4sight Health Roundup Podcast

Re-Imagining Maternity Care in the U.S.

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[Intro and outro music by C. Ezra Lange]

David Burda:

Welcome to the 4sight Health Roundup Podcast, 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, September 24th. I didn't know this until I saw it online this morning. Today is National Punctuation Day. That's right, National Punctuation Day. Who knew? It's the day we honor all the periods, commas, colons, question marks and the like that ideally make the meaning of our written words clear. Now, if you could see my script, you'd notice that I didn't use a ox or comma in that last sentence. There is no national Oxford comma day and for good reason. I guess if you like the ox or comma, you could celebrate it today, but I won't be at that party. That has nothing to do with our topic today, and that's maternity care, or more accurately, the lack of it. Two new reports are out that show we're not doing a good job taking care of moms and babies here in the US. To tell us how we can fix the problem are Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How are you two doing this morning? Dave?

David W. Johnson:

Using Julie's term, I just completed another rotation around the sun this week. My September 21st birthday is on the cusp of Virgo and Libra, as

well as on the cusp of fall in the northern hemisphere and spring in the southern hemisphere, , my two favorite seasons. And best of all, it's the date mentioned in the greatest dance song of all time by Earth, Wind & Fire. Which one is it?

Burda:

Do you remember?

Johnson:

Name that song.

Julie Murchinson:

Do you remember?

Burda:

Do you remember?

Johnson:

Yeah.

Burda:

Right?

Johnson:

The 21st day of September. Who gets a song like that on their birthday, man? Yeah. What a gift.

Burda:

If there was one person - Happy birthday. Dave, it would be you. Yeah. Yeah. There you go.

Johnson:

There you go.

Burda:

Yeah. I saw them do it live, , last summer. We went to Ravinia, and I think they have one or two original members left. And man, the whole place went nuts. So, - <laugh> Yeah, I get it.

Johnson:

Big brass section.

Burda:

Thanks, Dave. Julie, how are you?

Murchinson:

I am well. It's a beautiful day in Seattle, but I am headed to the city of the Orange Man, so wish me luck.

Burda:

Oh, man. Yeah. <laugh> Good luck. Good luck. Bring lots of ID and bail money.

Murchinson:

Yeah. I'm gonna check out the plans for the arch and, you know, have fun. <Laugh>

Burda:

Oh, man. All right. Well, we'll follow up with that next week. <Laugh> All right. Before we talk about maternity care, let's talk Oxford, comma. , Dave, you're a writer, you love words, you're a wordsmith. Thumbs up or thumbs down on the Oxford comma?

Johnson:

Oh, like you, Dave. , But unlike other members of our 4sight Health team, , I've got no use for the firstOxford comma. It's redundant, , when there's already an and or an or in the sentence. No use for it whatsoever.

Burda:

Julie, you gonna stick your neck out here? Do you like adding an extra comma in a list of three or more things?

Murchinson:

You know, I, about 10 years ago, someone had to pry me out of using it, and I don't know that I've been fully pried out, but it took me a lot to get out of it. But I think I'm over it now.

Burda:

Oh, good, good. Yeah, I'm not a fan. , You know, I think if you need one in a sentence you wrote to avoid confusion, it's a lousy sentence, right? <Laugh> better rewrite the sentence than add more punctuation. We're gonna make an awkward transition into maternity care with a few puns. Two new reports are out that say we're contracting rather than expanding access to maternity care here in the US. And I'm going to deliver some top line findings from each report and get your reaction. The first report is from the March of Dimes released last month. It's the group's biennial report on maternity care deserts. Here are some factoids from the report. 34.3% of counties in the US are maternity care deserts. That means they have no birthing facilities or obstetric clinicians. 35.9% of counties lack a practicing obstetric clinician. 52.5% of counties lack a hospital with a labor and delivery unit. And women in maternity care deserts drive an average of 42 minutes to get to a hospital with a labor and delivery unit. That's three times longer than for those living in counties with full

access to maternity care. The second report is from the University of Minnesota's Rural Health Research Center released earlier this month. This report said 718 hospitals lost obstetric services from 2010 through 2024, either because the hospital closed or the hospital closed its obstetrics unit. 67 of those happened in 2023 and 2024 alone. Of those 67, 42 happened in urban markets and 25 happened in rural markets. So it's not just a rural phenomenon. And 36,000 babies were born at hospitals in 2023 that subsequently closed their obstetric services the following year in 2024. Dave, it's not like babies are gonna stop being born. What are your big takeaways from these two new reports, and what would you do from a policy perspective to reverse some of these trends?

