Veronica - 00:00:05:

Welcome to aim for Safer Birth. I'm Veronica Gillispie-Bell.

Christie - 00:00:09:

And I'm Christie Allen. 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.

Veronica - 00:00:19:

And in this episode, we're talking about definitions. In the first episode, we used a lot of terms that are used interchangeably, terms that you may not be quite familiar with. And so in this episode, we're going to go into what those terms actually mean. And so Christie, I'm going to start just, if you could tell our audience, what is the difference between equity and equality?

Christie - 00:00:42:

Yeah, so words matter. I think we're going to end up saying that in every episode because it is such a part of how we do this work. I think we hear often equity and equality used very interchangeably. And equality means we treat everyone the same, right? Except people aren't the same and needs aren't the same. And if we truly meet people where they're at, we're using something that's different than equality. We can do better than equality. We can move towards equity. I think of equity as approaching people with knowledge of identities and those pieces and what might be different and needed in that space. I am definitely discussing that through a healthcare provider, clinical lens. I think it looks different in different settings. I also think we all define equity a little bit differently for our own expectations and lived experience, which is why the care I provide to you with your experiences may not feel as equitable. And I need to be able to hear that.

Veronica - 00:01:42:

I think it's so important to make that distinction because as I talk to other providers, that I commonly get the response, well, I don't know why we need to talk about this. I treat everybody the same. And I try to help them understand treating everybody the same is not the goal. We're trying to make sure that everybody has the same quality of care and that is equity. And I usually try to use a concrete example. So the one I try to use is, we know that for a patient that has a hypertensive disorder of pregnancy, when they're being discharged from the hospital, the AIM bundle tells us, if they don't have severe hypertension, but they have one of the other hypertensive disorders of pregnancy, they need to have a follow-up in seven days. If I just say, okay, all patients being discharged, we're going to give you an appointment in seven days. Am I really considering all of the circumstances around each individual patient to make sure that they're able to get there in seven days? For my patient that has someone that can provide childcare, that can drive her to the hospital, that is able to do whatever support or give her whatever support she needs to get to that appointment, then yes, i'm using she, can follow up in seven days. But if I have a patient that doesn't have childcare, that doesn't have that support at home, that doesn't have someone to bring them in for that appointment, it's likely that that patient's not going to be able to come in. So i've provided treating everybody the same using air quotes, but this is not equitable care because everybody's not able to get to that outcome.

Christie - 00:03:19:

I think you really highlight the role of access in equity and the importance, the central importance for equity. It's easy for me to make assumptions about patients. It's easy to make assumptions about colleagues and what they have access to. And I think the longer we exist in the space and we do this work, you see that it isn't always the same. And we know that unfortunately, people die from lack of access. We talk about improving access. Improving access really starts with seeing people as the individuals they are. I think that can be a hard concept for those of us that work in quality improvement spaces. And we're going to define some of that too later in this episode. But I think that we say we want to provide standardized care. Your care can both be equitable and standardized. The standardized is the end goal, not necessarily how you are delivering aspects of that. There has to be room for adaptation. I don't mean working outside policies. I don't mean going off script. I mean understanding. The, I don't want to say extenuating factors because there are not extenuating factors in people's lives, but the factors that are central to people's values
and lives. The thing that worries me is not the thing that worries you. The thing that I worry about for my children is not the thing you worry about. So to truly meet people where they're at, I don't need to know all of your identities. I just need to be able to be open to understanding they may not be aligned with what I'm thinking.

Veronica - 00:04:50:

I agree with that. I think one thing we haven't talked about and one thing we do very poorly in the healthcare system with is screening for social determinants of health. And it is recommended that we screen. It's all over the place that we should be doing it, but I don't know that a lot of providers, a lot of hospitals have really integrated that into their system. But it's important because as you mentioned, we are trying to make sure that everybody has access. And if you haven't screened for social determinants of health, you may not understand what those barriers are going to be for each individual to be able to access that care.

