AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PGSIG-845

Ending the Wait for Comprehensive Pelvic Pain Care

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PGSIG-845: Ending the Wait for Comprehensive Pelvic Pain Care

Chair: Janelle Moulder
Co-Chair: Ashley Gubbels
Faculty: Noor Abu-Alnadi, Adrian Balica, Ashley Gubbels, Janelle Moulder

Course Description

This course explores the ways in which clinical practice design can enhance the patient care experience and improve timely access to high-quality care. Beginning with the patient intake, we will examine selection of clinical questionnaires to provide both a comprehensive assessment and foster outcomes-driven research, while engaging the patient on their primary concerns. Next, we will evaluate smart health platforms and electronic medical record innovations to reduce barriers to and improve care for patients with chronic pelvic pain. By defining the roles of the physician-surgeon and advanced practice providers, we will analyze how integration of various advanced practitioners into a practice can improve a multidisciplinary approach to pelvic pain care in a surgical practice. Finally, improving access to care for pelvic pain starts with early diagnosis and raising awareness. We will highlight the importance of education and advocacy for patients and within the community, through the development of sustainable partnerships.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Describe how smart health platforms and EMR innovations are reducing barriers to care for patients with chronic pelvic pain; 2) Analyze best practices for longitudinal outcome measures when developing a clinical practice and research program in pelvic pain; and 3) Discuss the development of multidisciplinary and community partnerships to improve patient outcomes by raising awareness through advocacy.

Course Outline

8:00 am	Welcome, Introduction and Course Overview	J. Moulder
8:05 am	The Right Care, the Right Provider: A Collaborative Model for Pelvic Pain	J. Moulder
8:30 am	Turning Intake Into Insight: Using Questionnaires for Comprehensive Pelvic Pain Care and Research	A. Gubbels
8:55 am	Reimagining Chronic Pelvic Pain Care in the Digital Age	A. Balica
9:20 am	No Pain Period: Raising Patient and Provider Awareness Through Advocacy and Education	N. Abu-Alnadi
9:45 am	Discussion Questions & Answers	All faculty
10:00 am	Adjourn	

ADA Statement: In accordance with the Americans with Disabilities Act (ADA), please contact CMEsupport@aagl.org should you require any special assistance.

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Asterisk (*) denotes no financial relationships with ACCME-defined ineligible companies to disclose.

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The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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COURSE CHAIR DISCLOSURE

Janelle Moulder, MD*

COURSE CO-CHAIR DISCLOSURE

Ashley Gubbels, MD*

FACULTY DISCLOSURES

The following faculty have agreed to support their presentations and clinical recommendations with the best available evidence from the medical literature (in alphabetical order by last name).

Noor Abu-Alnadi, MD*
Adrian Balica, MD*
Ashley Gubbels, MD*
Janelle Moulder, MD*

MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary.

Ending the Wait for Comprehensive Pelvic Pain Care

Janelle K. Moulder MD MSCR
Atrium Health Wake Forest Baptist | Wake Forest University School of Medicine

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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Disclosures

Grant Research Support: 1P01HD106485-01 Collaborative Center to Develop Improved Diagnostic and Therapeutic Approaches to Endometriosis (JKM)
Speaker's Bureau: None
Consultant: None
Equity/Ownership Interest: None
Other: None

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What to Expect…



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Meet the Faculty

- **Janelle K. Moulder, MD MSCR**
  - Chair, Pelvic Pain SIG
  - Atrium Health Wake Forest Baptist | Wake Forest University School of Medicine

The Right Care, the Right Provider: A Collaborative Model for Pelvic Pain



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Meet the Faculty

- **Ashley Gubbels, MD**
  - Co-Chair
  - Pelvic Pain SIG
  - Cleveland Clinic

Turning Intake into Insight: Using Questionnaires for Comprehensive Pelvic Pain Care and Research



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Meet the Faculty

- **Adrian Balica, MD**
  - Past Chair, Pelvic Pain SIG
  - Chair, Women's Health, Obstetrics and Gynecology at Overlook Medical Center

Reimagining Chronic Pelvic Pain Care in the Digital Age



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Meet the Faculty

- **Noor Dasouki Abu-Alnadi, MD MSCR**
  - Associate PD, CBG Fellowship
  - University of North Carolina—Chapel Hill

No Pain Period: Raising Patient and Provider Awareness Through Advocacy and Education



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The Takeaways…

- Identify elements of a multidisciplinary care team to address multifaceted complex pelvic pain
- Analyze best practices for longitudinal outcome measures when developing a clinical practice and research program in pelvic pain.
- Describe how smart health platforms and EMR innovations are reducing barriers to care for patients with chronic pelvic pain.
- Discuss development of multidisciplinary and community partnerships to improve the patient outcomes by raising awareness through advocacy.

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Ending the Wait for Comprehensive Pelvic Pain Care

The Right Care, the Right Provider: A Collaborative Model for Pelvic Pain

Janelle K. Moulder MD MSCR
Atrium Health Wake Forest Baptist | Wake Forest University School of Medicine

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Objectives

- Identify elements of a multidisciplinary care team to address multifaceted complex pelvic pain
- Analyze best practices for longitudinal outcome measures when developing a clinical practice and research program in pelvic pain.
- Describe how smart health platforms and EMR innovations are reducing barriers to care for patients with chronic pelvic pain.
- Discuss development of multidisciplinary and community partnerships to improve the patient outcomes by raising awareness through advocacy.

