Welcome to AIM for Safer Birth. I'm Christie Allen.

And I'm Veronica Gillispie-Bell. On this podcast, we dive deeper into the rising severe maternal morbidity and maternal mortality rates in the United States through a data-driven quality improvement lens.

And in this episode, we're going to introduce ourselves and we're going to talk about concepts of identity and how it impacts the quality improvement work that we all do. To introduce myself, I'm Christie Allen. I am a nurse by background. I've been a nurse for about 25 years. I worked in obstetrics, critical care, and neonatal care, and then moved into more of a policy space. Currently, I am the Project Lead for the Alliance for Innovation on Maternal Health, and I'm employed by the American College of Obstetricians and Gynecologists. I live in the DC area, and all of those are pieces of my identity that shape who I am. Dr. Gillispie-Bell, do you want to introduce yourself?

Sure, thank you. I am an OB-GYN and I have been in practice for 15 years. And again, as you reflect on the number of years, it's like, wow, I can't believe I've been doing it that long. I also started to work in the area of quality improvement about four or five years into my career. And I currently, in addition to being in clinical practice and the Medical Director of the Louisiana Perinatal Quality Collaborative and the Pregnancy Associated Mortality Review for the Louisiana Department of Health. And I'm an AIM clinical champion. And I think other things that are important to understand and know about my identity is I am a black woman. I am a mother. I am a wife. And I also am from the South. I practiced in the South. I grew up in the South. And I bring those parts of my identity into this conversation because they have shaped my experiences and they shape how I think about things, how I respond to things, some of my biases and also why I do the work that I do.

Thank you so much for introducing yourself. You know what's interesting is you talk in a really broad way about your identities. And I'm going to admit right off, I did not talk about my race. I am a white woman. That's pretty indicative of my leaning into who I see myself as and somewhat centering my own identity. I think I am cognizant of the differences and similarities. And yet, that wasn't what I led with. Some of the other identities I hold, I use she, her pronouns, I am a cisgendered female, I identify as queer, although I am presently married to a man, which is an interesting way to introduce yourself. And also I am a cancer survivor. I don't often in public settings introduce myself as a wife or a mother. It's really interesting that while that does shape all of my biases and the way I come to the table, it isn't necessarily how I identify or share with people. And I think that's a really interesting point about how do we lead with our identities and then what might be more subtle.

I think that is very interesting. And just to go back to the fact of race, there is a saying and it's part of an acronym that race is, for some people, is very visible or is very invisible. And I think for me as a black woman, it's very visible because the first thing you see when you see me is very obvious that I am black. And I'm also in a lot of spaces where I am the only person that looks like me. And so my race for me is very visible. Whereas, as you mentioned, that was not one of the things that you led with. And so I think we have to understand and accept that for some people, again, race is very visible and race is very invisible. And it also shapes how you think, respond, and how you act in certain situations as well.

Absolutely. I think it's an incredible level of privilege to not think about that as I walk into different settings. And I think sometimes it is also a learned skill for me to recognize when colleagues, peers, patients, people that I'm close to,
people that I’m not close to, might feel uncomfortable in a setting, whether it’s social, whether it’s professional. I think it really goes back to making space where everyone can thrive and be successful. And part of it is acknowledging that race is impactful, especially more for some than for others. Thank you for that. That's helpful. It was an interesting gap in my introduction and it's a good way to start this out because I think we want to talk about the importance of how we approach quality improvement in even general healthcare, but particularly through a quality improvement lens. One of the factors that the AIM program has been working on and really thinking about for the last, I would say three to four years, although even from its inception, it was a known factor, is around the disparities due to health inequities for folks who are impacted, marginalized in different ways. We know that maternal mortality and morbidity are more likely, more common in people with marginalized identities. We also know that we don't know everything about how to fix that. It took us a long time to get here and it's going to take time to work on that. And some of that is what we want to talk about, about how we approach quality improvement, but with full integration of the concepts of equity.

