Welcome to Aim for Safer Birth. I'm your host, Christie Allen, Senior Director of Quality Improvement and Programs at the American College of Obstetricians and Gynecologists, or ACOG. 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. In this season, we're exploring the key factors experts want us to be aware of in the maternal health landscape. And I'm excited to be joined by Dr. Veronica Gillispie-Bell again for this episode. For those of you that listened to season one, you know no bio is needed, so I'm going to refer you back to season one. But I'm really excited to have this opportunity, so let's get into it.

Veronica - 00:00:42:
Hello. Hi, Christie. It's always great to chat with you.

Christie - 00:00:47:
I'm so pleased we get to do this again. Let's take a quick trip down memory lane. What are some of your favorite highlights from last season? We talked about the integration of equity with quality, kind of ran the gamut. There was a lot of talking. We got lots of practice in talking about this. And I know I've gotten some feedback from the community and I've gotten feedback from colleagues, some of it surprising, some of it not. What are your thoughts? What has your experience been?

Veronica - 00:01:15:
You know, the feedback that I've gotten has been pretty positive. It's been mostly how educational it was and how relatable it was. I think sometimes when we speak about equity, especially when we're very passionate about that topic, sometimes we present it in a way that's harder for those who are not in the equity world to understand. And what I've really gotten from individuals is that, again, it was relatable. They understood it. It made sense. It was inspirational. It inspired them to work on quality and to look at quality in a different way.

Christie - 00:01:50:
I think the nicest thing anybody said to me about it was how it made them feel excited to go to work. That is a huge compliment. And I thank you for participating in it with me. This is not always easy things to talk about. It's complex. And I think what we did acknowledge in most of our conversations was the continuous nature of the work around equity. Just like the work we do around quality improvement. And That can be tiring. And it's a lot and they aren't fast changes. I talk a lot about turning the cruise ship and not the speedboat. And that's hard work, I know, for our folks that are listening that are at the bedside and that are doing this work. So I really appreciate you joining me and for folks that have told us what they enjoyed. Hopefully we have a similar experience this time around.

Veronica - 00:02:40:
Yes.

Christie - 00:02:41:
So to get us started, I'd read an interesting article and we'll link to it with this episode. As we're starting off this year and this season of podcast, we are going to talk about a lot of different things. It isn't exclusively about equity, but just like we talked about before, nothing happens without it. So it's interwoven. And a lot of the focus. That I hear from the community and I hear from other clinicians is getting started and keeping it going. So we're never not going to talk about that in this work because we need the momentum. And I came across this article about health equity tourism, and it was an interesting concept to me. Now, this article was very focused on the researchers that are doing health equity measurement and research in those pieces. So a little bit less about what we're talking about, but I appreciated the framework because one of the big focus that they had. Was really on a process that folks engaging in the work could do to move out of a tourism phrase. So I know you read it. What are your thoughts on the term health equity tourism? Like, what does that mean to you? Because I know what it means to me, but...
Veronica - 00:03:51:

So to me, it means when individuals are really inspired by what is currently happening in the landscape and what we see in media, social media, and it inspires them to get into a topic, in this case, into health equity. They get engaged very strongly in the beginning. And then when it's no longer a hot topic, they leave. And we are seeing that in so many places across the country, either because individuals have lost interest, unfortunately, because it's no longer the hot topic, or because of the political pressure to not focus on that anymore as well. And it's really unfortunate. I anticipated health equity tourism when George Floyd was killed, and everybody wanted to have a DEI officer, everybody wanted to have a DEI program, all of those things. And my discussion with other people is, I hope that this is not a fad. And that is what happens with health equity tourism. It becomes a fad. And once the fad is no longer the fad, then people move on to something else.

Christie - 00:05:03:

It scary to hear that said out loud. I think that is a concern that a lot of folks held and do hold and are recognizing. I think it, again, aligns in so many ways, as we’ve discussed last season, with quality improvement. You know, there's this new shiny change and we're all going to do it. And then you do it and then maintaining that change. In fact, this season, we are going to have a whole episode about sustainability and quality improvement. Because that is, I would say that's a current fad, but I don't think it's a fad. I think as folks are getting more versed in the work of quality improvement, they are recognizing the limitations of continuing it, whether that's people turnover, political pressure, priorities, policies, compensation, staffing. There's so many elements. And I think what I hear you saying is that this aligns in a similar way with equity.