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Where to Begin?





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The Playbook

- Communication
- Make Connections
- Cross Disciplines

Your ability to grow as a professional, to grow your practice, and continue to provide quality care to your patients depends on the ability to create a team.

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#1 Communication



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YOUR MOST VALUABLE SKILL IS YOUR ABILITY TO COMMUNICATE WITH OTHERS

14



NURTURE RELATIONSHIPS

15



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Stay Connected



Source: istockphoto.com

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Setting the Stage

- YOU HAVE
  - 20 minutes
  - Open-mind
  - Your last patient had a hand-on-the-doorknob question about libido
- YOUR NEXT PATIENT HAS
  - 25-year history of chronic pelvic pain
  - 23 years of failed medical treatments
  - Multiple barriers to treatment
  - A healthy dependency on ~~google~~ AI
  - A talkative nature
  - Severe, diffuse pain



With permission, Mark Dassel MD

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Setting the Stage



- You take a history
- You perform a physical exam
- You are out of time.
- You take extra time for education and to make a plan based on shared decision making.
- It is tough to make a plan due to prior failed treatments, barriers to care.
- You are now an hour behind.
- Both you and your patient are stressed by the end.

THERE HAS TO BE A BETTER WAY.

With permission, Mark Dassel MD

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Organizing the Approach

- Recognize multiple disease states
- Recognize multiple disease states require multiple treatment plans
- Recognize the disease states do not live in a vacuum
- Recognize that treatments are not in a vacuum
- Recognize and anticipate barriers to treatment

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Moving Beyond the "Single Brick" Mindset

THE PROBLEM

- Single diagnosis drives the entire treatment plan
- Endometriosis found → excision performed → pain persists
- "We got it all" — but pain continues
- Patient feels dismissed; clinician feels stuck
- Repeat procedures without re-evaluating the full picture

THE REALITY

- CPP is rarely a single-source problem
- Multiple contributors are often active simultaneously
- Peripheral, central, and psychological mechanisms overlap
- Treating one layer may not silence adjacent ones
- Success requires identifying — and addressing — all active components

PMID 39410856

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CPP as a Modular Condition: Stacking the Bricks

Central Sensitization
Wind-up, allodynia, hyperalgesia

Neuropathic Pain
Pudendal, iliohypogastric, pelvic nerves

Pelvic Floor Dysfunction
Hypertonic / hypotonic muscle patterns

Structural / Visceral Pathology
Endometriosis, adhesions, adenomyosis

Psychological / Behavioral
Trauma, catastrophizing, avoidance

Key Insight

- Every patient's stack is different — the same diagnosis may have different active layers
- Treating only one layer (or problems out of order) explains most treatment failures
- The "missing piece" is often psychological or central — not structural
- The Provider role: identify which bricks are in play, not just the presenting diagnosis

With permission, Mark Dassel MD

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#3 Cross disciplines and know the players



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Identifying When to Bring in the Right Specialist

Pelvic PT
Refer when: Pelvic floor dysfunction, dyspareunia, hypertonic/hypotonic patterns, post-surgical pain
Timing: Early & often — first-line for most CPP

Behavioral Health / Psychologist
Refer when: Catastrophizing, trauma history, medical mistrust, depression, anxiety, treatment fatigue
Timing: Concurrent; don't wait for "physical" treatment to fail

Pelvic Pain Specialist / MIGS
Refer when: Suspected endometriosis, failed hormonal management, complex anatomy, desire for excision
Timing: When structural pathology is active and under-addressed

Pain Management / Anesthesia
Refer when: Neuropathic pain, pudendal neuralgia, failed oral pharmacology, nerve block candidates
Timing: Diagnostic and therapeutic — after mechanism identification

GI / Urology
Refer when: IC/BPS overlap, IBS-C, rectal pain, pelvic organ prolapse component
Timing: When visceral contributors are suspected or unaddressed

Integrative / Nutrition
Refer when: Inflammatory diet patterns, mast cell activation, refractory IC/BPS, supplement optimization
Timing: Adjunctive — particularly in complex/refractory cases

With permission, Mark Dassel MD

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When the Build Falls Apart: Barriers to Effective CPP Care

System-Level

- Insurance denials for multimodal care
- Long wait times for subspecialists
- Fragmented EHR systems; siloed records
- Prior auth burden for neuromodulators / procedures
- Lack of integrated CPP clinics

Clinician-Level

- Anchoring bias: one diagnosis, one treatment
- Limited training in central sensitization
- Discomfort discussing psychological contributors
- Under-referral to pelvic PT and behavioral health
- Normalizing pain ("it's just endometriosis")

Patient-Level

- Prior medical trauma and diagnostic dismissal
- Medical mistrust; years of unanswered pain
- Overwhelm from complex multimodal plans
- Fear of "it's all in my head" labeling
- Treatment fatigue; reluctance to try again

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Assembling the Team: Brick by Brick

- When you have prioritized which issues should be treated first, assemble your team for the patient.
  - Stress the importance of the hidden gems
    - Pain Psychology
    - Behavioral Health
    - Advanced Practice Providers
  - Find the easy way (does the patient already have specialists on their care team?)
  - Find your tribe (the hard-workers, the problem solvers, the "distance" collaborators)

PMID 28249696 With permission, Mark Dassel MD

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Now start building!