Veronica - 00:05:37:

And I want to just acknowledge and lift and thank you for using the word marginalized because I think a lot of others, when they talk about this work, refer to marginalized populations as vulnerable and being someone that is in that marginalized population, thinking about my friends, thinking about my family that is in that marginalized population, we don't consider ourselves to be vulnerable and words matter. And so thank you for framing it in that way. And then I hope that others that are listening to this podcast will also take away from that, that those words matter.

Christie - 00:06:11:

Words do matter. I think the way we approach people is incredibly important. It's important to me personally, but I've seen the impact of words. And I think there is a lot of dialogue out there about saying things right, I'm making air quotes, or saying things wrong, but I think it's about the impact. You can have the best intention with quality improvement, with the words you use, with whatever you approach, but the impact of how it affects the person or hurts, harms, or helps the person that you're speaking about or to is really the end product.

Veronica - 00:06:42:

And that's so important for engagement, whether again, it's the person that you're speaking to that's going to be impacted by the work or the person that you're asking to partner with you to do the quality improvement work. If you do use language that is offensive, then that shuts down that process of engagement, that process of trust, and really your improvement work stops right there.

Christie - 00:07:06:

Yeah, I couldn't agree more. There are so many concepts rolled into quality improvement and work inequity. It's an interesting parallel to me about the way we approach this. There's change management, there's acknowledging of deficits and I don't mean with populations, I mean in the way that care is provided, in the way things are approached and in the way we treat people. There are so many parallels in the two that is always interesting to me that we tend to often approach work inequity, which we'll dig into more in future episodes. As well as quality improvement through totally different avenues, both in healthcare, but also just sort of socially. You know, both are concepts where we want to do better. Both are concepts where people have to examine their own identities and what's happening. And yet we do it through a separate lens. I don't know what your experience of the integration of the two has been or the development about that.

Veronica - 00:07:58:

Yes, my experience has been one of learning and it has been one of having to be brave. I'll say it that way. When we started doing quality improvement work in Louisiana, we made the decision that we were going to approach equity at the same time and not make it a separate initiative and not make it some side project, but it was really going to be integrated into our work. And we had our second learning session where we were talking about introduction into equity, what definitions were, what the difference between equality and equity, just basic information. And we had two of our hospital teams walk out because they felt offended by the conversations that we were having, in particular because we did use the word queer, because we were talking about diversity and equity on all levels, not just about
race. And it was very shocking to me because I felt like we're just giving basic information so we can begin this equity journey. And so I was shocked. But I did learn and it helped me to understand how we have to call in. It's not about calling out that everybody is going to be in a different place on this equity journey. And so we have to meet people where they are, but it doesn't mean that we turn around and do an about face. And you mentioned change management. We know that part of change management is that resistance and feeling uncomfortable with any kind of change that we're talking about. And so it is a part of the process. And it doesn't mean that you don't go ahead and move forward with that equity journey as part of your quality improvement, just understand that resistance is going to be there. That's part of change.

Christie - 00:09:46:

I think you raise incredibly important topics, many of them in that. And I think that one that I'm really hearing is that this is uncomfortable work. And I think I want to lead with saying that I don't think Dr. Gillispie-Bell and I are experts in this space. We're people living it. We're people in that sort of proverbial journey. We're learners too. Even as we record this and as we talk about things together, I think I may do some of it wrong. I think that that's important to know that this starting in this work, you don't have to know how to do it. And you don't have to do it perfectly. That any effort you make in that direction is a positive. And being able to hear when you don't do it well without immediately stopping doing it or becoming defensive is such a learned skill. It hurts to be having the best of intentions and wanting the best for folks and being told you're doing it wrong. And I do it wrong all the time. And I hope that that's an opportunity for improvement. That's how we look at quality when we do things like drills and simulations. We want people to mess up in that space because it's a safe space when you won't harm someone. And I think we can seek out unique opportunities to really integrate equity into concepts with our colleagues. It isn't just patients, right? That is not an other. That patients are us. We are patients. We are colleagues. We are people that exist in the world. And I think that there are safer places to engage in those spaces where there's less harm that can be done. So if somebody is going to walk out of a session in a training and be uncomfortable. Maybe that's the place for it versus caring for the patient. But I do think we have to acknowledge the discomfort and really sitting in that discomfort. The goal is not to catch people. The goal is not to tell people how they're doing it wrong. The goal is to make sure we all do it better together. And I think that's the crooks of what you're talking about, right?