Veronica - 00:05:52:

Very much so. And just like quality, it is a system. And when you have pressure on the system, if the system breaks, it tells you how strong your processes and your system was in the beginning. And we see that all the time with quality improvement. We saw it, at least in my role with our perinatal quality collaborative, we saw it during COVID. There was a system in place, we had processes in place around treating severe hypertension, around obstetric hemorrhage, and then COVID was a pressure to the system. Those processes that were built in and were really, really integrated into our work stood strong and those that were not broke. So we see when we look at our process measures, specifically around severe hypertension, of timely treatment of hypertension, we saw a big dip in 2020. So we knew that that was not a really integrated process. And I think the same thing happens around equity. And if you really want to work on equity and not be a health equity tourist, then you're working on structures and processes with your outcome being equity, but working on structures and processes that are integrated into how you do things.

Christie - 00:07:06:

So continuous. And we have to acknowledge that fatigue is a real part of that, right? And I'm going to go back to the tourism. I think that's why it resonated so much with me. I am not big on tourism. I'm a homebody. I like travel, but travel's exhausting. It's a new thing. You're taking in new experiences. You're processing in new ways. And I think that's what really resonated with me of like, yeah, that's what some of the changes after the murder of George Floyd really looked like. It was this focus and it was intense and it was heartening in some ways for folks, and it felt redemptive. And then people are tired. It's new experiences. So again, building it into the structure. So it's in those structures. And it took a very long time to build the system we have now. And it's going to take time to dismantle it and build in new structures. And I think acknowledging that is so important. One of the pieces that I thought was really interesting was they talk about the transition from being a tourist to being a community member. And we talk about community a lot, but all of us are part of various communities, whether it's clinicians, quality improvement, the communities we live in, the school communities that our children or we attend, right? There are so many different layers to that. And I'm just interested in your thoughts on the idea of a transition into that and how it can mitigate harm.

Veronica - 00:08:26:

So I think that transition is extremely important. I think it also is important in that transition that the levels of hierarchy are changed and are removed. And I think they talk about some of this in the article. As you mentioned, they were
talking about it from a research standpoint. And I have seen this happen where researchers do try to integrate into the community that they are researching. But if they don't humble themselves and then really understand that they are not the experts, then they lose the beauty of what is gained from being integrated into the community. And I think when you move from a tourist to really, again, being part of the community, your role changes. Your role is not to learn about the community just for the sake of learning about the community, but your role is to use your voice as now a researcher or whatever your role is with equity to amplify the voice of the community. And I think it's really important to think about that transition.

Christie - 00:09:29:

Another piece, and this is, I want to be clear, I'm extrapolating from the authors. This is not the topic they necessarily got. But as we talk about community, I think about the aspects that make a robust community. Things like responsibility and accountability, that we all own those pieces. I have had the pleasure of living in small and then in bigger, robust communities where, you know, what the thing that I love to say of, like, there's no such thing as other people's children, that we've had other people say, that is a very real thing in some communities where you feel safer, where there's a sense of that built in and ingrained in those pieces. And I think this potentially is an alignment there of there's individual ownership in the community. I'm not throwing my trash out the window. I'm putting in the appropriate places. I'm participating in town meeting day, if you're a Vermonter or in, you know, Vermonters will get that, no one else. But you're participating in the practices that help build that community and sustain that community. And I believe the work of equity in a quality improvement lens is similar. Are we asking the questions as the project is being built about how will we make this equitable and how we will, will we not only sustain the equity, how will we sustain the project with equity considerations? Who is this impacting? Maybe initially, who is it impacting in the long run? I think these are all pieces that sometimes we don't think about when we're like, we have this new shiny thing. And I'm not really referring to equity. I'm referring to like a clinical practice. We're doing quantitative blood loss. We're doing this, this one thing rather than seeing the long-term effects. How are you teaching folks that are coming back into this space? And how are you maintaining that over the long haul to completely affect change and not just affect a subset of change?

Veronica - 00:11:16:

Yeah. And I think about as part of that, having those individuals that are going to be impacted at the table when you are designing so that they are co-designing from, again, a perinatal quality collaborative standpoint and for quality improvement, we have patient partners with expertise as part of each of our initiatives on the PQC leadership team. And then we encourage our hospitals and we will encourage slash require soon that our hospitals do the same thing, because I think that is how you want to create the sustainability, but also you create for the community. We commonly, I think, in medicine and quality improvement, design activities and processes and things for patients and the community without having them at the table to design with us. And again, I think that goes back what you were saying, then you have a shared responsibility. You have a shared accountability. And I think that's just so hugely important.

