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

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.

And in this episode, we're talking about Mythbusters, those frequently asked questions that we get around equity and measuring equity. We're gonna bust some myths and talk about what is real. So I get this question sometimes, especially again, when we talk about race, everybody's defenses start to go up. So are we saying that all clinicians are racist?

That is not a straightforward answer. I don't believe. That the terrible inequities that are resulting in disparities in care are because all OB-GYN providers, nurses, midwives, nurse practitioners, et cetera. All those who provide care on the team are racist. I believe, as we've discussed earlier in the podcast, and what we know from information is all humans have racist ideas. Do they contribute to a negative environment of care that undermines the absolutely high standard of care we want for all of our patients? Yes, they do. I think it's the data doesn't lie. We can see it. We can see it in the disparities of outcomes. We can see it in the harm reported by those patients with lived experience who are experts, unfortunately, in being marginalized and treated poorly. In fact, I think some of our patients don't have high enough expectations of us, or some are so demoralized by the system and disempowered by the system that they don't even help push for better care for themselves, nor should they have to. It's work of all of us. But do I believe that it is bad actors intentionally perpetuating racist care? I think it's a small, small number. I truly believe that most people approach this care because they want to do good and they want to help people. But they approach it as people. Clinicians are people, and we want them held to a standard that is higher than the rest of society or the rest of a community, which is probably really unfair at its heart. People provide excellent care in spite of ourselves sometimes, not because of ourselves. But I think that's part of the shift of integration of equity into quality. It gives us an opportunity to improve in both ways.

I think it's really important we remember that equity is quality, quality is equity. It is, you cannot have one without the other. And if we apply the same principles that we do to quality to equity. To your point, it's not about individuals, it's about the systems. And so that just culture of what is the system that has been created, that has caused clinicians to act in ways that are quote unquote Racist, ways that are not providing equitable care, and what do we do to dismantle those systems? We have to remember a system produces exactly what a system is meant to produce, and our system is producing what is producing, so we need to break the system. And I really believe that is the way that we undo some of the racist and some of the inequitable activities and treatments that we see.

Yeah, you are completely right. You hit the nail on the head. I think anytime we choose to see it as an individual breakdown, we basically let go of our responsibility. We have to improve the entire system. And improving the system will improve care for everybody served by that system, but it will, other than major intervention, continue to just repeat. And that's what I think we're seeing. And it's compounding on top of other systems that are problematic, including education systems, including employment, including housing. There are so many elements to this. But it doesn't mean we get a pass on not personally improving as folks providing care and not working to improve those systems.
I agree and I think there is an unintended, I'm gonna say that it's an unintended consequence that the system is what the system is and the system is founded a lot in not listening to voices of all women, particularly women of color. And so a lot of those women are choosing to not have care within the healthcare system or deciding to not reproduce at all. I've had at least three people in the last two weeks tell me as Black Women, they decided not to have children or they had one child and decided to not have more because of what we're seeing with maternal mortality, because of hearing the stories of women not being listened to when they're in the birth space. And so again, systems produce what they are intended to produce. And just one more reason to break the system. And again, there's another consequence that comes out of that.

Christie - 00:04:57:

It's heartbreaking to have to make personal reproductive choices based on such a broken system. That's why we need to do better. Next question. So in this podcast, we have talked about in a way that is not supportive of non-compliance or patients not complying with care. So I do think that there is statements out there, ideas out there that are Black Women dying more because they just don't do what their doctors tell them? I've literally heard those words from clinicians, too. Let's talk about that.

Veronica - 00:05:32:

