym to have to translate. Alliance Chicago is like OCHIN in that it's a group of federally qualified health centers across the country that come together around an Alliance as well as OCHIN. The way that we function is to provide support to those health centers, often centering on a health information technology platform that allows for research and quality improvement efforts to take place at a more centralized location where these health centers come together through our efforts. And I function as the director of research at Alliance Chicago. Given my background in OB-GYN, I definitely have a focus and a passion for reproductive and maternal health.

#### Disparities in access to outpatient maternal health 07:08

**Health Hats:** I see in the literature that 60% of maternal deaths are considered preventable, and that mortality rates vary significantly amongst disparate populations. But it seems to me this must be the tip of the disparities iceberg; that the quality of maternal care, whether it's before, during, or after childbirth. Can you summarize the significant disparities issues that we should be aware of in maternal care?

**Michele Whitt:** When I read, or when I think about that question, I put healthcare disparities, not maternal health so much, but health care disparities into certain buckets. And the buckets that I use are quality, access, and outcomes. If you think about maternal health and that kind of paradigm if you think about quality, certain things, whether outpatient organizations or hospital systems, can affect that. Hospital systems put all these policies and procedures in place to try and manage how clinicians practice. One, standardize it, and two, improve quality. And so a significant initiative within the OB-GYN world was they recognize that delivering babies before 39 weeks, notably by C-section, could be detrimental because you're looking at babies that even though they're considered term are early term and can have an impact on outcomes. From a hospital system standpoint, what they did was they said, okay, we're not going to let clinicians deliver babies electively before 39 weeks, whether that be by C-section or by induction, we're just not going to do that. It changed physician behavior about how they brought patients into the hospital. Quite frankly, it has had an impact. Several studies have been out there that it has had an impact on morbidity and mortality in babies. The real question becomes can you translate some of those things to the outpatient clinical setting, which is where we work.

**Health Hats:** *Outpatient setting, also referred to as ambulatory care, means in the doctors' office, the clinic, as opposed to inpatient, in the hospital. Different settings can have different ways of doing things and different electronic medical record systems. That makes it hard to find information across those settings and standardize how moms are cared for. In my quality improvement career, I was always struggling first to ask clinicians to set standards, follow those standards, and then to see if those standards made sense for everyone. If they made sense for some people and not others, then you adjust by individual conditions and preferences. Sometimes a system can mean a fragmented system, piecemeal, not standardized. Confused yet?*



**Michele Whitt:** I would tell you that's a bit harder to do because you've got many different clinics with their own set of policies and procedures in place. And even as an organization that hosts an EMR, there are certain things that we can do and suggest putting in clinical decision-making tools to impact that. But that's a much tougher nut to crack on trying to standardize even across which hosts, and it can affect individual clinics, not so much the clinicians. So that's one sort of bucket that I put things in. If you think about disparities concerning access, certainly about the patient population that we serve at OCHIN. You're looking at federally qualified health centers primarily which tend to have patients of a lower socio-economic place or status in life and trying to get O.B. care into those places can be difficult. I live in Indiana, and they have state maps, and you will have what I call O.B. deserts. You will have places that do not have providers that provide O.B. care in those deserts. FQHCs help, but that's a broader issue because it has to do with how O.B.s work and how we're made to deliver babies. What is the logistical support that you can provide to those clinicians to put access in areas where you have a lower density of patients, and therefore, care is more physically spread out? I just want to think of access like that. There certainly are other access problems. Where patients live, whether they just can't physically get to the clinics. There are other types of access problems that have nothing to do with providers that play into that. But that's certainly something that we look at.