Johnson:

The key takeaway for both reports pretty obviously is that, , maternal care is fundamentally broken in many areas of the country and, and particularly in, rural areas, The March of Dimes, report said one in three counties are maternity care deserts. All of those counties are in rural areas. Now, one thing I will say in, in the, in these analyses, , is that the numbers focus only on births, which is probably the easiest metric to measure. But the problem itself extends far beyond births, Medicaid pays for almost 50% of the births in this country. And if we're being honest, , the system does, , at best a lousy job on prenatal care, postnatal care, and early childhood care in addition to the actual, , birth care. And even if you don't care about health equity, which obviously I believe you should care about, as a society, we should care that half of our future

labor force is starting out with one arm tied behind their backs. That's not good for anybody. The final point I'll make on the, the takeaway section of this discussion is that the numbers for rural births, are small..Again, according to the March of Dimes report, 149,000 babies are born each year to women living in maternal care deserts. , That may seem like a big number, 149,000, but it's less than one half of 1% of total annual births in the United States, or about three and a half million annual births in the US each year. , So just the sheer size of that problem is, is pretty small, seems fixable. From a policy perspective, , maternal care deserts, , are just part of the broader challenge confronting healthcare provision in rural, , underserved rural communities in, in the country. As the University of Minnesota report illustrates, most analyses of rural healthcare focus on hospital closures. Is that really the right metric? I don't think so. Most hospitals that close have low patient senses, uneven service provision, and poor quality. , Should we just keep them open for the sake of keeping them open, even if they don't treat that many people and the people they do treat, they don't treat that well? I, I think the answer is of course not. Instead, we should look at desired health outcomes broadly and design access and service provision accordingly. Steve Orr, that's a blast from the past, he was the last CEO of Lutheran Health Services, LHS, headquartered in Fargo, which had a large rural footprint. Lutheran merged with Samaritan and became Banner, and Steve was the first CEO of Banner. And he used to say in the '90s, <laugh> that rural communities should have urgent care centers to patch people up and travel agencies to get more acute patients to locations that could address, their care needs. , So that was in the 1990s. Not really much has changed since then. I think we can't fix rural

healthcare incrementally, which almost every report seems to try to figure out how to do. It needs transformation. There's an opportunity to, , take out a white sheet of paper and redesign the model, get primary care right, you know, chronic disease management, , health promotion, mental health services, that type of thing. , there's lots of room for experimentation. We've got thousands of rural, , communities, counties in the United States. We've got the demonstration program going on, within CMS right now for rural transformation. Let's figure out what works and replicated. That goes for maternity care as well as all other forms of care.

Burda:

This is a symptom of a bigger problem. Thanks, Dave. , Julie, any questions for Dave?

Murchinson:

Well, Dave, you alluded to this, and we've often argued, and the data shows, that higher volume centers produce better quality, safety, and outcomes. So, you know, is, s- seems like you are advocating that closing rural units is sometimes the right call. So how do you think about, like, the quality and outcomes? People have to travel an extra 25 miles or 50 miles or, you know, these. Some of these communities are r- really rural. How does that get factored into the quality score? Who takes accountability for that disturbance?

Johnson:

Yeah. Yeah. I actually don't know. The exact incremental add-on for, you know, time travel in terms of determining a better or worse care outcome. But I do know that triage works. , You may both recall the Atul Gwande book, Better, from 2007. He had a chapter and they were called Casualties of War, I think it was chapter three. And it's pretty remarkable, battlefield deaths, , from the Revolutionary War up and, up and through the, the, the first Gulf War, basically averaged around 25%. So 25% of those wounded died. In the Afghan war, the, the military reduced that to 10%. And the way they did it was by triaging wounded soldiers effectively. So they had three levels. They had, a forward, stabilization unit, would come in, They'd, they'd look at a wounded soldier, patch 'em up to the best of their ability. If that was enough, that, that's where they would stay. If they needed more treatment, they went to a regional hospital, for no more than a, a one to three-day stay. And if they needed more care than that, they went to Germany or the United States. So the military has, has kind of figured this out, and they have this concept called austere military environments. You know, think of those as places where it's hard to get to. And it, that's very much akin to rural healthcare. And so in those places, you need what the military terms is prolonged field care. So things like microsurgical teams with nurse care practitioners, ready supply of whole blood, because that's often the difference between keeping somebody alive or not. You can think of telemedicine consults, and we're actually very close, to remote surgeries as well. So I just think we need to think about rural healthcare, not the way it's been, but the way that it could be. And my guess, Julie, is if we did that, we'd see almost no impact, on quality outcomes based

on how far you're away from driving to a care center, because we'd be able to intervene effectively in the moment where we had to stabilize and those that needed more care could go elsewhere from there. And if we can do that in the fog of war, , we should definitely be able to do it under, , conditions found in civilian environments, right?

Burda:

Yeah. After listening to that, Dave, I think I wanna watch a few, , reruns of MASH tonight. <Laugh> <laugh> What they, I think they called it meatball surgery, right? <Laugh>

Murchinson:

Yeah.

Burda:

Yeah, they did, so.

Murchinson:

Alan Alda.

Burda:

Love it. Oh,what a show. Thanks, Dave. Okay, Julie, you're up. What are these two reports telling you about the market for maternity services,

and what would you do from a innovation perspective to expand access to care for pregnant women and newborns?

Murchinson:

Well, before I jump in, I will say, I saw something last weekend, of course, because I'm served up everything from San Francisco, having lived there for so long, that a woman gave birth in her car in Golden Gate Park because the traffic was so bad she couldn't make it to the hospital. So crazier things happen in urban environments as well.

Burda:

Oh wow. Wow.

Murchinson:

Baby's healthy, healthy happy.

Burda:

Yeah, good outcome.

Murchinson:

Okay, so Dave, you covered a lot of this, but, you know, this March of Dimes number of almost 35% of counties or deserts has barely changed, right? It's all the stuff underneath about, you know, the number of

hospitals that lost OB versus gained 67 to six. Like, it's more than just about OB, but these deserts are, are suffering. And I think it's the market telling us that maternity's more of a fixed cost business in a really, really, really variable volume-driven world. And when I looked at some of the reasons why the March of Dimes talked about declining birth volume and the like is hospital closures, workforce shortages, and financial pressure. You talked about the Medicaid representing almost 50% of our births as it is. But at the end of the day, like, we have a staffing the standby problem. And California's actually doing a lot of work here, which is great. You know, hospitals today use an OB and an anesthesiologist and nurses ready twenty four / seven for, like, what, maybe a birth or two a week in the rural settings, a handful of births maybe in suburban settings. Like, regardless of where you are, whether you're urban, rural, suburban, like, It's just, it's how we staff that is problematic. So I dug obviously more into the birth side of this and just the broader primary care challenges in rural health. But, you know, the innovation is definitely an answer here. And Dave, you offered some, some ideas here as well. But if we stop treating the hospital as the unit of maternity access, you can unbundle the journey, right? So most pregnancy isn't delivery. There's actually 10 months technically of prenatal care, and then there's postpartum care after that, that can all be done virtual first. You can use home blood pressure monitoring and mobile clinics to, you know, monitor how things are going and just reserve the hospital for delivery. It's not always gonna work, but, you know, it's, it's definitely a start. Second, you know, you can pay for readiness the way that we fund fire stations, and this is what California's experimenting with. If you give rural hospitals, and I would even argue

again, like, doesn't have to just be rural, but a fixed standby payment or more of kind of a, let's call it like a regional maternity budget, like a global budget, instead of paying per birth, of course, we're all about the volume game here, right? California is trying to do this new standby perinatal services model this way, and it's pretty cool, honestly. I don't know that they have any outcomes data from it yet, but it's, it's definitely an idea. And third, Dave, like you were alluding to, we should set up a model where we can share the scares talent through virtual hub and spoke networks, OB hospitalists, a lot, you know, midwife-led units. There's so many ways that you could think about orchestrating the structure of who's needed where and when to actually redesign what the access looks like. And I mean, states have the money to try this with the Rural Health Transformation Program, right? Now, I'm not arguing that that's actually the number one thing you should focus on, but, , it would. Focusing on births as your use case and the extendability to other areas of healthcare, Dave, would solve a lot of the problems that you just raised. So, you know, access can't depend on, like, whether these delivery units can keep their lights on, right? It has to, it has to change.