I have also heard that statement from clinicians and really, you know, that's disheartening on a lot of levels. Black Women are not dying because they're Black. They're dying because we don't listen to them, we don't give them equitable care, and then we turn around and blame them for the outcomes. Again, as we talked about in our earlier episode, when we're talking about adherence to care, you can't have or expect adherence to care if you don't partner with your patients and have your patients invest in whatever the decision making process is and whatever the decision is, as well as your patients to understand why that healthcare decision is the right healthcare decision. And so when we talk about non-compliance, we really have to think about the why behind that. And again, Black Women are not dying because they're Black. It's because of what we do to them. And we have to always remember that race is not a biological condition, it's a social construct. And that social construct is what has, one, makes it hard to comply with care, even if you want to comply with care. I mean, I'm thinking of, I am someone that is in the healthcare system. Like I work in the healthcare system. It is really hard to actually go see a doctor. My son is on a medication for his eczema. That's an injection he gets every two weeks. I have been on the phone with the insurance company every day for at least an hour trying to get, sorry, not the insurance company, with the drug manufacturer, for at least an hour every day for the last two weeks, trying to get whatever they need from me to approve him getting the medication. Who has time to do that? We have built healthcare systems where it is really hard to access care. And if you have any other barriers where, I'm somebody that's well-resourced. If you are not well-resourced, if you work an hourly wage job or you can't take that time off, if you don't have childcare, if you don't have transportation, all those are systems and barriers that make it so much harder to access care.

Christie - 00:07:41:

It's access and it's navigation, right? So you get there and then what? It's overwhelming. Even the physical structures of healthcare. Is your clinic on a bus line? Do you have public transportation in your town? Is that available to people? I've lived without a car before and not in a big city and it was. Constant trying to figure out where do you go? How do I carry groceries home? Maybe not choosing fresh produce because I didn't want to carry it home, right? There are so many pieces that feed into these problems, these systems, these barriers, and I think it can be really overwhelming. And what we're talking about right now is hard. It is hard to hear because you feel like you may not be able to impact it. I'm one person, I'm already working in the system, yep, I see the outcomes. And I think there is a freezing we've talked about earlier. We're gonna talk about that more in our next episode where we talk about getting started and action steps. But I think that it's important to, as we're discussing this really openly and honestly, that we also keep in the center of that, that that's why we need change and we're gonna chip away at it. I think that's what I have to remind myself, that I might not solve all the problems today, but I need to start taking baby steps towards it. So I think part of it is examining the care we provide. Rather than the person we're providing it to. Through a lens of the system.

Veronica - 00:09:02:

Yeah, I 100% agree with that. It's interesting, when I was getting my master's in patient safety and healthcare and quality, I think this is when I really started thinking about the system. One, my degree is from Johns Hopkins Public Health School, and so half of our courses were in quality and safety, the other were in public health. And so one of my
first classes in public health was around racial residential segregation. And so we were asked to take a one-mile radius walk in a neighborhood. Could be the neighborhood you live in, it could be another neighborhood. I chose a neighborhood that was at that time near my boxing gym, a little different than the neighborhood that I live in. And so we were asked to think about when you’re doing this one-mile walk, think about transportation, think about access to food, think about economic stability, like all of these things. And so what I noticed in this one little one-mile radius walk, it was a predominantly Black neighborhood. Average income $40,000 a year. The closest place to get green vegetables or to get vegetables and fruits was a Whole Foods, which is not quite affordable when you’re making $40,000 a year. There was no green space to do anything. There were no crosswalks where it was designated on the street that you could walk safely. The sidewalks were broken, so there's no bike riding. Conveniently around the corner, instead of a grocery store, there was a Raleigh's, there was a Mcdonald's, I think maybe a Burger King. There was a convenience store on the corner. There was a nightclub. I saw an ad for menthol cigarettes. I mean, when you think about that's the environment that a patient comes from. They are behind the eight ball before they walk in the healthcare system. And so again, thinking about compliant or not compliant, think about all of the barriers that patients have to be able to be quote-unquote Compliant with Care.

Christie - 00:11:02:

Yeah, it's a deeper understanding. And I don't think we, frankly, in the healthcare system have time to allow our clinicians to work through some of that. I think that's one of the barriers. When you are meant to be doing nutrition counseling, but you can't ask about food access in a way that is meaningful or sustained. And again, it's back to something I think we've talked about already, which is when we ask, what do we have to offer in case somebody says, yes, I need help with that. I think that's why one of the key concepts in the AIM Bundles is building in resource lists, referral lists. It's not a meaningless task. It empowers us to actually screen people, whether they choose to use the resource or not is completely up to them and sometimes doesn't happen. But at the bare minimum, we need to equip people with tools that we know exist. Sometimes you just don't know what's out there. Along this line, as we're examining the patient's sort of life, really, and the barriers that creates, can we talk about concordance of provider and patient race? So there's a lot out there, I hear a lot, like people do better if their provider is concordant with their race, if they look like them for lack of a more formal term. Thoughts?