Christie - 00:05:24:

So while we're on definitions, I'm going to reflect back at you that social determinants of health, and sometimes we call them social drivers of health, are hard. They're scary. I remember as a new nurse, as I was asked to screen for intimate partner violence, I didn't do it well. I was so afraid somebody was going to say yes and I wouldn't know what to do or I would mess it up that I didn't do it well. Had I done it better, I wouldn't have needed to be scared. So everything okay at home? I've actually been asked that as a patient, you're like, what are you even talking about? Do I have housing? Do I have transportation? Do I have heat? Or are you asking if I am safe in the environment with which I live due to the other people or relationships? It's a scary thing. I want to acknowledge that for providers and clinicians. It's one thing to say, we need to do this thing. We need to teach people how to do it well. And then we need to make sure that on the flip side of that, we at least have a pathway to offer someone something when they don't. And the reality is that those systems and structures are lacking in every community. It's not unique to one. But they're not insurmountable. We talk a lot about social and structural drivers in AIM and in the bundles and in screening. And sometimes the best you can do is screen and refer. It falls short. Let's just acknowledge that, but it's a start and it's a start of a move towards equitable access, which is really the crux of it.

Veronica - 00:06:48:

Yeah, it's a 100%. As a provider, there are many times i've not asked the questions because as you said, if they say yes, then what? But that also does not give us the license to put our head in the sand and pretend like these are not issues. And we never will be able to get to equity if we're not considering those issues. And like you said, sometimes the best is to screen and refer, but regardless, just to open up the door, I think is the start. Even when it's uncomfortable.

Christie - 00:07:20:

I feel like that's like the tagline for those whole recording, or every episode, it's going to be uncomfortable. It's still the right thing and it's still going to lead to better things. So changing tracks a little bit, talking about definitions. I think... We have an aversion, I'll own it. I have an aversion to buzzwords, to these words that just everyone's saying because it's popular, because it's just built into our vernacular now and it's just a normal thing. I like to use them sometimes just to annoy my teenagers. But one of those sort of buzzword, buzz phrases, one of the high focal areas, I think, especially in healthcare and why we're talking about it is equity, but also DEI. DEI is the thing that we keep hearing about. And we have DEI consultants and we have DEI chairs and we have people who specialize in this work. I want to talk a little bit about what is DEI. And I want to break out the D and the E and the I because they aren't all the same concept, right?

Veronica - 00:08:18:

Correct. We have put them all together. It sounds, air quotes, it sounds nice. It rolls off the tongue. It's easy to put a stamp on that DEI. But those are three separate concepts. When we're talking about diversity, that is differences in physical characteristics, in abilities, in religion, in every way you can really think about it. It's those differences. But if you're not also working on inclusion, I'll skip to the I, then you lose the beauty of diversity. We know that when you have a diverse group, you're able to realize your goals in a much faster way, a much better way, because you have all of these different perspectives. But if you're not honoring those perspectives by having inclusivity, then you're
really making and asking everybody to conform, and you've lost the beauty of diversity. And so I think it's so important to understand that, yes, diversity and inclusion go together, but they're not the same thing. And if you don't understand the differences, you're going to lose the beauty of that diversity.

Christie - 00:09:28:

I think it's not only creating diverse teams, groups, settings, communities, it's making it one where diverse people want to stay. We can't put people in positions because of the way they look or our perceptions of their identities. That becomes tokenizing, you know, putting someone up as the representative of their race, their ethnicity, their sexual orientation, their gender identity. That feels really dangerous to me. And it feels like a real risk in this work.

Veronica - 00:09:57:

Absolutely, and depending on what level of diversity that individual brings, and as you mentioned, as you tokenize them, it's really exploiting them. And you are really putting salt on a wound because a lot of individuals, when they're bringing in their diverse experience, have trauma that they've experienced because of that. And if you are asking them to bring that diverse opinion forward or that experience forward, then you are asking them to discuss their trauma in some instances, in some situations, and to tokenize them is then, again, just opening up that trauma all over again.