Christie - 00:12:18:

And we do this in other places. This is not unique. We have PTA now, for better or worse, depending on your involvement in like a parent-teacher association or the education system and the board meetings. That is an expectation that a parent or a family member, community members will engage in that space. Interestingly, and I think the authors touch on this in a slightly different way, I am not part of academia at the moment. And so I don't intend to call it out, but academia is a bit of a closed door system. Healthcare has been similar, not quite to the same extent in my mind, but similar. And I think that that alignment and the expectation around the opening is really frightening to people. And we don't see the expertise that you're referencing.

Veronica - 00:13:02:

Yeah, I think it's frightening for a lot of reasons. I think one, you're airing your dirty laundry. You don't feel, you know, you know, there are things that happen in your family that you keep in the family. And now you feel like I'm airing my dirty laundry outside. I think we have to change our frame of mind and our patients are part of the family. And so that's not our dirty laundry. And they can help us to clean the laundry. So, you know, so it's really important to have that perspective. I think that's one part of it. And medicine is very hierarchical, very, very hierarchical. And we've created a very paternalistic hierarchical system where the doctors and the nurses have all the answers. And we are
here to serve the patients because the patients, they need our help. We have to save the patients without understanding that the patients also have expertise that makes them on this in some situations that make them on the same level as the doctor and nurse. And so that hierarchy is important for us to get rid of in a lot of ways. And I think we've done a better in some aspects of getting rid of the hierarchy between doctor and nurse and creating some of the psychological safety that you need to do quality improvement. But we've got to move to that next step to get rid of that hierarchy, even as it involves our patients.

Christie - 00:14:22:

I mean, ultimately, our patients live with the results of their care. In a way, I really don't. And I think we don't always acknowledge that.

Veronica - 00:14:30:

Yes, very true. It's interesting you say that because I do in my clinical work, I do a lot with fibroids and fibroid treatments. And a lot of times patients will ask me, well, what's the best option? What should I do? And I say, oh, no, no, no, no, no. You will physically have to live with whatever option we choose. I have to live with it emotionally, but you have to physically live with it. So we need to make a decision together. I'm going to give you the risks, the benefits, alternatives. I might give you a suggestion of what I think is best for you, but you are going to choose what you're going to do because, and that is, again, that shared responsibility.

Christie - 00:15:11:

It's interesting that you mentioned the sort of counseling and decision-making piece. I recently was having a conversation and I'd mentioned in the previous season that I had the experience of having breast cancer at a relatively young age. And I'm very fortunate that I got wonderful care and that I'm healthy. But I remember the most terrifying part, in spite of being what I felt like was very educated and part of the healthcare system, I was asked what I wanted. And while that sounds wonderful, there were big decisions to make, and I was terrified of choosing wrong. And I think a lot of times in healthcare, we have this mental model that I am going to tell you what I think you should do because I understand what is best. Sometimes, and this is true a lot of times with oncology and breast cancer counseling. There are commensurate interventions that will have almost the same outcome and there are different values placed on different things, whether that's aesthetic, whether that's screening in the future, whether it's, you know, I won't go down the rabbit hole on that. Anyone who's had the lived experience does know about it. But I had to have actually, instead of trusting that my provider would tell me what I was going to do, I had to trust that they were giving me the options in a way that aligned with my values or at least would listen to my values. That was terrifying and very hard and something I didn't expect from the healthcare system, which is really telling since I had been practicing clinically for quite some time at that point. But it's that trust that I wouldn't be given options if they weren't safe research. That is the expertise I was looking for. And then they relied on my expertise of what I could essentially live with and what values were going to be supported by different types of care. And removing the fear of you're going to choose wrong. Was an amazing concept to me.

Veronica - 00:16:58:

Oh, yeah. And again, that part of equity of listening of the provider, the care team, listening to what is important to you. We in healthcare have traditionally been trained that a good outcome is, depending on what you're talking about, if we're talking about maternal health, you have a baby that survives, you have a mom that survives, that's a great outcome. But that doesn't speak to what is important to the patient. Yes, the patient, I'm sure, wants a healthy baby and wants to be a healthy mom. But there may be other things about dignity, about respect, about who is a part of the conversation when they're making their decisions. That may or may not be honored, that are equally as important as what we traditionally think of as an outcome. And so it's so important for us to listen to the things that are said and the things that are not said as clinicians to make sure we're honoring our patients, to make sure that we're getting to the outcome that is important to them.