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Acknowledgments

- Mark Dassel, MD. Intermountain Health. Salt Lake City, UT.
- Eva Reina MD. Associate Professor, Atrium Health Wake Forest Baptist | Wake Forest University School of Medicine. Winston-Salem, NC.

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2. Ogbonmwan D, Graham Y, Hotonu O, Hussey J. Development of a regional urogenital pain network: Sharing good practice. Eur J Obstet Gynecol Reprod Biol. 2017 Apr;211:222-223. doi: 10.1016/j.ejogrb.2017.02.012. Epub 2017 Feb 21. PMID: 28249696.

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Streamlining an Endometriosis and Pelvic Practice to Thrive

Optimizing Clinical Efficiency

Ashley Gubbels, MD FACOG
Cleveland Clinic

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1

Disclosure

I have no financial relationships to disclose.

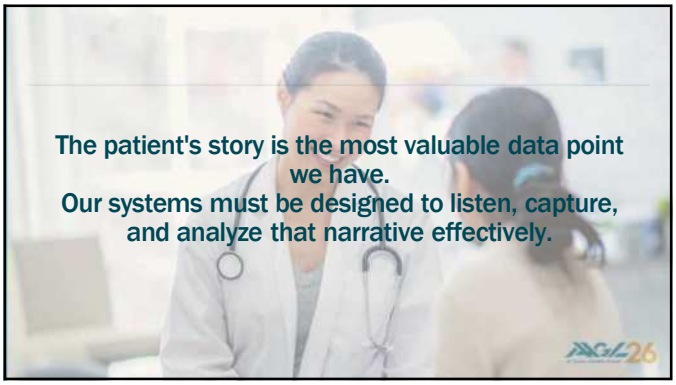


2

Objectives

- Discuss the use of patient entered data to enhance clinical decision making and documentation
- Review longitudinal tracking for both clinical and research output
- Consider the impact of AI technology on cognitive burden and burnout reduction

3



4

The Power of Patient-Entered Data

5

Modernizing the Chronic Pelvic Pain Clinic

Leveraging Technology for Patient Outcomes and Research Insights



Current Challenges
Managing complex, longitudinal care environments characterized by fragmented data systems.

The Goal
Improving overall clinical efficiency and enhancing research utility through comprehensive digital transformation.

Our Strategy
Seamlessly integrating real-time patient-reported outcomes (PROs) with the EMR and REDCap

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Workflow Optimization: Intake and Documentation

Moving from manual to automated processes



Patient-Entered Data

Standardize intake data collection to ensure consistent and reliable information entry.

Automated Note Generation

Leverage structured data to automatically populate EMR clinical notes, reducing manual entry time and improving accuracy.

Efficiency Gains

Significantly reduce administrative burden while improving the overall accuracy and quality of patient history records.

7

Intake to Documentation

Automation and reducing clicks



Patient welcome and questionnaires

MyChart communication in three clicks

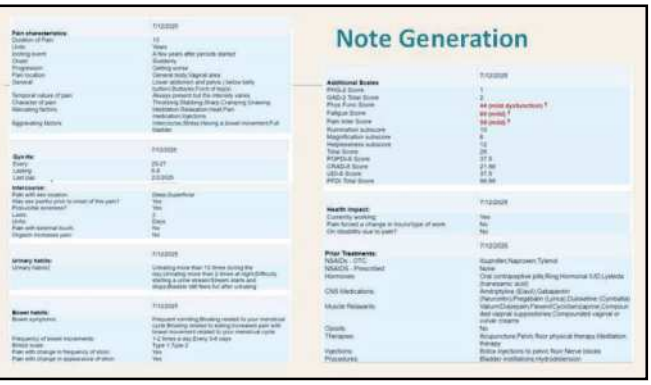
Pertinent history

Medical, surgical, and family history imports directly

PROMs

Summary of patient reported measures

8



9

Data Integration Metrics

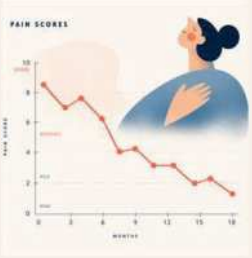
Comparing old vs new workflows

Metric	Manual Entry	Automated/Digital	Impact
Intake Time	15 mins	3 mins	80% reduction
Documentation Time	10 mins	2 mins	80% reduction
Data Accuracy	Variable	High	Higher reliability

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EMR as a Longitudinal Tool

Tracking pain & function over time



Longitudinal Data Collection

Utilizing the EMR beyond a single encounter to capture continuous patient data.

Patient questionnaires to track variables of interest

Trend Identification

Monitoring pain scores and functional outcomes over months and years to assess treatment efficacy.

Unified Record

Ensuring a holistic, clear view of the patient's chronic condition across the entire care journey.