Christie - 00:10:40:

I think it's something that as we enter this work, especially as we engage in quality improvement with patients with lived experience, with colleagues, with community members, community organizations, we have to take a really intentional approach, all of us, but particularly those like myself who are white and have positions of privilege, we can't just pull someone in because they check the boxes. And I think that also, to be really honest, will make people who are resistant to these changes more resistant. We are not trying to change how we look. We're trying to change how we work and process and act. I think as communities, as groups, as healthcare providers, healthcare teams, I think often we have a tendency to want to check boxes. That's some of our training, and we've talked a little bit about wanting to categorize either people or experiences just because of our human brains. And I think this is maybe an extension of that, where we want to check the box in a positive way by putting people into that box, but people aren't made for boxes. And it feels incredibly unfair by my observation and not my lived experience, but to make one person a representative for everyone. Because that again, boils people down to their identity.

Veronica - 00:11:51:

Yes, from someone with a lived experience. Yes, it is a lot of weight put on you when you are made to feel like you represent that one group and you're the representative for all people that look like you. And, you know, my first experience actually was in high school. And I remember being in my honors English class, and we were reading Zora Neale Hurston, and I cannot remember the name of the book now. But in the book, there was a black woman and she endured violence and intimate partner violence. And really, she stayed with the partner. She didn't move on. Oh, Their Eyes are Watching God. That's the book. And I remember my English and I was the only black girl in the class. There were no black boys, but I remember my English teacher asking me in front of everybody in the class, so veronica, is this how black women respond to being abused? I was... I was 16 years old first of all. And to think that I am supposed to give an answer for how all black women respond in relationships, and I think I very politely said, because again, I am from the south and there is a level of hierarchy that is ingrained in us very early. So I did respectfully say, I am not able to speak on the experiences of all black women and how they respond in relationships.

Christie - 00:13:18:

That's such a stark example. I'm horrified, i'm making faces at you right now. That's just horrified. But it can be more subtle than that or it can be that dramatic. It's such a spectrum. And I think part of our work, and our work, I mean all of us, is examining the impact of those kinds of words. I'm so sorry that happened to you. I think my blood pressure's through the roof right now.

Veronica - 00:13:42:
And the thing is, I really think, we talked about in the first episode about having forgiveness of ourselves, but also having forgiveness of others. I really don't think she understood what she was doing. I really think she was trying to bring out this experience that black women may have. She just did not know the right way to go about it.

Christie - 00:14:06:

Maybe not very well.

Veronica - 00:14:09:

And so, again, I think as we do this work, then we have to not only forgive ourselves, but we have to forgive others as well.

Christie - 00:14:19:

Forgive and learn maybe.

Veronica - 00:14:21:

Yeah. Forgive and learn.

Christie - 00:14:22:

It's a fine line. So one of the things I'd love to talk a little bit about is what is health equity? We've talked about it being access. We've talked about it being meeting people where they're at. Do you have a definition for it? How do you think about it?

Veronica - 00:14:37:

For me, when I think about health equity, I first think about, well, what do we mean by good health? I guess if we wanted to say it in a Layman's term. And so to me, that means everybody is able to achieve health outcomes that are favorable. And if I think about, okay, well, what does that mean? That means that we have to ensure that everybody has access to whatever those things are that allow us to achieve good health outcomes. And so for me, it's making sure that everybody has the same quality of care. We mentioned before, not the same care, but that same quality of care. And so again, understand that we're all trying to get to good health outcomes and health equity is the way we get there.

Christie - 00:15:22:

That makes a lot of sense, I think. As you're talking about it, i'm thinking about how we also don't always get to define what good outcomes are. I think that's been one of my struggles as a nurse of a lot of years who's worked in different spaces. We overlay our values sometimes on people and, you know, there is, we talk about terms like quality of life or equitable care or... And I think the hardest concept for me as a clinical type person, and then doing some of this work non-clinical administrative is the really painful concept that people get to define what equity is for themselves, or what a good outcome is for themselves. It may not be what it looks like for me, and being willing to provide high quality care while letting the outcome not be my standard is a really fascinating concept to me.