Christie - 00:17:58:

You used an interesting word there, which was honor. We talk about respectful care, which is incredibly important and foundational to the work that we do and to equitable outcomes and equitable care that we're seeking. It's
interesting. Honor is a little different. They're kind of synonymous, but not exactly right. Honor is a little bit more than respect, right? It's acknowledging the importance and placing value on it. And I think that that's a really important distinction to make when we're talking about patients values around their care and types of care we render.

Veronica - 00:18:30:

Yes. And that goes back to, again, seeing our patients as experts. If you see them as experts, then you're right. You're right. Because respect is a nicety. That's how I see it. It's a nicety. But if I honor you, then I am treating your value as equal or over my value. And so it is a really important thing for us to embrace. I'm not going to even say consider, for us to embrace.

Christie - 00:18:59:

I appreciate the thoughtfulness around the collection, as always. The paper mentions a transition from the tourism to community member. In your experience, what are a few maybe actionable or fundamental pieces? We just highlighted one, which I know we always come back to, which is words matter, language matters, how we talk to people as people and sort of honoring those pieces of people and the pieces of their values and what they wish. Other thoughts on that or other pieces we haven't covered today?

Veronica - 00:19:32:

I think it is, yes, the words matter. I think language matters. I think culture matters. I think it is, again, considering what is important to that individual, to that patient, to that community, meeting them where they are from a medical standpoint, from a clinical standpoint. I think it is understanding for that individual that's sitting in front of you, the things that you can do to facilitate the care for those patients. And I know those things, I think as clinicians, we feel like it's completely unattainable, but it's thinking about, to me, even the different ways of delivering care. If you have patients that are working a nine to five hourly job, how do you still integrate into a way or provide care in a way that is meeting them where they are? And thinking about alternative ways to deliver care like telehealth, home visiting, encouraging, supporting a doula. I think for me as a clinician, being able to convey to my patients that I am open to different ways of delivering care that are not quite traditional, I think is one way I have been able to integrate into the community because I think there is a little bit going on a tangent. I think there is a little bit of an assumption, for example, that I'm a Black woman. So when I have a Black patient, I'm automatically integrated in the community. There is a level of trust, I think, when my Black patients walk into the room. But even though we are both Black, we may have completely different experiences. We may be completely from different socioeconomic demographic information and all of this stuff. And so there is still a need for me to integrate into that patient's community and their understanding and to gain that trust. And so some of that is doing the things that I mentioned before.

Christie - 00:21:29:

Meeting people where they're at is a very good segue into what else I wanted to talk to you about today. So as this season progresses, we're going to have a little bit of a mini session, mini season within our season, talking about rural maternity care. Rural maternity care is discussed more and more. We're recognizing that there are, in fact, unique barriers and accessibility issues. It doesn't even begin to cover it. But there are unique factors that impact that. And that there are, you know, we have data that shows significant differences in outcomes, both maternal and infant outcomes in rural maternity care. You hear maybe in the media for those that are at all involved in maternal health work, you're hearing about maternity care deserts, for lack of a better term, or areas where folks don't have access in their county to obstetric or midwifery care, that there isn't a hospital that delivers babies or a birth center. And some of this is new. Some of it is not. Some of it is advancing with closures of obstetric units because of socioeconomic reasons, sometimes with changes in the reproductive health care access landscape. Some providers have chosen to relocate or have felt that they had no option but to relocate. And I think there's going to be a growing focus on this. We also recognize as we talk about disparities, disparities are not only race-based, but we know that folks of color, that black and brown people, who exist in rural spaces, have even poorer outcomes than their counterparts that are white in the same area. So it is harmful across the board. So we would be remiss to move from talking about equity without talking about rurality and the nature of that care. Now, some is supporting hospitals that don't have obstetric services to provide care when it's absolutely critical. And it's very easy for somebody who lives in a relatively urban environment to say, well, just, you know, you're going to drive a little farther. Is that two hours? Is that three hours? In labor? I remember it took me 25 minutes to get to a hospital in labor, and I was ready to walk. I'm pretty sure my husband was very ready for me to walk at that point because I was out the window in the winter. But the discomfort
aside, the barriers can mean that patients literally can't access prenatal care, postpartum care, can present to an emergency department that is unprepared to care for them, not because people don't care, but because... They don't have the training. They don't have the resources or the equipment. So I know this is a big focus and this is a very broad topic. And we're going to really dig into it with some experts in the field and some truly actionable steps of sort of where the landscape's going and lessons learned and innovation. I'm really excited about that. But I want to talk about the thoughts that you might have on the impact of where we receive care, because I think that sets the stage for really diving into what is rural, what is critical access, we can talk about that and we will. But where we receive care. The whole meeting folks where they're at can be geographical and cultural. Your thoughts on that, because I know you practice in Louisiana.