Specific follow up questionnaires linked to note types

- Follow up
- Post op

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Consistency via Note Templates

Uniformity in Data Entry

Follow Up



Postop



12

Response Tracking

Optimizing chart review



Tracking prior therapies

Allows for quick assessment of treatments not yet tried

Improves prior authorizations as all previously tried treatments are listed in every note along with side effects/response

- Decreases staff administrative burden/time

13

Eradicating the Data Silo

Connecting clinical care and research



The Challenge

Clinical data often stays locked in the EMR, creating barriers to longitudinal study.

The Solution

Implementing a secure, interoperable pipeline between clinical systems and research database.

* Translates into faster publication cycles and deeper, actionable insights into long-term treatment efficacy

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Bridging to Research: Migration to REDCap

From clinical care to scientific advancement



CLINICAL DATA INTEROPERABILITY SERVICES (CDIS)

What is CDIS?

Clinical Data Interoperability Services (CDIS) is an advanced feature of REDCap that must be enabled by a REDCap administrator. This feature allows an individual REDCap project to interact with an electronic health record (EHR) such as EPIC, Cerner, etc. and pull selected information from the EHR into the REDCap project. This is done through the Fast Healthcare Interoperability Resources (FHIR) web service inside of an EHR which can pull structured data into REDCap using OAuth2 authorization. For a complete list of available data that can be pulled into REDCap please see CDIS documentation below:

REDCap

*Can be integrated with most EMR's if your institution sets up a compliant FHIR server or custom RESTful middleware connectors. *

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Ensuring Data Quality and Compliance

Governance and security protocols

Data Standardization

Aligning EMR fields with REDCap instruments to ensure consistent data ingestion.

Compliance

Maintaining strict HIPAA standards throughout all stages of data migration and storage.

Validation

Implementing routine audits to verify dataset integrity and identify discrepancies.



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Artificial Intelligence

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Ambient Scribes

Focused attention and improved cognition





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AI Best Practices

Optimize input and output

Provide Clinical Context
- Summarize patient history in 2-3 sentences before entering room
- Aids AI in plan generation

Review and Edit
- Tendency to lose complex clinical decision making/differential diagnosis in favor of action items
- Add in thought process-individualized vs dot phrases

Attest
- Document that AI assisted documentation was reviewed



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Transform the Future of Your Clinic

Strategic Pillars for Clinical Excellence & Efficiency

Efficiency	Longitudinal Care	Research
Streamlined intake processes, freeing up valuable clinician time for direct patient interaction.	Utilizing EMR tools to enable superior tracking and management of chronic pain trends over time.	AI/ML integration, converting daily routine care into actionable scientific knowledge.

ADVANCING PATIENT OUTCOMES THROUGH INNOVATION AND DATA-DRIVEN CARE.

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Acknowledgments

- Cleveland Clinic Patient Entered Data Team
  - Shelly Armstrong
  - Antoinette Liss

22

References

- None

23

Transforming Pelvic Pain Care: AI-Driven Smart Phone Apps And EHR Platforms

Adrian Balica, MD · Atlantic Health OMC

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1

Disclosure

"I have no financial relationships to disclose."

2

Objectives

- Outline elements of AI use in EHR/EMR
- Digital and mobile health use in chronic pelvic pain
- Evaluate the quality of evidence in digital health

BLOOM'S TAXONOMY VERB LIST · COGNITIVE DOMAIN

3

Content Slide

- Duplicate this slide as many times as you need for your talk.

4

Signs of the Future : EHR/EMR in AI world

5

Key Insights

- **The Problem:** EHRs have created a significant administrative burden, leading to clinician burnout and "pajama time"
- **The AI Solution:** transforming EHRs into intelligent assistants that automate tasks and surface critical insights
- **Key Features:**
  - Generative AI (ambient scribing)
  - Predictive Analytics (risk assessment)
  - Agentic AI (workflow automation).
- **Quantifiable Impact:**

AI can reduce "pajama time" by up to 2 hours per day and has been linked to a 44% drop in physician turnover
AI applications key clinical health have the potential to **create $150 billion in annual savings** for the United States healthcare economy by 2026(Accenture analysis)





https://www.ama-assn.org/practice-management/digital-health/physician-burnout-solutions-using-ai-improve-electronic-health-0

6

Key AI Features in EMR/EHR Systems

- Natural Language Processing (NLP) & Voice Recognition vs Speech Recognition
- **Ambient Scribing:** The AI listens to the doctor-patient conversation and automatically generates clinical notes, saving time on manual data entry
- **Clinical Data Extraction:** NLP can be used to process unstructured text, like clinical notes or old paper records, and convert it into structured data.
- **Smart Suggestions:** AI can provide autocomplete and autofill suggestions for clinical terms, codes, and patient information, increasing documentation accuracy and efficiency

- Predictive Analytics:
- **Risk Prediction:**
  - analyze vast amounts of patient data to identify patterns
  - predict a patient's risk of developing certain diseases, readmission
  - proactive and preventative care
- **No-Show Prediction:** AI can predict which patients are likely to miss their appointments, allowing practices to optimize scheduling and reduce lost revenue
- **Operational Efficiency:** AI can predict
  - patient volume
  - optimize staff scheduling
  - resource allocation
  - reduce wait times and improve overall efficiency

