**Podcast Transcript**

Episode 3: Redistributing power to marginalized individuals and communities and creating systems that meet people's needs inside and outside the formal health care system.

Dr. Raegan McDonald-Mosley (00:09):

Hello, and welcome to a new podcast series focused on advancing equity in family planning. This podcast is a partnership between Power to Decide and the Reproductive Health National Training Center, with funding from the Office of Population Affairs and the Office on Women's Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA or HHS.

Dr. Raegan McDonald-Mosley (00:32):

Throughout this series, we will explore tactics, programs, frameworks, and ideals to increase reproductive and sexual health equity in health centers across the country. Through this podcast we hope to give Title X clinics, providers, and staffers, practical, easy-to-access, action-oriented training resources in order to advance health equity at family planning service sites.

Dr. Raegan McDonald-Mosley (00:54):

My name is Dr. Raegan McDonald-Mosley, and I'm the CEO of Power to Decide, the campaign to prevent unplanned pregnancy. I have over 20 years experience in this field, including as a practicing OB/GYN with a dedication and commitment to reproductive health and justice.

Dr. Raegan McDonald-Mosley (01:09):

Today, we have with us Dr. Karen Scott. Dr. Scott is a Reproductive Justice Informed Sexual, Reproductive and Perinatal Epidemiologist, Educator, and Obstetric Hospitalist with more than 20 years of experience in supporting persons across the sexual and reproductive life course in high-need, low-resource communities across different practice types and locations. Dr. Scott's research focuses on the analysis of structural, institutional, and interpersonal factors that inform healthcare access, quality and utilization, focusing on equitable patient provider and community hospital partnerships and shared decision making.

Dr. Raegan McDonald-Mosley (01:47):

Additionally, we have Mandy Fleming with us today. Mandy Fleming is the Manager at Flathead Family Planning in Kalispell, Montana. She has over a decade of experience conducting youth outreach and providing sexual health education to her community. Mandy's goal is to normalize talking about sexual health. In this episode, we're going to discuss centering the needs of and redistributing power to individuals and communities that have historically been inadequately served by the healthcare system, in order to create systems that meet patients' needs inside and outside of the formal healthcare system. So let's dive in.

Mandy Fleming (02:24):

Flathead Family Planning has been providing outreach and STI testing services to inmates at our local detention facility for over a decade. While providing these services, we decided that we needed to go a step further and figure out how we could help these folks succeed once they were released. While conducting services, our staff had open and candid conversations regarding what the inmates felt like they needed to be successful when they were released and what barriers they were facing around their health.

Mandy Fleming (02:51):

We also had folks fill out anonymous surveys regarding their needs. The topic that trended the most was a need for a local syringe exchange program. After hearing this, Shauna, our HIV Prevention Specialist, said she would go to the end of the earth to create a syringe exchange program so she could help this population. In less than a year, she did just that. She created and deployed a syringe exchange program that's housed in our family planning clinic. The goal of the program was not only to provide safe injection supplies, but to build relationships and to learn the needs of this population as well as provide wraparound services.

Mandy Fleming (03:25):

At first, participants were hesitant to discuss their healthcare needs with Shauna, as they've had negative experiences with healthcare providers in the past and were concerned about being judged. As time went on, she put in the work and she developed relationships and trust with the participants. She was able to successfully provide thousands of referrals and warm handoffs from our family planning clinic to primary care, to social service agencies, and to substance use service providers. Her passion and drive to build trust with these folks was key. We saw people accessing care who had not seen a provider in years. So this partnership has helped Family Planning Clinic make connections and build trust with folks who have continued to seek out reproductive health services at our clinic. We are lucky to have passionate and driven staff who truly care about our community and are excited to continue the work in the future.

Dr. Raegan McDonald-Mosley (04:18):

Wow. Strong work, Mandy, to you and your team, and thanks so much for joining us and telling us about your efforts. So now I want to pivot to you, Dr. Scott. How can healthcare providers, clinic administrators, work to redistribute power to communities most affected by historical and structural forces that limit their ability to achieve reproductive and sexual health equity and reproductive well-being?

Dr. Karen Scott (04:39):

Yes, Dr. McDonald-Mosley. What I think the beginning needs to be is just shared language, using concepts such as sexual and reproductive health equity means different things to different people. I would imagine just first if we could start off really with history and then with shared language around what sexual and reproductive health equity means to individuals, to systems, and to disciplines across different power relations, differences in dynamics. What I also think about the most... The consequences for misalignment with the healthcare provider and the payer matrix. The consequences disproportionally fall on the population seeking the care and not usually on the individuals or systems providing or paying for care.