Veronica - 00:24:31:

Oh, yeah. And we have the majority of our state is considered rural. And as you mentioned, we see more and more hospitals closing. I think Florida, I think, has the most that have closed since the last maternity care desert report. And so this is something that I think has to be top of the mind for all of us. It is about meeting patients where they are and it's thinking about different models of care. For me, I've been a big proponent of thinking about how we better incorporate midwives into care. And how, you know, because there are midwives that I know I've had conversations with that are happy to go into rural areas. But we have lots of barriers also that are preventing those midwives from practicing, whether that be the collaborative practice agreement or their distance to care or whatever it may be. But it's a problem that I think we're not going to solve by building more hospitals like that's not happening. We're not going to ask more hospitals to start delivering babies like that's not going to happen either. But we've got to improve readiness where patients are and we have to start bringing more access to patients. And again, that may be thinking about different models that we are not currently using.

Christie - 00:25:45:

Interesting concepts because this is not unique to obstetric care. It's just marked right now, right? I know that primary care has struggled with this. And we have primary care clinicians that do deliver babies. But we need to be sure.

You've mentioned some innovations earlier about telehealth and different access. You know, it's also easy. Like I did telehealth during COVID-19 and still do. I love telehealth. It's very convenient, personally. But I also want to acknowledge that, you know, we're talking about areas that don't have broadband, that don't have internet, and then maybe can't have their provider reimbursed because they can only be on a phone or don't even have access to a phone at that point. So, you know, the co-location of clinics or having clinic days and making sure people can access them, things like that are really telling. And I know this is always the thing that gives me hope. I know there's a lot of really smart, really dedicated people doing really good work on this. And we really need to amplify that. Is there any model you can think of that you think has been impactful either in Louisiana? Or elsewhere about getting folks ready for obstetric emergencies or to provide care?

Veronica - 00:26:49:

Yeah, there are some things that we are currently working on that we think are going to be very, very helpful. And I want to come back to something that you said just a second ago, Christy. In working with the FCC, there is work there that they are trying to show how broadband is actually a social determinant of health. If you go to there, they have a map that shows broadband coverage and then certain outcomes. And you can see that the outcomes are worse in places where they don't have access to broadband. And so it really is something that we have to think holistically about. I think telehealth is a great tool. And actually, I have used telehealth for some of my patients that are in rural areas for doing different consultations so they don't have to drive so far. But you're right that there's a but then there's a challenge of what it does doesn't work. And so it really is so many sectors having to come together to address the issue of rurality and access there. From emergency preparedness, I think I'll say it kind of that way. We are doing some work with our ED physicians so that we can spread the work that we've done with our perinatal quality collaborative in our birthing facilities, in our emergency departments. What we're finding as we're starting the grounds of this, they are like, yes, please, please, please, we want this. We want this. Yes, we're seeing the patients. And so we just don't know what to do. So please, please, please educate us. We've had a really, really great gift from the Laerdal Foundation where they are gifting us 110 mannequins and birthing mannequins. And so we are prioritizing our EMS providers and our emergency departments, especially the ones that are freestanding and not connected to a birthing facility. We're prioritizing them to get the birthing mannequins with a requirement that they do so many drills throughout the year. We're giving them a drill handbook that has the scenarios. They just have to actually conduct them. And so we're trying to do more things to improve readiness because as you mentioned, we're
having more deserts. The patients are still in the deserts and they're still having the need for care. And so we do have to improve readiness for whatever services we have that are able to provide the care to them.