#### Transitions of Care and outcomes in maternal healthcare 13:37

**Michele Whitt:** The third thing we look at is outcomes. Are there specific things that we can do in our clinics or suggest in our clinics that look at outcomes? Indeed, there are organizations - I'm thinking about the state of California - that have initiatives or groups that look at maternal health and look at quality issues and say, what is it that we should focus on? One of the things that I've recently become involved in is looking at postpartum patients and the fact that those patients can have sepsis or other postpartum complications. And then how does that transition with care? And then how do we get those patients back in, and then how can we affect outcomes in that regard? So that's how I look at it, which is not, which is a broader question then, are there certainly from just an O.B. standpoint, just maternal health standpoint, are there things that we can do that are known problems? There's postpartum hemorrhage; many known medical issues affect outcomes both for the moms and for babies.

**Lisa Masinter:** Michele nailed that one. I would highlight and maybe add to say that I think what Michele's talking about with the hospital systems is important to underline here is that many of the perinatal quality collaboratives, like Michele, is talking about in California, have one here in Illinois. Many successful models in that space for the hospital setting bring about behavior change Michele was talking about with the inductions at 39 weeks.

**Health Hats:** *Let's note that Michele and Lisa speak about systems in several ways. They could be referring to hospital systems meaning a business arrangement between many hospitals and clinics locally or across regions governed in one hospital system. Or they could be talking about electronic medical records systems that hospitals and clinics use. System can also mean the way people do business, the processes they use to deliver and pay for care—three different system meanings.*



**Lisa Masinter:** The challenge that I think she highlighted is that we don't have a system like that for the ambulatory care space. There are organizations looking at improving quality at a systemic level, at an infrastructure level in the ambulatory care space. And that is something that I care very deeply about here in Illinois, and I'm working with some local sites to try to address it. But nationally, I will say that some of the perinatal quality collaboratives are looking at outpatient metrics. Yeah. But it's challenging because so much of what they're doing is rooted in the hospital. That's where they have access to the data. So, where things become challenging is the ambulatory care space and the data and the connection, like the episodes of care what Michele was talking about, connecting the patient between that acute and the outpatient setting and their data. And so that's part of the limitation of why I think there hasn't been a lot of activity happening in the outpatient space. I wanted to highlight that. And then the second thing that I wanted to say, and I say this as a woman, not of color. Still, a woman who's deeply invested in patients of color is that there is an emerging understanding that we need to do better as providers to listen to our patients and to hear our patients and to ensure that when someone brings something to us, we check our biases because we know that we have biases. And I think this is an evolving conversation, and we're getting, we're starting to, I think, measure how that impacts care. But from a data perspective specifically, it's also really challenging to measure that. And so, what matters is for providers, for all of us to recognize that, reconcile that, and think about how we bring that to our daily practice and how we can all do better.

#### [A long-known, worsening, unsolved problem 17:26](#)

**Health Hats:** Oh, my goodness. That's a lot. What I'm familiar with is the challenge of boundaries. That there are different settings. Our systems are terrible across boundaries. It makes me crazy that half the population can be mothers. This is like life. This is no mystery. That this is something that should have attention, I know when I was a quality management leader, I would say to my staff when you hear the words, should, that's like a red flag like nothing should, but it's not like this is a mystery how is it that the whole night? I know how it is. I gotta ask a different question. It just seems like such systemic sexism that this is not an area that gets way more attention. That we're in 2021 and we're having this conversation is nuts.

**Michele Whitt:** Let me say. So, if you think about it, because one of the things we're focusing on at OCHIN, and I believe and obstetrics in general, the care model has changed. So, if you think about patients and think about boundaries, and you think about how care transitions occur within the obstetrical space, how providers care for our patients is a team. A lot of times, it's a team setting. Multiple providers provide care. And so, there are a lot of transitions of care for women, whether it be who provides their outpatient care like they have complications, then how every O.B. patient goes to the hospital, which is, I don't want to say, unique, but it's different. From this standpoint, you can treat a primary care patient who might need some inpatient care. They might, but every single O.B. patient, home birth aside, goes to the hospital to deliver their babies.