7

Predictive Analytics



Barriers to clinic implementation:
-lack of validation in diverse patient populations
-lack of infrastructure
-limited provider understanding of these tools
-difficult user interfaces with existing technology

- **Risk Prediction:**
  - analyze vast amounts of patient data to identify patterns
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No-Show Prediction: AI can predict which patients are likely to miss their appointments, allowing practices to optimize scheduling and reduce lost revenue

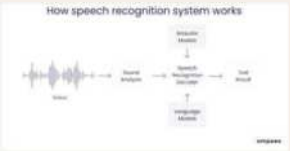
- **Operational Efficiency:** AI can predict
  - patient volume
  - optimize staff scheduling
  - resource allocation
  - reduce wait times and improve overall efficiency

8

Natural Language Processing (NLP)

Voice Recognition vs Speech Recognition

Decrease documentation time by up to 50%.
spend approximately 15.5 hours per week on paperwork
Physicians using medical voice recognition re 61% reduction in documentation-related 54% improvement in work-life balance





- **Ambient Scribing:** The AI listens to the doctor-patient conversation and automatically generates clinical notes, saving time on manual data entry
- **Clinical Data Extraction:** NLP can be used to process unstructured text, like clinical notes or old paper records, and convert it into structured data.
- **Smart Suggestions:** AI can provide autocomplete and autofill suggestions for clinical terms, codes, and patient information, increasing documentation accuracy and efficiency

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Key AI Features in EMR/EHR Systems

- **Clinical Decision Support Systems (CDSS):**
- **Diagnostic Suggestions:** analyze a patient's data, including symptoms and test results, to suggest potential diagnoses and warn of high-risk conditions
- **Personalized Treatment Plans:** recommend the most effective treatment options and suggest alternative medications based on allergies or other health risks
- **Medical Image Analysis:**assist in the analysis of medical images like X-rays, MRIs, and CT scans, and helping radiologists
- **Risk Alerts:** AI-driven CDS can predict potential complications, such as sepsis or hospital readmissions, allowing for proactive intervention

- **Administrative Automation:**
- **Automated Documentation:** AI can automate the creation of prescriptions, reports, and other documents
- **Billing and Coding:** assist with medical coding (CPT/ICD-10), conduct insurance verification, and detect potential errors in claims, improving revenue cycle management.
- **Fax and Inbox Management:** automatically process inbound faxes, categorize documents, and match them to the correct patient records, saving time for administrative staff.

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Key AI Features in EMR/EHR Systems

AI-Powered Patient Engagement

- AI tools improve patient communication and engagement through various applications
- **Chatbots and Virtual Assistants:** AI chatbots can answer common patient questions, manage appointment requests reducing the administrative burden on staff.
- **Personalized Reminders:** automated, personalized messages to patients, such as reminders for follow-up appointments or preventive screenings, which helps improve patient adherence to care plans.

https://www.itpathsolutions.com/how-to-build-an-ai-chatbot-for-healthcare/



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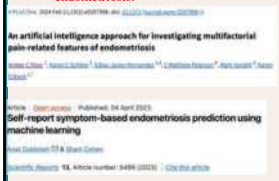
Notable Companies and Platforms

- **Epic:** A leader in the EHR market, Epic is a major player in integrating AI for clinical decision support and workflow automation.
- **Oracle Cerner:** Its EHR platform has a focus on feature-rich capabilities and interoperability, with ongoing AI integration to enhance its services.
- **eClinicalWorks:** This company offers a suite of AI-powered tools, including Sunoh.ai for documentation and AI assistants for various administrative tasks.
- **Athenahealth:** This platform uses AI to automate repetitive tasks and manage revenue cycles.
- **Praxis EMR:** Praxis is an AI-based EMR that uses neural networks to help physicians with charting, moving away from traditional templates.

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Enhanced Diagnostic Accuracy and Reduced Diagnostic Delay

One of the biggest challenges with pelvic pain is the long diagnostic delay, especially for conditions like endometriosis.



- **Symptom Pattern Analysis:**
  - analyze a patient's EHR data clinical notes, patient-reported symptoms, and medical history
  - to identify **subtle patterns** that may be indicative of specific conditions
  - This can flag a patient for a condition like endometriosis
- **Non-Invasive Screening:**
  - AI-driven, non-invasive screening tools that analyze patient-provided data, such **as symptom questionnaires**, to predict the likelihood of a condition like endometriosis.
- **Imaging Analysis:**
  - analyze medical images, such as ultrasounds and MRIs, to detect subtle lesions or abnormalities
  - detecting endometriosis lesions

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Personalized Treatment Planning

Pelvic pain is highly individual, and a one-size-fits-all approach to treatment is often ineffective.
AI helps to create personalized and effective treatment plans

- **Predictive Analytics:**
  - analyze a patient's clinical and genetic data to predict their response to different treatment options, such as hormonal therapies, physical therapy, or specific medications.
  - choose the most effective intervention from the outset
- **Multi-modal Treatment :**
  - recommend a combination of therapies, including pharmacological, interventional, and behavioral treatments
  - an AI tool might suggest a combination of physical therapy, a specific medication, and mental health support for a patient with chronic pelvic pain.
- **Patient-Reported Outcomes :**
  - EMRs with integrated AI can track and analyze PROs
  - understanding how a patient's pain, mood, and daily activities are affected over time
  - provide insights on the effectiveness of the treatment plan and suggest adjustments