Veronica - 00:16:15:

And I think that's been part of my journey as well. I think for us as clinicians and especially in OB-GYN, we feel that if we have at the end of the day, a good delivery, good in quotes, with a healthy mom, and we have a healthy baby, that we have a good outcome and that we have achieved health, in that case, that we've achieved health equity. And it's
not just about what we typically measure as a good outcome, but it's also about respect. And it's about the experience that individuals feel during that process of healthcare delivery.

Christie - 00:16:59:

I think it can really work either way. Someone feels disrespected and has what we consider an excellent outcome. It's fascinating. I've talked about this with other folks. I think you and I have even spoken about it in the past. Healthy mom, healthy baby. Healthy parent, healthy family. How I define health. Might be different. And even if I have what is perfectly clinically healthy care and exemplary clinical care, but I feel marginalized, disrespected, not heard. It's no longer equitable care. And there are more risk factors to not being heard if you are part of a marginalized population or are typically disempowered by society group or even perceived to be. And I think that can be socioeconomic, it can be race and ethnicity, it can be how you present to the world, that puts you at real risk of not being able to self-determine what's equitable for you, but also disrespect in those settings.

Veronica - 00:17:57:

Absolutely, and I think that fear and the many stories that we've heard of women not being heard in the birth space, and I'm using women understanding that not all individuals that give birth identify as women, but that those many stories of not being heard in the birth space is actually making those individuals, some other individuals that are pregnant, not want to come to the hospital at all, and it is killing them, because they are fearful that they're going to come into the birth space and they're not going to be heard, they're not going to be respected, they're going to be put into a box. So we have a lot of work to do to create trust in our communities so that our patients do feel comfortable to come into the birth space, and it's a lot of work that we have to do on that respect, on that level of respect, and understanding that respect and respectful care is part of that health outcome that we want to achieve.

Christie - 00:18:52:

Yeah, absolutely. I think that fear is real. And I think clinicians, providers, physicians, midwives, nurses, it's a hard burden to carry to speak to present time, because a lot of that fear of disrespect is rooted in reality. We know that healthcare is somewhat anchored, if not fully anchored, in white supremacy. We know that black and brown bodies were experimented on at the inception, to use the term oddly, of gynecology and obstetrics. And we know that there has been experimentation. There's very public things, Tuskegee Airmen, the research that was done, that was incredibly racist and harmful to black and brown people. And the ends justified the means in someone's mind. So as a current clinician, who isn't anchored in any of that, it's a heavy burden to carry when folks feel mistrustful, and you have to work that much harder to build trust and rapport. You need the area you provide care in to be a truly safe space where people feel heard. And sometimes you may not jump that hurdle with folks. You may not get to a trusting, wonderful relationship. We still need to provide exemplary care. And we still need to make it a space where people find joy. Birth, when things work and even sometimes when it's hard and there are complications and there are very real risks and things happening that nobody wants, there's still joy. It's beautiful. That's why you and I have done what we do, right?

Veronica - 00:20:20:

Yes. Oh yeah, absolutely. And I think it's so important that we do talk about the joy of birth because we have had a lot of attention on morbidity and mortality and we need to because there are things that we need to be doing to make it better, but we need to also understand that that is not the majority of outcomes and we need to not create fear so that individuals don't feel comfortable coming into the hospital around just the numbers. And you're right. I see joy every day in the birth experience and as a clinician and having patients in my care and in the delivery room, I'm very, I'm definitely very present during the delivery process. We are singing, I'm thinking of a patient, we sang the entire, like every Isley Brothers song that she had on her soundtrack in between push-in, we're all singing in the room and it's a joyful experience, it is. We need to be ready always, readiness, recognition, response, we need to do all those things to help mitigate when things don't go well, but we need to understand that the majority of the time things go very well.