Dr. Karen Scott (05:27):

When we look at healthcare supply and demand, what actual consequences do systems, including health plans and healthcare systems, experience for failing to meet the sexual and

reproductive health needs and priorities of the general population, let alone historically, systematically, and structurally excluded and erased or minoritized and marginalized populations?

Dr. Karen Scott (05:48):

In thinking about redistributing power, I'm always thinking about what if instead of exclusively focusing on clinical outcomes, we focus on the patient experience of navigating elitist, racist, sexist, trans and queer phobic, body shaming and agist institutions. And what does it feel to be in the hands of our care versus being handled in our care? What if we expanded our knowledge and beliefs about safety beyond the absence of adverse events and efficacy, beyond the ability to do what is defined as desired, which is usually based on the perspectives of scientists, providers, and payers? So I imagine this redistribution of power would require us asking patients to redesign or reimagine safety, quality, value and efficacy from a place of belonging, liberation, autonomy, love. Great question.

Dr. Raegan McDonald-Mosley (06:47):

Wow. I love the framing that you have provided for us to think about these concepts and to really focus on the patient experience rather than just clinical outcomes. I think that's sort of what Mandy and her colleagues at Flathead Family Planning attempted to do by asking the community what they needed. If they had just focused on their clinical outcomes, it might have led them in a different direction to use their resources, to focus on STI rates or unintended pregnancy. But instead the community said, "You know what? What we really need here is a needle exchange program." So, that led their efforts. In that a vein of sort of what Mandy discussed with us and in your experience, what are some person-centered models of healthcare that you have encountered? When people talk about providing culturally humble or appropriate care, what does that look like in practice?

Dr. Karen Scott (07:32):

Person-focused models of care see the person as a human being, sees their humanity in context within their life course, within their relationships, within their community. You also see person-focused models of care that actually have patient or public representation as a decision maker, either on the board directors or a part of the policies, maybe development and review process, or actually builds the capacity and activates the power, not empowers, but activates the innate power, potential promise of the person or the persons in a community to be a part of health services design, provision, evaluation, and training. It's almost like the peer models, where you see people like if someone has completed or graduated from a program or been a patient at a healthcare system over time, you see that pathway and strategy to build up their skills to be a part of the healthcare system as not just a recipient or a beneficiary, but as a change maker, as a thought partner, an action partner.

Dr. Karen Scott (08:56):

I see most person-focused models of care through midwifery models of care or with models of care that utilizes multidisciplinary teams, but not just when thinking about medicine or nursing, but like the community health workers might model, right? Like having someone with lived experience also be a part of the health service provision team. Again, I'm always thinking about ways to like dismantle that hierarchy, close that gap between those with power about people's health and their bodies versus those living in their bodies who have their own power. And how do we facilitate the ways in which they can show up in their body, show up in their health, that

most aligns with how they view themselves, how the community views them. Right? And so, I just always see doulas, I think of midwives. Doula support models, midwifery led models.

Dr. Karen Scott (09:56):

I think of even Dr. Shalon. Right? Maternal Action Project that's being led with you and Ms. Wanda, it's sparked by someone's experience that usually is having lived experience through this phenomenon that we're trying to observe and modify and transform. And when it can't be that person directly, but someone in relationship with them, I think those are the models that... Those are types of models of person focused care that we need to think about in the ways of re-imagining and redesigning health services provision. This kind of one to one unidirectional physician or nurse practitioner to patient model is not going to save us. It's not going to save our communities. And the more we continue to hold fast to that unidirectional model and really exchange information and knowledge around advancing our health and our wellness we're going to continue to feel miserably.

Dr. Karen Scott (11:04):

So I just always feel like... Whose power, I should say, has been constrained. I don't think we have the least power, but whose power has been constrained and controlled the most by structures and systems? We should always start there and think of those in relationship with those who sit at the margins, because it's right. We're not dealing with single issue human beings, right? We are always thinking, we are living as human beings in relationship, even if we don't admit it. So I think, again, person focused models really are like multi-issue models that really bring the community together. And there's this consensus building, right, and decision making. Whether it's through screening tools that you use, right? The way the diagnosis is given, how it's shared, how it's documented, the different type of treatment models, don't always have to be pharmacological, they can be non-pharmacological, they really address the body, mind, and soul. That's what I think about. And I, again, see those usually in spaces that are not focused only on the eradication of disease or are physician led.