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AI automates key parts of the clinical workflow for pelvic pain

Workflow Automation
Clinical Decision Support

- **Automated Documentation:**
  - AI-powered natural language processing (NLP) tools can automatically transcribe and summarize patient-provider conversations, creating detailed clinical notes
  - reduces the time a provider spends on charting and documentation, allowing them to have a more empathetic conversation with the patient
- **Clinical Decision Support (CDS) Alerts:**
  - AI-powered CDS systems can run in the background of an EHR, providing real-time alerts and recommendations. For a pelvic pain patient,
  - flagging potential drug-drug interactions
  - suggesting additional diagnostic tests based on new symptoms
  - reminding the provider about follow-up care
- **Population Health Management:**
  - analyze data across a large patient population to identify trends and risk factors for pelvic pain
  - allows healthcare systems to implement proactive screening programs

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MARCH

AI in EMRs for pain and women's health

- **ModMed:** ModMed offers EMR software for pain management, that uses AI to streamline clinical workflows and improve patient management.
- **Praxis EMR:** This platform AI core processing system that
- learns from a physician's charting habits
- making the system more efficient and intelligent over time
- particularly beneficial for complex conditions like pelvic pain.

- **March Health:** endometriosis and pelvic pain and overall women's health
- provides AI-based screening, personalized recommendations
- a five-layered care model that integrates AI with virtual and direct clinical care

- **Lasa Health:** AI-powered chatbot personal health assistant for women with chronic pelvic pain
- providing coping strategies, answering questions
- supporting pain management

LasaHealth

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Future is here: EHR AI Trends for 2025

- **The Rise of Agentic AI: Towards Autonomous Workflows**
- **The Gateway for Innovation: App Market**
- **Emphasis on AI Trust, Validation, and Governance**
- **Implementing Custom AI within the EMR Environment**
- **Connecting External AI**
- **AI agents for autonomous tasks :pre-visit prep, care gap closure)**
- **Increased integration of multimodal AI : video, image, genomic data**

17

A Guide to Digital Tools for Chronic Pelvic Pain

- **digital health technologies to augment their care**
- **categorizing them by their primary function**:
  - symptom tracking
  - physical intervention
  - holistic pain management
- passive trackers and active therapeutic programs
- leveraging the **biopsychosocial model** of pain management combining physiological, psychological, and social support elements
- **Clinical validation** and **expert backing** are becoming key differentiators for premium applications

18

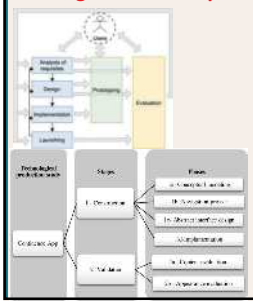
A New Era of Chronic Pain Management: Apps ?

- leverage technology to treat, manage, prevent
- Digital therapeutics (DTx)
- Mobile health (mHealth) applications
- Web-based (eHealth)
- digital delivery of behavioral interventions Cognitive Behavioral Therapy (CBT)

- scalable
- accessible
- data-driven way
- evidence-based interventions remotely
- complement to traditional medical care
- continuous support
- data tracking
- educational resources
- **outside of clinical settings**

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App Design and Development



- user-centered methodology with feedback from the users
- users participate in the design process
- adapted to different devices
- friendly and clear design such as fonts and colors
- emphasis on image visualization space
- user interface: buttons and slides comfortable to every users
- multilanguage
- benefit both patients and clinicians

20

Health applications for chronic pelvic pain

- **Category 1: Comprehensive Symptom and Wellness Trackers**
  - **patient-led data collection**
  - log a wide array of symptoms, triggers, and activities to identify personal patterns
  - generate organized reports for clinicians
- **Category 2: Pelvic Floor Physiotherapy and Exercise Apps:** targeted physical intervention.
  - provide structured exercises with visual and audio guidance
  - a digital companion to in-person physical therapy
  - Potential increase adherence to prescribed exercises
- **Category 3: Holistic Mind-Body and Pain Reprocessing Programs**
  - these applications combine education, psychological techniques such as CBT
  - emotional support
  - Therapeutical intention and designed to "rewire" the brain's relationship with pain

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Characteristics



App Name	Primary Function	Target Conditions	Key Features	Clinical evidence
Curable	Holistic Pain Program	Chronic Pain, Endometriosis, Migraine, Fibromyalgia	Pain science education, guided meditations, expressive writing, peer community	Peer-reviewed RCT, ranked #1 in a peer-reviewed study
Bloume	Holistic Pain Program	Endometriosis, Vulvodynia, Vaginismus, PCOS, etc.	Personalized plans, mental/physical/sexual health support, symptom tracking	expert
Ella Health	Holistic Pain Program	Chronic Pelvic Pain, Endometriosis	Pain flare toolkit, guided breathwork, stretches, meditations	expert
Squeezy	Pelvic Floor Physio	Pelvic Floor Dysfunction, Bladder/Bowel issues	Visual/audio guides, customizable plans, "Professional mode," Apple Watch support	Professional Society
ENdi	Symptom Tracker	Endometriosis, Adenomyosis, PCOS, PMDD	Health journal, medication/appointment trackers, personalized insights, data export	Emphasizes data privacy and security
Bearable	Comprehensive Tracker	Wide range of physical and mental health conditions	Highly customizable logging, medication reminders, fitness tracker integration, data export	Relies on user customization and personal insights
Phendo	Symptom Tracker/Research	Endometriosis, period-havers, general population (controls)	Symptom tracking for research purposes	Columbia University research project (Citizen Endo)
Pelvic Pain Chronicles	Symptom Tracker	Pelvic Pain	Visual tracking, report generation for providers	Expert