**Michele Whitt:** And so, there's another transition of care, and their outpatient provider may or may not be their inpatient provider. When they're cared for in the hospital, their inpatient provider may or may



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not be their outpatient provider again. There are a lot of transitions of care that are wrapped up in O.B. care. And even how we as clinicians care for those patients have changed from the time that I went through residency and care for patients to now. You've had that transition where it used to be. You'd had that country doctor who took care of that patient who delivered that patient. And so, it was always the same doctor. And then it was a more team model where in the outpatient setting, you would have a group of doctors who the patients rotated through, but still, that group of doctors cared for that patient inpatient. It was the same group, at least of doctors. That has even changed because now it could be a group of doctors who work as an outpatient, and then there's an O.B. hospitalist who now cares for that patient as an inpatient who then transfers that patient back out. So, there are many transitions of care for which there's no system in place, whether from a data perspective or a clinician perspective, to have those transitions go smoothly. And quite frankly, a lot of patients don't understand. They don't understand that their medical records in the ambulatory setting may or may not be able to get to that hospital, depending on what their inpatient system is being used. And that those records in that inpatient setting then can be transferred back to the outpatient setting. Nowadays, people walk around with smartphones, and they expect everything just to go, and it doesn't work that way at all. So, from the standpoint of maternal health and O.B. care, because so much has changed about how patients are cared for, it has just made it very complicated to move from those settings just because the integration just does not exist.

**Health Hats:** *Interesting to me that home births and midwifery have not been part of this conversation with Michele and Lisa. Full disclosure: More than forty years ago, my wife and I, back to the land hippies with a strong family history of midwifery, were part of the home birth movement. In the mid and late 70's we perceived the hospital maternal health system as unsafe and lacking compassion for low-risk pregnancies. Our family history opened us to taking control with alternatives such as home birth with midwives. Now I wonder about the impact of midwifery on maternal and child mortality and morbidity.*

**Lisa Masinter:** What I was going to say is that I agree with that. And I would say that when I'm sometimes talking to other stakeholders in the public health space, I hear, we know that this issue of documentation and transition and all of what Michele's talking about and we mentioned before. Different inpatient teams back to the outpatient from outpatient to inpatient. This is not unique to maternal health by any means. And so, I think the question also becomes if we're all operating under the same system. We know that there are these challenges for every patient, be it a primary care patient who shows up with chest pain and cannot access their health record. Why is it that you're saying Danny, why is it that we do? We now are getting a grasp on the fact that it seems that we haven't been looking at maternal health specifically. And why are we now looking at it? And I would say that I think there are many reasons why that could be, and we could spend a long time talking about that. I definitely have ideas. I believe that the good news is that there is heightened awareness. There are many more conversations happening at the local, city, state, federal policy levels. And I think that there are policies that could be implicated in why we see this. Why maternal health has been overlooked, I would also say that because maternal death, thankfully, is very rare. I think that it has taken this cumulative effect of time to bring it to the forefront. And it represents something larger than itself, right? Because



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thankfully, there's not a lot of incident maternal deaths. And for that, we should be grateful. But when you start to peel the onion of those deaths, and you look backward, that's where the story begins to become more telling. And like I said, I'm grateful that we're having the conversation. I have a hypothesis for why this might be happening. And I think we can now start to be excited that there is support and federal leadership and state and local leaders to rectify the situation.

#### Pushing up regulations and financial incentives hills 24:51

**Health Hats:** So, share a hypothesis.

**Lisa Masinter:** One thing that I'll share, and I'd be curious on Michele's thought is that I think that when we look at, for example, I think a lot of what Michele was saying around what drives culture change and clinical change comes from regulations at whatever level you want it to be. Plus, you also have issues with compensation, right? And so, I think those are the two levers that you can look at in many different areas. And what are the regulations in place? What is the oversight in place? And then what are the financial incentives by which we might change the clinical culture to prioritize maternal health. And I think that would be where I would start and leave it broad like that. I don't know, Michele, if you have any other thoughts.