Dr. Raegan McDonald-Mosley (12:15):

I love that. And I think words are important in sort of changing the model from a patient-centered approach to a person-centered approach is important, because that person's only a patient for a moment and then they may walk out of our door and they're a person in the middle of their community with all of their intersectional identities. And I also love the idea of really thinking of the people we serve as thought partners rather than just identities or entities that we need to treat or manage. Right? But actually thought partners and really centering the folks with the most barriers to access and the most barriers to success in our society and really using them to help inform our strategies. I love that.

Dr. Raegan McDonald-Mosley (12:53):

And how do we also push the systems to be better? How do we push the systems to this reorientation to humanity and to focusing on the person. Right? Rather than sort of the bottom line. How can we communicate with transparency and center the person in front of us while we're also disrupting to make the system better?

Dr. Karen Scott (13:17):

When the system is able to acknowledge and then reconcile the traditional, individual level, disease centered, oriented interventions are not working for community. Like when you keep

doing things over and over again and it's not producing the outcomes that are intended. And, again, outcomes are not exclusive to the goal, its not exclusive to the outcome, but also the experience. And I think when actually asking patients what they... When asking the public and the community what is it that they need to, again, be able to pay, to reach, to seek health and healthcare within a system. Again, what are their barriers? What are their burdens? What are their benefits to engaging your health system? And if we actually listen to the community and then mapped those areas that are different across... Again, that concepts a risk facilitator burden barrier benefit. I think we would begin... I think it then would identify opportunities for this system to reimagine the provision of care and support and services from the perspective of the community that's actually engaging the system and has been doing that for decades, but also just being in the community. Right?

Dr. Karen Scott (14:47):

And so, health systems don't exist as an island, although we think we do. But what if we actually, again, apply this kind of socially ecological model, this relational and power differential perspective onto the health system. Then I think the health system will realize that it sits in relationship to the local pharmacy, to the local grocery store, to the local faith based institutions, the local gangs, honestly, right? The local... The people who are living or trying to survive on the streets. The health system may think that it is a place of safety that people enter into and think that they're separate from the system in which they were built themselves, but they're not. And so, I think community driven, patient driven systems or interventions are ones that connect history with contemporary times and brings that grounding of truth to a health system to say, "Hey, you may be X number, C, or a leader in this hospital, but our families have been here for centuries or for decades or since the 1930s or forties and sixties. And we've seen the pattern over and over and over again, which may be new to you, but it is not new to us."

Dr. Karen Scott (16:09):

And I think that is humility, that grounding of truth, right, that there are many different truths and the one the hospitals and health systems hold usually is incomplete. And what if we were to, again, build the capacity of the community to identify the problem, characterize the problem, characterize the solutions and then provide the solutions that always involve them, right, at every decision point from design to dissemination. That is actually when we see success, right? Because we did something very simple. We made space for the community to solve their own or manage or address their own needs based upon how they defined them. But also based on the ways that they believe are the most authentic to fulfilling their needs with the health system as a partner and not as the sole leader or own ness power.

Dr. Raegan McDonald-Mosley (17:16):

I love that. I love that. I've been following your work for some time, which is super powerful and centers around advancing cultural rigor and quality improvement, science practice, and interprofessional education and training. How do you see this framework playing out in the setting of family planning health centers, right? And what would your family planning utopia look like?

Dr. Karen Scott (17:37):

Oh, wow. That is an amazing question. And thank you for the positive feedback. So, for cultural rigor, I see it as four modalities, right? One is a vision, as a practice, as an analytic framework. And I believe family planning has already adopted the concept of seeing itself, meaning it's special to you or group... It's discipline as a movement, right? As a movement in the provision of

sexual reproductive health in a way that I don't see other parts of our specialty, and I'm speaking about OBGYNs in general. What I... This utopia of mine would really think about... It is going back to... It would recognize that for centuries, historically and structurally minoritized and marginalized communities have been erased or excluded in just the existence of their own bodies. And it goes to this concept of production versus reproduction. In this utopia family planning, I would need to bring in cultural humility, but expanding upon that, that it's not just in the training, but it's also in how one shows up in the interaction, in the communication, in the counseling, and the decision making, and the documentation, and the dissemination of information, right? In a patient handoff or an electronic health record.