Veronica - 00:11:38:

Absolutely, absolutely. And we did approach that team after and say, hey, we understand that this is uncomfortable. We really want you to continue to partner with us. And they did become a part of the journey that we've taken together. And we have advanced as a PQC and all of our birthing facilities much further than I thought we would ever get from that one experience. But again, it was a very eye-opening experience for me and in the way you approach equity in quality improvement work.

Christie - 00:12:10:

Well, and I think that you come to a crossroads when folks struggle or feel uncomfortable, right? And it's, do you just decide they're not capable of change or come at them? You should care about this, you know, and not you personally, obviously, and not the PQC. I think that's always the opportunity. It is hard to hear that folks don't feel ready for change or don't understand the change. You mentioned the word queer. To me, that's a reclaimed word. That is a word that was in the past known as a slur. It is a word that to me sums up parts of my identity. But I also understand there are generations of LGBTQ+ people that have had a different experience of that word and some younger folks even who've had a different experience of that word who are less comfortable. And it is about what the person in front of you needs in that moment and meeting them where they're at. I think I would have hesitation to use that word when speaking to somebody that it makes really uncomfortable. And that's including other LGBTQ people. It's a fascinating concept and language evolves just as our work does. And I think that the concepts of equity and how we approach it through healthcare are evolving as well.

Veronica - 00:13:20:

I agree. It's not really different from quality improvement in general. I experienced that same type of hesitation when we started doing quantification of blood loss. Before we had a PQC, I was working on implementing the AIM bundle in my hospital around postpartum hemorrhage. And we were working on quantification of blood loss. And I had got the nurses on board, and they were ok with it, and they were going to put it into their workflow. And then I approached my physicians just to say, hey, I just want you to know we're going to be doing this. This is what's recommended. And I
thought they were going to throw rotten eggs and tomatoes at me. And I, again, at that point, because I was very new to quality improvement, was like, oh, my gosh, I must have done it wrong. I didn't prepare enough. I didn't give them enough evidence. And I just did not understand change management at that time to understand that resistance is part of the change. And so when we see that resistance when we're talking about equity work, yes, it can be a little bit more deep rooted, especially in the United States, when we talk about especially around race and our relationship to race. It can be more resistance than some of the other improvement changes. But we have to just realize that is part of quality improvement.

Christie - 00:14:36:

Yeah, I think initial resistance to change is so common. In QI, as I've done quality implementation, I joke about the five stages of data grief. You give people their data, whatever a C-section rate is, or rates of hemorrhage, or timely treatment of hypertension, any of the topics that the AIM bundles cover. And they first go into denial. That can't be right. You must have included some number that I don't like that doesn't fit in the broader scheme. And then you can sometimes show your pathway, and they go, oh, that's so depressing. I thought I was doing so much better. And you lose some momentum for change. Then there's some of the they move into, well, I can't do better than that. Some of the anger phase. Then you see people move into the bargaining, well, maybe if I do X, Y will improve, but I don't know. And then they kind of get to an acceptance stage. Okay, that's where we are. What do we do next? I think it's true also as we talk about equity and integrating those concepts. Another thing to think about. Now I have to think about it. Yep, that's how we learn and change. We first have to think about it. The goal of the implementation of the AIM patient safety bundles is not that you do a bundle forever. The goal is that you integrate the best practices in those bundles into day-to-day practice. And then it's just what you do. And of course, you have to monitor yourself constantly for sustainability concepts. Am I still doing it the way that I agreed? Are the policies still being followed? Are the outcomes the same? I would say there's a really strong parallel there to the lifetime work we do in anti-racism around equity that impacts our care of patients, but also just becomes part of how you approach other humans.