Christie - 00:29:09:

I know that readiness is part of this solution. And I will say the aim worked on last year, the OB emergency readiness resource kit. We've talked about this a little bit. It's not a bundle. It's a resource kit for establishing readiness, trying to pull those resources together because it does require a fair amount of resources. And we know that the folks trying to do the work probably have less of those available to them around this. And I'm incredibly grateful for the collaboration with our emergency medicine colleagues and family practice medicine folks that are just more than willing to engage in the work. It's broken down some silos that I know traditionally have existed where we don't do OB is no longer an option. And so we're collaborating as a medical community to support those people. I look forward to the next progression of this, which I think is providing care so we're not dealing with emergencies. And that's, I think, the next frontier in this, perhaps. We still have a long way to go in readiness. And as we always talk about, it's a continuous process, right? So it's going to be an ongoing thing. But I really look forward to some of the models. We've seen some mobile clinics. We've seen, I think, of living in rural areas myself and practicing as a nurse. We had prenatal clinic where a maternal fetal medicine specialist or a cardiologist would come to an area and see all the patients that day. And as a patient who's also engaged in a clinic space that way, I mentioned oncology earlier, I would go in and see everyone in one day. That was amazing. I could go clear one day. I had child care. I could figure out how to get there. I wasn't, you know, even if my husband had to drop me off because he needed to be at work, I could be there. As opposed to, here are the next five appointments you have. They're each an hour and a half, two-hour drive. They're just really innovative ways. But it requires real collaboration and prep, you know, finding this clinical space, finding the clinician time, making sure they can get there. And to your point, unique partners. I'm thinking of the FCC, which you mentioned for broadband. I'm also thinking the Department of Transportation. I have been at hospitals that one of their issues was that their roads weren't passable enough to get and neonate through in an ambulance without considerable risk because of potholes. That seems absurd until you've seen it. Even in some cities, we're dealing with some of those infrastructure issues. So I really appreciate the broad lens that you're taking, not just in Louisiana, but as you do this work. I think with that, I have a question that I want to ask you, and I want to give a little context. So with this season, one of the threads we'd like to pull through the entire season is a conversation about the one thing. I think all of us have things that we're passionate about or that we keep seeing or that keep popping up or the thing that we're really trying to amplify, whether it's in this moment or across our lifespan and our professional lifespan. And so I intend to ask all of our guests when they come, what is the one thing, and I'm making big air quotes, but what is the one thing that you would like to leave listeners with from this episode, if nothing else? And so that's my question for you. What is the one thing, as we talk about all of these huge topics, equity and quality and maternal health and innovation, what's your one thing today?

Veronica - 00:32:28:

Christie. It's so hard. I am a woman of many words. So one thing is really hard.

Christie - 00:32:34:

You can use a lot of words to talk about one thing. That's fine. I'm cool.

Veronica - 00:32:39:

I'll say something that's really been at the top of my mind. And I think we talked about it some in the first episode, but I'm not sure that we named it as much as I've been thinking about it. But you actually started talking about it just a few minutes ago. But medical mistrust, I think that we as clinicians underestimate how much the... Patient community does not trust us. And it has been a progressive, progressive thing. When I was a child, whatever the doctor said, that was it because you could trust the doctor and that's what you do. That is not the generation that we're in right now. And understandably so, the medical community has not been trustworthy towards a lot of people, towards those individuals that identify as women, towards Black individuals, Brown individuals. We can go on and on and on and name all of the ways that we have broken that trust. And so when we talk about equity and we talk about respectful care, really the whole crux of the matter and the goal that I hope providers understand that we need to achieve is that we are trying to build trust with our patients again. It's not enough to say that we have expertise in a certain clinical area and so they should trust us because I'm an expert. No, because we've not shown that we are respectful towards the patients, regardless of what our medical expertise is. And so I hope that those that are listening, especially those
care providers that are listening, do what they can to earn the trust of our patients. That is when we say patients don't quote unquote follow our directions or they quote unquote are not, and I'm doing the air quotes, non-compliant, where does that come from? Some of it is that they're barriers to care. They can't be compliant. But a lot of it is they don't trust what you, what you're saying. And so what, what do you do? What can you do? And again, that really is a lot of what we were talking about in the beginning of integrating into the community and going from, from tourism, health equity tourism to really, really being part of community. We're talking about building trust. And so that's what I hope the listeners take away from this episode.

Christie - 00:35:04:

Thanks 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. To get involved in work related to addressing maternal mortality, be sure to check out the Alliance for Innovation on Maternal Health at saferbirth.org. Together, we can work towards safer births and healthier outcomes for all families. I'm Christie Allen, and I'll talk with you next time on Aim for Safer Birth. This podcast is supported by the Health Resources and Service Administration, or HRSA, of the United States Department of Health and Human Services, or HHS, as part of an award totaling $3 million annually and is 100% funded by HRSA. The views are those of the hosts and do not necessarily represent the official views of nor endorsement by HRSA, HHS, or the U.S. Government.