#### Clinicians that look like you 25:36

**Michele Whitt:** I'm going to take it in a slightly different bend. I think, first of all, I think what you say is true. I echo that. The other thing, bringing back something that you brought up earlier about our biases as clinicians. I'm going to give a local example in Muncie, Indiana. They talk about the railroad tracks. They talk about how most African American patients or the African American population are on one side of the railroad tracks and that the hospital sits on another. And where did those patients get care historically? And what was the quality of the care that they got, and are those clinicians supported?

There has been some data to say that amongst minority patients, if they have a minority doctor who cares for them, that they get better care. Now the question to that is why? There's a lot that's wrapped up in that why? Because I do, I think that doctors are trying to provide poor care or anything like that. I think the answer to that is no. Okay. But I do think that if you think about where our hospital, our tertiary care center sits. A lot of them are in urban areas, but there are large institutions. I'm thinking of Hopkins and other large institutions primarily staffed by majority clinicians taking care of a minority patient population because they're in urban areas. I wonder how that ultimately ends up affecting the care of those patients. I don't have a good answer. I know anecdotally for myself, my parents, my friends, that kind of thing, but I don't know if you were to look at that as a more systems approach what that data would show.

#### Research what we know or study potential solutions? 27:12

**Health Hats:** So that, that leads me to. I'm very involved in research. I'm on the board of governors of PCORI, but I sometimes wonder what research does for us? I was just in a conversation with Julia, who introduced me to you two. And we were talking about how measurement drives change, so whether it's system change or behavior. How does that happen? And I asked the same question about research, like.



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So now there's like all this effort to research disparities and the Academy of Medicine, they're having a conference right now, and I've been dropping in once in a while to listen to that. I hear about measuring disparities, and I'm thinking, wait a minute, we know there are disparities. How does this information, how does this research, how does it inform, motivate action change? Can you talk about that?

**Lisa Masinter:** Yeah. I'll take a stab at that. I agree with you. We know there are certain things we don't know about. I don't know that we necessarily need to do a lot more research to uncover disparities. I think we need to keep that data transparent and ongoing so that we can follow it. And I would also say where there are still areas of research to understand better what Michele was saying with the why? Why is it that the papers that Michele was talking about found what they found and tried to understand how we can measure better the experience of patients when they're in the inpatient or outpatient setting settings? I think that's certainly an area of research that can enhance our understanding of disparities. Where I would also say is prospectively moving forward, where I believe we need to move using research to answer how we mitigate the disparities? What are the interventions that we need, what are the effective intervention? And that's where the data and the research and well-conducted research can help us understand what we can do again to address it. So, I agree. Maybe less effort in identifying disparities with the caveat of understanding why, and then two, moving forward, effective research around what makes the change, what are the levers to push? What are the measurements that need to be done that help us to make changes?

[Low-hanging fruit gone 29:50](#)

**Michele Whitt:** I completely agree with you because I think that one of the struggles that we're having now is that we've got this information, and we don't know what to do with it. Like we can't figure out, what is it that we need to change? What is a solution to some identified problem that we have? I think all the low-hanging fruit is gone. If you think about that, we had with Epic,

**Health Hats:** *Epic is an electronic medical record system.*

**Michele Whitt:** We discussed renal function, and do we need to change measurement for African Americans versus everybody else? Do we need that? Can you know, that's low hanging fruit, you can say yes or no or whatever, you can change it in the EHR that's you know, it was there. They found that it's easy. Okay. But changing the patient patterns or changing physician patterns is hard. If you identify some disparities but changing those and seeing what works, that's much harder. If you think about what we're doing with NACHC

**Lisa Masinter:** National Association of Community Health Centers. How Michele and I met.

**Michele Whitt:** Yes, so we're doing these studies to say, what is the patient experience concerning their contraceptive care? What is that? We're doing these surveys about that. We'll get that data. I don't know that's going to be helpful or not. We could see, and we can make some adjustments for that. If the patient experience that they're, they have a poor patient experience, what can we do to change it? And is that going to affect the rate of adoption of people about their contraceptives? I don't know, but we're





at that point now because we don't know the answer. We're at that point of trying different things to see if it's going to impact some of the disparities that we find. And it's hard when you're asking organizations to put in dollars, time, energy, effort, and dollars, and an outcome that you're not at all convinced or sure that it's going to make a change? A difference, I should say. I think that's hard.