Dr. Karen Scott (19:27):

We need to really build the consciousness and the skillset to ask, to inquire from a place of, again, cultivating belonging. Like that's... That's what's on my heart now. Like if we were led by the motivation to curate spaces and health systems where people feel belonged, where people can feel liberated, they can be the autonomous agent of their body, of their life, and also feel loved... I think we would behave, and think, and do differently in our questioning, in our history taking, and the options that we would describe to someone that there are, again, options, because no one really, truly, has choice when they come into a system and the providers are already hired and working that day. I tell that to systems when I do training that people really don't have choice when they show up and you're on the schedule. We think that they do, but they didn't get to choose. They didn't build the health care system, they didn't recruit, select, and hire the providers. They didn't even choose who gets to work on the day they show up.

Dr. Karen Scott (20:42):

So, again, that's that culture humility showing up saying that there's always a presence of constraint, period.

Dr. Raegan McDonald-Mosley (20:56):

I love that. I love that. So, I mean, it seems like the sort of thread I'm hearing throughout our conversation and designing your family planning utopia is, again, really seeing the person in their totality and complexity and having a healthcare system and institutions that help people to meet their goals, understanding that they're the experts of their lives, right? Rather than the other way around. Designing the healthcare system so it's that we meet our goals through the patient. And really centering cultural humility and love and care for people that we are interacting with. I love all of that.

Dr. Raegan McDonald-Mosley (21:33):

So for our last moment, any action items or things that you want to implore our listeners to take away from this conversation and to implement in their own settings?

Dr. Karen Scott (21:42):

Yes. I would behoove... Like community systems. I always ask health systems, "What community based organizations are you in relationship with?" They name some of them but, no. What does that relationship look like? Who does the community trust? Not who does the hospital trust? So, I would ask health systems to really begin to, again, reimagine and reflect upon their existing partnerships with community and are those relationships with community reflective of who the community would deem right as being trustworthy and safe for them to also navigate. And I think I would love for health systems to bring on community as a part of, again,

their internal review board or their QI committee. What are ways that community can show up and some of the ways in which policies and practices are developed but also evaluated.

Dr. Karen Scott (22:52):

So I would recommend, when I'm thinking about the practice of culture humility and person focused care, is where does the person, the community, show up in the evaluation of your systems? And if there is a lack of community participation in quality improvement evaluation, then that is a message to the community that the impact of care is of no value or consequence to the provision of care. And I would love to see more representation, participation, and actual power, decision making. Participation from, again, those who have been historically and structurally excluded and erased in society. Again, like where do they show up in places of power, decision making and the provision of care? So I just think more community led models, more peer... Like really supporting people who are living through something and have been able to navigate the system in the context of their lives, really building their capacity to be heard and to partner with other community people.

Dr. Karen Scott (24:14):

So we support peer support, which would go back to supporting... Which would go back to divesting as opposed to divesting from social to capital social networks. As I speak for... As a black woman, there are many opportunities for systems to learn the power of black sisterhood or kinship. I speak a lot about that. I would love to see that. What would it be like to have our chosen and given fam or tribe show up in the care and be a part of the care and be able to critique the care and redesign the care. I think communities would be so much more responsive if the health system acted as a community, which I don't know if it can, but I think that we need to, as healthcare providers working in this matrix, really just take pause and look at what communities are already doing, right? In terms of their acts of resilience and resistance and replicate those models, because community has been taking care of itself for a long time.

Dr. Raegan McDonald-Mosley (25:33):

That's such a powerful framework to think of the healthcare system as a community within a larger community. And those two entities interacting positively rather than sort of a top down approach. That's really positive. Well, thank you so much, Dr. Scott, for this informative discussion. You have given us so much to think about. And to our listeners, we hope that you will walk away with not only a better understanding of how to advance equity and family planning and reproductive wellbeing, but also actionable steps that you can enact today to follow the work of Dr. Scott. And to hear more about the work that she's doing, please follow her at @RJEpiOBWarrior. Again, that's @RJEpiOBWarrior on Twitter. Follow me at @DrRaegan on Twitter. And please stay connected with power to decide by following us at @PowertoDecide on all platforms. This podcast was produced as a partnership between Power to Decide and the Reproductive Health National Training Center. Learn more at rhntc.org.