Christie - 00:21:33:

It's an and, it's not an or, right? We can be ready, we can set high standards for our care, we can be prepared to save people's lives. We also can rap the lyrics in the background that my patients enjoy during labor, right? Like I have
done that, especially on night shift, I'll own it, but that's, it's an and or we wouldn't do this. I think it is a dangerous space when we lose joy. Joy is part of equity. I don't want a birth without joy. If we can find joy, we can foster it, we can make it safer, but we can also find an end in that space. And I feel like that's an incredibly important thing. I think with that, I want to turn towards definitions around quality. Because exactly as we've been talking about in order to bring joy in the space and to have equity in the space, we need quality. Quality is hard. I think even within professionals, someone asked me the other day, like, who coins the term continuous quality improvement? Bunch of people, and they may have different definitions. Can you talk to me about what continuous quality improvement is to you?

Veronica - 00:22:36:

Yes. And again, this is my definition, so others may have other definitions. To me, quality is providing care that is consistent with evidence-based guidelines. The continuous part is evidence-based guidelines change the way we define hypertensive disorders of pregnancy from when I was trained as a resident to now completely different. And so to that end, quality is always going to be a continuous process. Also something that we mentioned in the first episode, when we're talking about change management in general, you get to an unfreezing and then you get to a freezing, but then there's a sustainability part. And if you're not doing continuous quality improvement, then you will not sustain whatever change you gained.

Christie - 00:23:27:

We talk in quality about some terms like, I talk a lot personally and we use an AIM PDSA Cycles, or sometimes it's PDCA depending on who's doing the implementing because we love standardized, unstandardized terms, but it stands for Plan, Do, Study and Act. Those are all really important. And if you take one of those out of the equation as you're implementing quality, so planning is what are we going to do? We look at the problem, we look at solutions, we start putting things in place, policies, guidelines, maybe staff education. This aligns with kind of the readiness part of the bundle for patient safety bundles and aim. And then, the do is we actually implement the thing when it is necessary, either for all patients, something like screening, or for patients experiencing a clinical condition. Study, how did we do? I think this is the crux of both equity and quality. We need to constantly be reassessing, not questioning ourselves, but reassessing, are we meeting the intended standard? Are we meeting the intended concept? And then act is when we do better or plan to do better. And I think any one of those concepts gets dropped, either in working on our own anti-racism, either working towards equitable care or working to continuous quality improvement, you're going to be in trouble because it's not going to meet the standards you are working to achieve.

Veronica - 00:24:46:

Yeah, and as I'm talking to people that are new to quality improvement, I again try to create concrete examples. And we probably don't realize it because it's not a concept if you're new to quality improvement that you think of. But we do PDSA Cycles every day. When I wake up in the morning, it's Monday morning, i'm taking my son to school, i'm going to plan, am I going to go this way or this way? Because this way I know has a lot of school zones and we're going to be slowing down. But if i go this way, it's more likely i'm going to run into traffic at this area. I'm going to pick one. I'm going to do it. I'm going to bring him to school. I'm going to study it. Well, did I get here faster? Did I get here at the time I wanted to do that to get there? And then I'm going to act on that. That did not work at all. We're going to abandon it. Or I like that way, but we're going to adjust it and we're going to leave 15 minutes earlier because maybe then I can skip some of those school zones. Or actually that worked out just like I wanted it to. We're going to act on it. That's going to be the way I take him to school. And so again, I think we do PDSA Cycles every day in our own life and just don't realize that that's what we're doing.