#### Hyper-local solutions 31:40

**Lisa Masinter:** But I think part of the solution is a lot of it does have to be hyper-local, right. One of the gold standards of research is generalizability. You want to try to measure something and bring something forward that can be applied and scale it up across multiple communities. And I think that we have to take a step back from that sometimes had to think about what's going to work here and measure whether it works here. And most importantly, who's at the table in thinking through these research questions and what might work in a given location. And so, it's essential to include clinicians who are working on the front lines in the communities that we're trying to support. Equally necessary to include the patient, people with lived experience, and community stakeholders to help identify Michele's point; what do we think will make a difference? And then let's test that and build something around that. I think that's another sort of prong of what might be missing in some of the research that we're doing. And I know that as you said, you sit with PCORI; they're working very hard to emphasize and prioritize those activities.

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#### Holes in our data, gaps in our knowledge 33:49

**Health Hats:** So, circle back a little bit to the informatics. We're talking about the exchange of information across settings, across time, across providers, and the challenges of that. But do we even collect as a regular part of our operation of caring for people, information that can be used to study the things you're talking about, or is it always that there has to be a special study? Because that routinely the kind of information that people need to understand hyper-local isn't like collected? I'm not sure that made sense, but

**Michele Whitt:** it does. I, what we've found is that it's supposed to be. In this sense, within the EHR, there are multiple ways that you can skin a cat. There are numerous ways that you can do something within the EHR. The data should be collected, but because we don't put what are called hard stops. We don't require every single field, every single this, every single that to be filled out. We found concerning the project that we're on now is that there are holes in it. There are spaces. That those holes should be filled, and if the clinician went through and they did every single thing, that data would be there. But we have found that it's not the common workflow and that there are many holes in our data. And so



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certainly within the projects that we're working on, having found that we're now going back and saying, what can we do in our EHR because this is essential data. We don't want that hole to be there. XYZ can be left out, but this piece of information is critical. We want to know, did the patient get a postpartum contraceptive medication? Did they get it? And so, we're trying to put in stops. We're trying to make it so that it's harder to leave that information out. Yes. What we've found is that there are holes in our data, and Lisa, you can speak to

**Lisa Masinter:** What I'll say is yes. A very strong yes to what Michele said. And I would say that I've learned throughout this project, working with Michele about the USCDI, the United States Core Data for Interoperability. And what I've learned is that there's very little standardization across data sets and electronic health records related to maternal health. The United States Core Data for Interoperability standards, as I understand it, to establish interoperability across disparate electronic health records and disparate systems has not traditionally had a lot of guiding information for maternal and reproductive health data. This has allowed these holes to emerge across electronic health records, with different health record companies having additional holes to plug. And I think we know that the American College of OB-GYN are working with and have made recommendations to improve this. And Michele and I, both through our collective work with NAHCH, are also trying to, within our own systems, try to address the holes that we've identified.

**Michele Whitt:** To echo what Lisa said, not having that national standard is problematic for reproductive health, and they've done it for some other specialties. They just haven't done it for OB-GYN.

[How can we, mere mortals, participate? 37:38](#)

**Health Hats:** Okay. So, I'm gonna go to this issue of participation. So, if people are listening or reading and want to participate in either the design, the operations, the dissemination, the recruitment, or whatever of this research, where would they go? Like, how would people participate? Where do you go looking for people to sit at the table?