Veronica - 00:16:20:

Yeah, and you speak of what's known as the Lewin Model and that unfreezing and freezing and the stages of grief, how that's all a part of it. And I think it's really, again, I think it's just so important to call that out because again, as I was beginning that journey, I kept blaming myself and was like, oh, but I don't. And as you mentioned, it's not about making a one-time change. It's not about doing what I used to tell my nurses when we were implementing the AIM bundle on postpartum hemorrhage. This is not Veronica's project. This is changing how we do things so that we can have that improvement. And again, as you said, that improvement that's sustained.

Christie - 00:17:06:

That's an interesting Veronica's project in QI. I don't want to be the owner of that, but I think it requires the equity work requires two levels of work. Asking that the care team approach things through an equity and inclusive lens is not one person's job. But each person has to do some of their own work in that space of understanding their own identities, like we talked about, understanding maybe things they have biases about that they never realized. I think that's been painful for me. I think I'm very inclusive. I think I approach things through equity. And in all reality, when I think back about care I've provided at the bedside into families, even with the best of intentions, even caring deeply about my patients and wanting to advocate for them and those families, I absolutely provided racist and biased care. There's no way to quantify or qualify that, but I did it from the lens of what I understood. And I think I've talked a little in the past to friends, and I think even with you, about undergoing something of an adventure in trying to learn more. There will be some resources that we also offer as a reading list along with this podcast. That's kind of up to the listener. You want to dig in a little bit, make yourself a little uncomfortable before you work on integrating into your practice, or maybe you want to look at your, again with the air quotes, look at your own data. How do I actually compare and think about this? And I think it's still a process. It's always going to be a process. It's a practice. I think anti-racism inclusivity, approaching folks through that lens is a practice. My brain default is not always anti-racist, is not always equitable. But it's a little bit like building the muscle so that when I see that I'm like, yup, that was not right in my own mind and I'm able to fix it before I cause harm, if that makes sense.

Veronica - 00:18:55:

Yeah, and I think it's so important, just what you are saying right now, we all have biases. None of us are immune to biases. Biases are our unconscious beliefs that are formed by our social experience around our social conditioning,
some from lived experience as well. And it is our brain’s adaptation of trying to understand how do we, there’s all this information coming in, so how do I process all this information? Well, the way it processes all the information is it takes shortcuts. But the shortcuts are formed in stereotypes and formed in biases. And it’s important to understand that because it is unconscious. So to undo those biases or to not act on those biases, it is intentional. You have to do intentional work every day. And again, I think it’s important to understand that this is something that impacts all of us. It doesn’t matter how inclusive you think you are. It doesn’t matter if you are a member of the marginalized group that we are talking about in whatever way that is. None of that matters. We all have biases. And so it’s important to know what your biases are so that you can call them out when you’re starting to lean into those. Understanding that you’re going to lean into those biases when you’re tired. You’re going to lean into those biases when you’re hungry, when you’re not taking care of yourself. And so being able to understand those conditions that are also going to make you fall into those biases is really important so you can address them.

Christie - 00:20:28:

The human brain really likes to sort. They like to put things in categories. I'll tell you, I think that's why I'm attracted to quality improvement. You sort, you understand the process. You've heard us refer to theories and structures. I think both of our brains work that way. And I have to acknowledge that I think my brain tries to sort people in the same way. It's a normal human experience. I think one of the concepts I really appreciate is Dr. Kendi's book, Stamped from the Beginning. He also wrote How to be an Anti-racist? fantastic books, they're going to be on the reading list. But one of the things I really appreciated was talking about everyone has racist ideas. That it isn't that somebody is in fact a racist, but that we all are. Our brains are programmed. And then through social reinforcement, sometimes lived experience, sometimes trauma, sometimes media, there's a lot of components of this. The things that we see shape how we sort people. And in fact, we all have racist ideas. The trick. Trick, skill maybe, for myself. And what I’m learning is to catch myself before it's something that is executed and causes harm. It reminds me a little bit in quality improvement when we work on things like medication errors or on other near miss events. Sometimes I feel like I have near miss equity events or inclusivity events. I'm not proud of them. They feel bad, but you have to pause and examine what went wrong, what could go better. And I think the pieces you highlight about hungry and tired, under stress, under, I mean, lord, jet lag alone will throw you for a loop, right? And so I think that those pieces are also important to examine because it isn't through a lens of judgment even at yourself. There's a real need. I'm going to sound real crunchy here. I'll own that. But there's a real need for self-compassion in this process in the same way where if you are a quality professional who is working with somebody who has made an error that resulted in harm. Hopefully, if you are approaching that three just culture lens, you are looking at the systems, at the structures, and then at the actions, and you seek to impact the systems and structures. You're not yelling at the person. You're a terrible nurse. You're terrible to, that's not productive, right? We know that doesn't lead to change. So when you catch yourself and you're like, wow, I sorted into a category really fast there, that is probably a racist idea. Yep, it is. Okay, instead of being, I'm terrible person, all of those attachments we have to those observations, it's probably a little bit of a root cause analysis through a just culture lens using our quality terms, right? Where we really need to approach the concept of self-compassion and wow, my brain really sorted that fast. It wasn't okay. How could I do it differently next time?

Veronica - 00:23:08:

I think that's so important to bring that up and to have that self-compassion, have that self-forgiveness, because as I talk to others that are doing this work, there's a lot of defensiveness when we even talk about the work at all. So I think to have that understanding, one, that this is continuous work and that we're all doing it, and to understand it's okay. This is not nobody is pointing a finger at you. This is not to make anyone feel guilty. It is okay. And have some compassion for yourself and have self-forgiveness because you're not going to get it right every time. I don't get it right every time. And I will say I've looked back at some situations that have happened earlier in my career before we started really getting into equity, as you mentioned, and even with my good intentions, didn't do things right. But I have forgiven myself for those situations because I didn't know what I didn't know. And it is a journey. It is a journey.

Christie - 00:24:07:

It really is. I hate saying things are journeys because I don't know what the destination is. And in this, I don't think there is a destination. We all want to believe we are good people. We are good people at the core. I don't believe anyone sets out in healthcare to cause harm. I believe that the majority of people want to provide exemplary care. I believe we want our patients and families to thrive. I believe we want the same things for our patients that we want for our own families. And I don't believe any of the patients that we take care of love their families less than I love mine. I think that's an important place to start. So it is really painful when you realize you have provided care that doesn't
align with your values and doesn't align with those core concepts. And I do think the compassion piece is huge. I believe that it is possible to be a good person and to also acknowledge your racist ideas, your non-inclusive ideas, your biased ideas, whether they have to do with marginalized identities or even just the annoying person driving in front of you on the highway. There are very real reasons to pause on that because it's often harmful to the other person, but it's also harmful to you. There's like an injury that happens and you're the one who's angry or upset or causing harm. And so it's bidirectional.

Veronica - 00:25:21:

Yeah, I think that's a really, really interesting point and a very good point. It's like the whole adage of I'm going to drink poison or yeah, I'm going to drink poison and expect you to die. And understanding that we are both impacted as we do this work.

Christie - 00:25:40:

Yeah, you're absolutely right. Connected whether we choose to be or not, both through healthcare, community, and the rest. And I think it's something that we can't forget. And it really raises the imperative to do this work in a way that benefits everybody. Thank you for tuning in to AIM for Safer Birth. If you like the show, be sure to follow wherever you get your podcasts so you don't miss an episode.

Veronica - 00:26:11:

And to learn more about the Alliance for Innovation on Maternal Health, visit saferbirth.org. I'm Veronica Gillispie-Bell.

Christie - 00:26:19:

And I'm Christie Allen. And we'll talk with you next time on AIM for Safer Birth.