Burda:

It’s an old model. , Everybody's measuring it by hospitals and obstetricians, right? And there's a lot, a lot more going on. Thank you. Dave, any questions for Julie?

Johnson:

That birth in Golden Gate Park was one of about one and a half percent of the births that don't occur in hospitals each year in the country, so 98.5% occur in hospitals. Based on what you just said, my guess is you think 98.5% is, is way too high a percentage. So if you could flip it around and started thinking about, doulas and home-based births and other ways to, I guess, accommodate the very natural, phenomenon of women having babies, what would that start to look like? ,

Murchinson:

It's not like I would say 98.5% is too high. But what worries me is that in this country, we have essentially one option, and that option is disappearing in a lot of places. So, and by the way, it's not. Again, I come back to, like, this is not just a real issue. So hospitals are the right place for high-risk pregnancies. There's no doubt about it. But the evidence, frankly, on planned, like, I don't know, out of hospital birth is mixed. Like, outcomes depend heavily on screening and midwife training and, you know, there's just, there's a whole host of things it depends upon. So many other countries are having a meaningfully larger share of midwife-led births outside of a hospital for the births that are relatively low risk, and they're having, like, great success. So I guess the stronger argument might be that, like. Well, I don't know. You know, home birth rates are. I think if you look at the data in one of these reports, home birth rates are higher in counties that don't have the access, right? They're higher in desert. So you're already seeing people transition to models that, you know, they're adapting to the system that

has left them. The question, of course, is, like, do they have all the, the tele and, you know, shared resources and things in the model that I talked about or not? And is that a good idea for them to just be having a home birth without actually having all the proper preparation?

Burda:

More options for low-risk pregnancies, right? I think about my dad. He was born on my grandma's kitchen table. <Laugh>

Murchinson:

Oh, my goodness. Burda!

Burda:

Oh, goodness. <Laugh> All right. It just popped into my head. Sorry about that. But they say you can tell a lot about a country's priorities by how well they treat women and children. And if that's true, we have our priorities screwed up, and it's time for the market to do something about it. Thanks, Dave, and thank you, Julie. Now, let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

You know, two things caught my eye.One, a little more political, so I'll just, , I'll leave politics out of it, but both NYU Langone and, UPMC

Sutter are ending pediatric gender-affirming care. We've come full circle on this issue. I think you'll start to see others fall. Second is, and perhaps really scary, is, the White House has been making some moves to take control of NIH grants, so to see how that all plays out.

Burda:

Yeah, big groan on this end of the line, that's for sure, when I saw that. Yeah. All right, Dave, what's your big healthcare news of the week? <Laugh>

Johnson:

Well, I, I'm gonna pick up on Julie's second point there. But in addition to that, RFK went to his anti-vax organization and said that they had a friend in Washington, so negative progress on the vaccine front. Yeah. But the battle about NIH Funding within the Trump administration is getting heated. On one side, you got Jay Batacharya, who's the director of the NIH, and on the other side is OMB Director Russell Voigt, who's the author of the Project 2025 report. In his world, he wants to control where the funding goes, and he wants to cut it. Batacharia is fighting to keep it the way it is, same levels and, and independent. It feels like Voigt is winning this battle, which is bad for the industry as a whole.

Burda:

How about that deal they wanna break one vaccine into five separate installments, right?

Murchinson:

Yes. Stupid.

Burda:

Who's going back, who's going back for two, three, four, or five, right?

Murchinson:

Nobody.

Burda:

Nobody. Nobody. oh, my goodness. We'll always have something to talk about. Thanks, Dave, and thanks, Julie. That is all the time we have for today. And before we go, Dave, again, happy birthday.

Johnson:

Thank you.

Burda:

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wherever you listen to your favorite podcast. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.