**Lisa Masinter:** That's an excellent question. I would say that much of the movement towards this has come more from the research side, actually trying to find people to participate rather than the flip. And I'm hopeful that as Michele has talked about the change in how we provide obstetric care that's happened over the last several years that we'll also see a change in how we conduct research, such that in the years to come, it will become more commonplace for community-based individuals to say, I want to get engaged in research and understand the pathway to do that. I think there are many efforts underway in many jurisdictions to try to establish how that the infrastructure for something like that. And I think that again, thanks in, in large parts to PCORI and other funders, it is becoming more and more commonplace in research to include meaningful participation and partnership with people outside of the research team that are formally trained.

**Michele Whitt:** I'm going to take just a slightly different tack. First of all, I completely agree with Lisa. The one thing I will say that is at least unique, and maybe it isn't unique. I, somebody would have to tell



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me that, but in the FQHC world, their board requires that they have people from their community. And at least have an engaged board at a clinical level; no matter what you're going to have, I don't know if it's 50%, there's a certain percentage of those people who have to be from the community. If you have that, that might be an interesting or at least an avenue to make sure that you had some stakeholders that are not physicians or within more the corporate structure, but have the people from the community because that's an opportunity to go to an executive leadership team to say that we want to do some research, to be in front of people who have some decision-making power to then push that out to community members.

[Wave your magic wand and do what? 40:23](#)

**Health Hats:** So, I have two different sort of ending questions and deal with it however you like. From what we've talked about, are there a couple of critical things, and are there critical things that we haven't talked about in this discussion?

**Lisa Masinter:** It's really good question. I would say the first one is this plugging of the holes and things that are happening and the NACHC and the Centers for Disease Control and ACOG

**Health Hats:** ACOG is the American College of Obstetrics and Gynecology.

**Lisa Masinter:** Are working on to try to promote more of consistent documentation and data elements across electronic health records. So, we can develop metrics that we can actually use consistently and across systems to better measure and better understand impact for any of the things we discussed earlier. So, I would say first I'm glad to see that there's effort happening with respect to measurement and data. I'll pass it to Michele to see if she wants to add anything while I think about something, maybe we haven't talked about.

[Health Information Exchanges HIEs 41:39](#)

**Michele Whitt:** If I had a lot of money and I was going to do something a little bit different within the communities, we have HIEs, some of them good

**Health Hats:** HIE health information exchange.

**Michele Whitt:** In Indiana at the state level, we have a very active one that works really well.

**Lisa Masinter:** not all states.

**Michele Whitt:** Okay. And I know that. The high-tech act. They gave dollars to people to try and get these HIE throughout the states to get them more robust. And I don't think it worked out too well in many states because they just couldn't figure out a model for sustainability. But that was at the level of the hospitals essentially. The information exchange was at the hospital level. I think an interesting thing might be trying and getting that at the community level in an outpatient setting. And I understand that we have care everywhere. You can push data from your outpatient EHR, but I was having a discussion with one of our member sites. She was talking about, she works in an urban area, and they do have



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quite a lot of patient movement because patients move or they're just not as stable in a locale that they might start at one clinic. They go to another clinic, or they might end up getting cared for at two or three different clinics. And because of the way the data is exchanged, it's very hard. And even to do some analysis, they talked about, could we dump it into Tableau, could be dumped into some other data structure, so that as a community, we could better look at our outpatient data to do some analysis? So I think if I had money to try and plow into a project, it might be interesting to see what it would look like if you could get the disparate systems if you could get Alliance Chicago and OCHIN, be able to exchange data within local. You were talking about to look at local problems to look at, to really then plow into that outpatient data and then try and come up with, after looking at it and coming up with some solutions. And so, if there was something that I would do, I think that would be.