22

Evidence analysis

- randomized controlled trial (RCT)
- official approval for clinical safety by the health agencies
- expert/founder opinion
- affiliation with a reputable academic institution



23

Evidence

A short-term mobile app intervention resulted in significant improvements across physical and mental health outcomes compared to wait-listed usual care



24

Evidence

mHealth Intervention for Improving Pain, Quality of Life, and Functional Disability in Patients With Chronic Pain: Systematic Review

Authors | Cited by (67) | Tweetations (25) | Metrics

Conclusions:
The use of mHealth systems indicated positive effects for pain intensity in CNP, FM, IC/BPS, and OA; for QoL in CLBP, CNP, IBS, and OA; and for functional disability in CLBP, CMSP, CNP, and OA mHealth seems to be an alternative to improving pain-related outcomes and QoL and could be part of multimodal strategies for CP self-management. High-quality studies are needed to merge the evidence and recommendations of the use of mHealth systems for CP management.

25

Evidence

Do pain management apps use evidence-based psychological components? A systematic review of app content and quality

Mobile Health and Gamification of Chronic Pain Management: A Narrative Review

Predicting chronic pain using wearable devices: a scoping review of sensor capabilities, data security, and standards compliance

most common psychological components
1.psychoeducation
2.sleep hygiene
3.behavioral activation
4.coping skills training
5.social support

- least commonly components
- goal setting, values, and culture/diversity
- 2/3 of the apps involved health care practitioners in their development
- Limited independent scientific review

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App Integration: Strategic Approach

Single App

Single indication for a specific task
- Symptoms tracking
- Pelvic floor exercises
- Mind Body Psychological

Multi App

- Concurrent use of multiple apps for different indications
- strategic combination a highly personalized and effective digital care plan

cost concerns :
free, onetime fee, subscription

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The Future of Digital Pain Management



- Give reports for clinicians
- integration with electronic health records
- align with an individual's personal goals
- complementary component of a collaborative and integrated healthcare plan

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The Future of Digital Pain Management

advanced algorithms powered by artificial intelligence and machine learning
personalized interventions
wearable technology for real-time biofeedback and continuous pain monitoring
blockchain technology for privacy and HIPPA
utilized principles of gamification to motivate patients









https://www.hipaavault.com/resources/hipaa-compliant-hosting-insights/the-future-of-blockchain-in-healthcare

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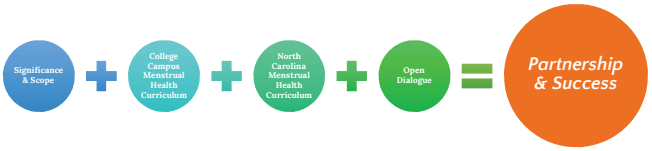
Menstrual Health: From Informal Education to an Active Curriculum

Noor Dasouki Abu-Alnadi MD MSCR, UNC School of Medicine
Janelle K. Moulder MD MSCR, Wake Forest School of Medicine

Funded by the National Institutes of Health P01 Center for Endometriosis Research Grant

1

How do we get there?

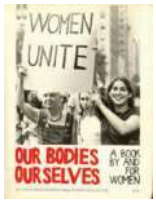


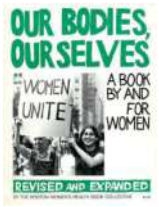
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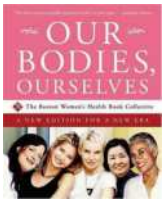
Significance and Scope

3

Where do we learn about our bodies?







4

> J Pediatr Adolesc Gynecol. 2006 Aug;19(4):271-5. doi: 10.1016/j.jpag.2006.05.002.

Knowledge, attitudes, and consequences of menstrual health in urban adolescent females

Avril M Houston [1], Anisha Abraham, Zhihuan Huang, Lawrence J D'Angelo

- Cross sectional study of urban post-menarchal adolescents 12-21 yo
- 90% of study participants were Black
- **40% did not know the correct cycle length, and 24% reported irregular menstrual cycles**
- **2% report receiving information regarding menstruation from their health care providers**

5

> Adolescence. Winter 1995;30(120):795-811.