Christie - 00:25:55:

What's interesting is you talk about that to continue to use your example. So say something goes really off the rails. You were doing that and you hit construction that you didn't know was going to be there. I think that sometimes is maternal morbidity and mortality cases that we look at, maybe retrospectively. And we, oh, what we're doing isn't working. Here's the crooks. You don't stop thinking about that. So to use your driving example, the next day driving your son to school, it's Tuesday. You're going to consider that and maybe adapt to prevent that problem again, but you're not going to stop driving him or only take one route. Right. You don't have that as an option. We're not going to stop providing care or stop trying to do this work. We're going to continuously reassess. I joke that i do PDSA Cycles at the grocery store. I do it with getting the kids ready in the morning because we figure out what works and what
doesn't. And we want to do it in a way that doesn't cause inconvenience or harm in those settings and doesn't cause harm to our patients and to the families we care for.

Veronica - 00:26:52:

Yeah, and I think one of the, you mentioned that if you drop any part of the PDSA Cycle, then you can't, like it just, it doesn't work. And I hear a lot of teams that we work with really hesitant on the measurement part because of the challenges with trying, depending on what data we're looking for, the challenges of trying to actually abstract it from the patient chart or just the time to use the data. But that measurement part is so, so, so important to quality improvement. Whether it's quality improvement because we're trying to implement timely treatment of hypertension, or because we're trying to ensure that we're doing this in an equitable way. You have to measure. If you don't measure, you don't know what you're doing. And I love the statement that all improvement is change, but not all change is improvement. And you don't know that if you don't measure.

Christie - 00:27:44:

So luckily we're going to have two episodes, I think this season, where we talk about measurement, because you say measurement to me five years ago, and I would have clenched, right? It's an excel spreadsheet, it's data, I'm not a data person. So some of you listening might be data people, and you're like, cool. And some of you listening are like, well, I'm going to skip those episodes. It's important, measurement is important. You can't do better unless you know better. And if you tell me you're providing equitable care, let's look at it together. So we're going to dig into that a lot more. It is incredibly important. We see in process improvement and continuous quality, people sometimes use terms like quality assurance. That's not really what we're doing, quality control. Also not what we're doing. It is continuously cycling towards improvement. And the goal of those PDSA Cycles isn't that you just do them forever, although you do, they should go up on a little ramp. I'm envisioning this. And you improve because you build skills. Just as in your work personally around equity and in the equity care you give, you build skills as a team, as a unit. There are things you have to continuously work on. You have new staff come in, you have staff depart. You're going to be training them, but it becomes integrated into the care, integrated into the culture. And it requires less thought maybe as someone who is currently teaching someone how to drive. It blows my mind what feels very automatic to me because it's integrated in my day-to-day versus what feels absolutely terrifying to her and to me right now, honestly, that is facts. But there is an integration that happens here. I don't want quality to sound without joy. I find a lot of joy in recognizing the improvements. So I do think that's the quiet part of the measurement that isn't all just numbers and data. It's really seeing, wow, look how far we've come, right? As a team.

Veronica - 00:29:33:

Yes, absolutely. I think that's the part that when I talked about in the first episode, when I first started doing quality improvement and at that time didn't have a lot of skill and did not have a lot of training and met resistance, it was the joy of really putting something into place and going through those multiple PDSA Cycles and starting to see things change and starting to see things improve. That is the joy that kept me in the space of still doing quality improvement where I had, after that I doubled down on quality improvement. And it is such joy when you get there.

Christie - 00:30:12:

I think it's multi-pronged joy, because sometimes it's the biggest resistor who becomes the champion, which is just a fascinating phenomenon for me. I think it's also seeing the difference it makes for a patient. Sometimes we can't measure the thing that didn't happen. So we do back circling back, because I do think this is a key concept of this conversation is finding the joy. And you might not recognize it as a success, but success in our work can also be an absence of harm or an absence of pain. 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 - 00:30:54:

And to learn more about the Alliance for Innovation on Maternal Health, visit saferbirth.org. I'm Veronica Gillispie-Bell.
And I'm Christie Allen. And we'll talk with you next time on AIM for Safer Birth.

Voiceover – 00:31:26:

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