### [Integrating public health/community resource use 43:36](#)

**Lisa Masinter:** I concur and would say that using electronic health records to produce local data is critical and representative, so not missing pockets of patients that might be going somewhere that don't have their data contributed. That's equally important. The other piece that I think is also really important that I learned when working in the public health sector is outside? It's not just an ambulatory acute care issue. It's also a community-based issue. And we have so many wonderfully intentioned programs in the community that touched the patients we serve that are disseminating health-based information or health education, or what have you—providing case management support to families. I could tick off 10 of them if I wanted to. And those systems also are not interacting with the healthcare providers. So, the healthcare provider may not be aware of what supports the patient is receiving in the community and the fidelity by which they're receiving that. And there's no interaction between the healthcare provider and the support or social support organization. And so, I think to make this comprehensive and patient-centered, we have to be as inclusive as possible as we build this dream data system so that anyone who's interacting with the patient on behalf of his or her. That all the people who might have a hand at play can see and understand that. So, we do break down the silos and fragmentation that I think are also really at play here and could be harnessed to do great good. The patients that we care about.

**Health Hats:** If I had all the money in the world, I would say that the information should follow the patient, not the institution, not the setting because I have M.S., and I'm the one that's the connection. And the idea that it's going to be institutions that will take care of putting all my data together, I've lost hope even with all the providers I have who care and do a lot of work to share information. I am still the primary sharer. But I'm not a typical patient.

**Lisa Masinter:** I think what you're saying is correct. Suppose we want to move towards genuine patient-centered health exchange. In that case, we have to exchange the information with everyone, and patients need to be at the center so patients can understand who's doing what, where the data are in a way that's not overwhelming also. And I think right now across both provider to provider, community to patient, patient, to provider, like all of those are unfortunately not working at their highest efficiency. And so, I think that your idea combined with mine and Michele, we got it. Let's make it happen.



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**Michele Whitt:** It's funny. Cause they always come out, whether it was Google or Microsoft, people came out with these patient-centered, how can we get it down to your smartphone kind of thing? It's always that interoperability piece. There's no way there's just no good way to merge and manage that data at this point.

**Health Hats:** Thank you very much. I really appreciate it.

**Lisa Masinter:** Yeah. Michele, I'm so glad you were able to join.

**Michele Whitt:** Oh, no, I'm just glad that I got invited. I think it was interesting and it was a good time. I think we were. I think we did well.

**Health Hats:** You did good. Thank you.

**Lisa Masinter:** Thank you, Danny. Best of luck with all of this. I think it's amazing that you're doing it. Thank you so much. I completely agree. Take care.

#### Reflection 47:24

Maternal health delivery suffers from systemic sexism and racism. Suppose women of any color, religion, and gender identity controlled 50% of the levers of power, money, business, funding, policy. In that case, I can't imagine that our maternal and obstetrics health systems would be so fragmented, hospital-centric, and unresponsive to the needs and preferences of women. I know, I am a 2-legged, cis-gender old white man of privilege who watched maternal care in the '70s and '80s and now in 2021. We may have stepped backward, not forward, since the '70s with the business-ification of maternal medical care. But unfortunately, we will not solve the injustices of capitalism and paternalism here and now. Oddly, I can't find any resources that lay out the business model of equitable maternal health. If you know of something, let us know please. I do appreciate the hope and optimism of Drs. Michele Whitt and Lisa Masinter. We need an endless supply of hope and optimism. I celebrate that they're in the trenches advocating for our pregnant, delivering, and post-delivery moms and partners. My crystal ball is as opaque as ever. I can't see how the necessary power dynamic can change without women at the helm. I agree with them that patients and caregivers with systems and communication skill need to sit at the tables of healthcare governance, operations, design, and research. We need medical records with a minimum of standardized maternal health data from inpatient, outpatient, and the community, within a framework of interoperability that follows people not institutions or clinicians. We need to include the roll up of all settings of care and service – inpatient, outpatient, community services. Phew. A lot to ask. If we don't ask, who will? I've included some more resources in the show notes and below. Thanks for listening and thanks to Drs Whitt and Masinter for joining us. Onward.