Preparing girls for menstruation: recommendations from adolescent girls

E Koff [1], J Rierdan

- **Mothers** are the most common source of menstrual education (90%)
- **Friends** are the second most important source (78%)
- Menstrual education materials (health classes or providers) are the third most common source (42% - 60%)

6

BBC Sign in

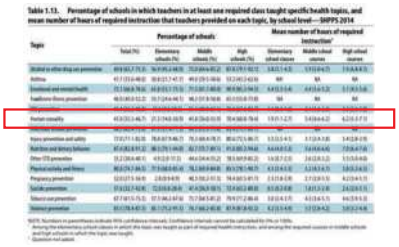
NEWS

Sex education: Menstrual health to be taught in school by 2020

England has mandated ***menstrual*** health curriculum.
US has mandated only ***sexual*** health curriculum.
What is the difference?

7

CDC National Survey of School Health Policies and Practices



8

Significance

Painful periods most common cause of absenteeism

Minimal formal menstrual health education

9

Objectives

- Enhance understanding of menstrual health (dysmenorrhea & endometriosis)
- Foster constructive dialogue between patients, caretakers, and providers
- Create sustainable, inclusive curriculum

10

Our Three-Tiered Approach

- **Outreach 1:** Menstrual Health Curriculum
- **Outreach 2:** Training Program for Campus Health
- **Outreach 3:** Engagement of Community Stakeholders

11

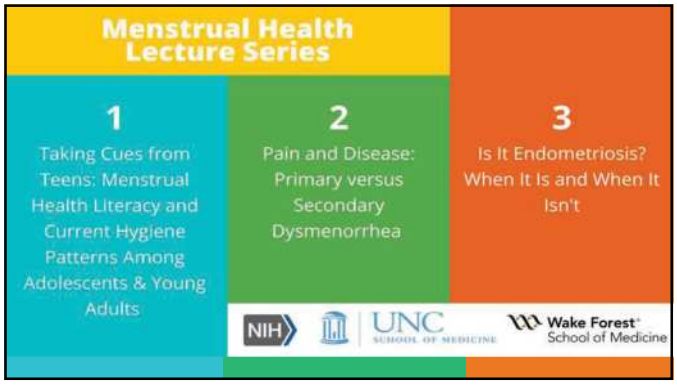
Outreach 2



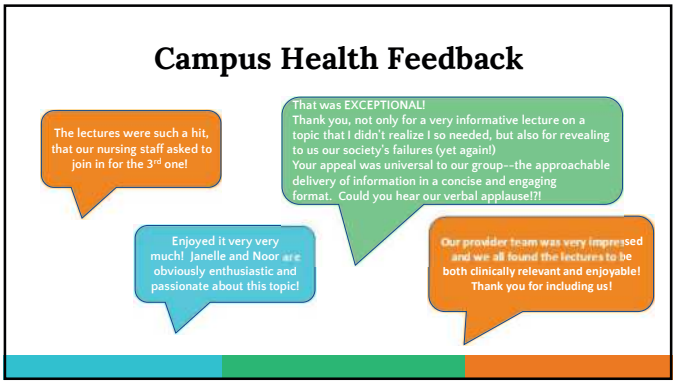
By the numbers...

- 10 – 29 participants per session
- Participants include nurses, physicians, APPs
- 7 universities with an estimated 80,750 undergraduate and graduate women

12



13

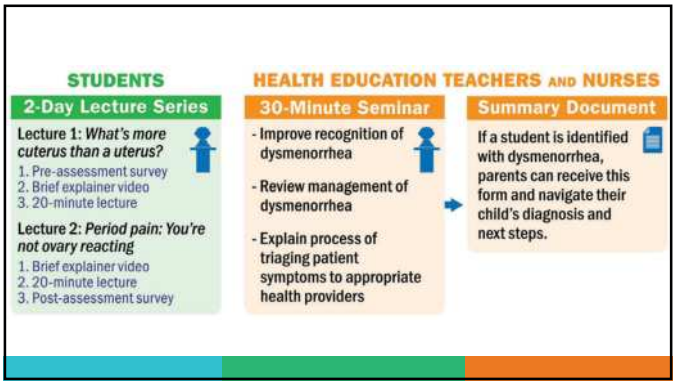


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Charlotte Public Schools

Menstrual Health Curriculum in Healthful Living

15



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Example video:



17

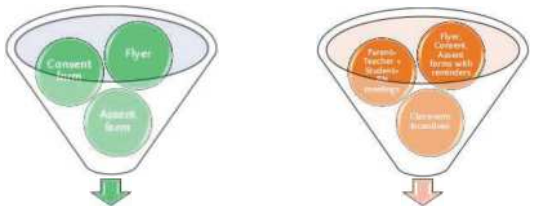
Setting:

- **Participants:** 6th–8th graders
- **Lecturers:** Drs. Noor Dasouki Abu-Alnadi + Janelle Moulder
- **Timing:** Healthful Living Class, spring semester
- **Media:** Electronic

All students can participate in lectures and videos whether enrolled in study or not.

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Recruitment:



Recruitment
(First glance)

Recruitment
(Reality)

19

Barriers:

- Potentially low recruitment
  - Parental concerns about topic choice
  - Parental concerns regarding gender
  - Tracking down consents
- Potentially low teacher participation
  - Class time commitment

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Questions for us?

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CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) outlines standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations which began on January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Act, Communicating, Implicit Bias (racialequitytools.org)
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/
https://hr.ucdavis.edu/departments/learning/certificate/implicit-bias
https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/