Veronica - 00:12:11:

So there is data that shows that, and really is found in when you walk into a room and somebody looks like you, especially we talk about those positions of power, if you're the patient, then you immediately exhale because this is somebody that you feel is going to quote unquote get you, and so or understand you. And so it establishes trust immediately. With that being said, we cannot solve this problem or expect for Black and Brown people and physicians and providers to fix the disparity problem by making only Black and Brown providers or saying that patients only have to see Black and Brown providers. We know from a physician standpoint, only about 6% of physicians identify as Black, 5% is Latino, and then it goes even further down when we’re talking about American Indian and other minority racial and ethnic groups. And so if we say that concordance of race improves the outcome and then if we just hang it on that, what does that say for our patients then? Again, that concordance of race is not just because we look the same, it's because of trust. And so any provider can establish trust with their patient. I, as a Black provider, can relate to my patient that is White and still establish trust, even though we may have different backgrounds. We have made, we, you know, many of my patients and I have different backgrounds and different understandings. And even my Black patients, we, I'm taking care of patients in New Orleans that have never been, a lot of them never been out of New Orleans. I grew up in Mississippi, completely different. So we still have different backgrounds, but we are still able to establish trust. And we remember trust is the foundation of any relationship that includes patient-physician relationships. So yes, there's data that shows that concordance of race does improve outcomes, but that doesn't mean we can't have great outcomes when there's not concordance of race.

Christie - 00:14:10:

Thank you, that's really helpful clarification. Because I think, I mean, I think the focus on that sometimes. Let me first say we absolutely need more physicians from the communities that are most at risk to be served by people who look like them, come from there, understand the real barriers. I think it cuts the learning curve, right? You don't have to do a walkthrough if you grew up in that neighborhood. I think that's incredibly valuable and there should be resources and access. To move people through the education system and support them into that professional. That said, I think the establishment of trust is critical to all equity work. And I think that it is very unfair to expect a certain population of physicians. To carry the weight of the chronic long-term disparities and outcomes, much like I cannot ask one Black person to explain racism to me. It is not their job. It is my job to work on that as a White woman. To educate myself.
And to do better. There are people who graciously offer input and make great resources, some of which we will have attached to this podcast series for folks who want to dig into it. But I would add that we can't put the burden on one. It's not on the patients for all. Non-compliance again making it. Air quote when I say that or non-adherence to our treatment plan. It can't be on the providers. This really is, again, back to the system piece.

Veronica - 00:15:32:

Yeah, no, absolutely it is. And we've got to change the system.

Christie - 00:15:37:

I think one other piece I'd like to highlight, and this may be common knowledge to our listeners, and it may not, but I think it is one of the most startling facts when we talk about disparities in outcomes, and we talk about. Black Women in particular experiencing those disparities. There is a tendency within White centered communities and folks who have that experience to attribute it to socioeconomic status. I need to highlight that underneath that, the data is very clear that even White women with very poor socioeconomic status have markedly better outcomes. Than college-educated Black Women thoughts. Something you'd like to add?

Veronica - 00:16:14:

Yeah, I think that's important to note, because I do think a lot of people think it's poor Black Women that are having these outcomes. For me, it really speaks to what we were talking about earlier, and that's that difference in how we deliver care to Black and Brown women, but in particular to Black Women, because we don't always give the same quality of care because of our biases. And I think that data right there shows it, because when you've adjusted for those socioeconomic factors, and we know socioeconomic factors play a part, but when you've adjusted for that, then you still are having bad outcomes. And again, we know that race is not a biological condition, so there's nothing about me as a Black woman, I'm not biologically any different or predisposed to dying because I'm Black. And so that really speaks to, well, what does the care look like that I'm receiving in the hospital? To me, it's the biggest argument for why we have to do equity work, why we have to measure in a disaggregated way so we can make sure that we are providing the same quality of care to all patients, regardless of race and ethnicity.

Christie - 00:17:25:

It's checking ourselves as a system. I think that when I hear you talk, I like to condense it down while I'm trying to figure out what I'm thinking. You know, the bodies of Black people who give birth aren't broken, it's the system. And so we can work on both, though. Which is the provision of care. Within that system. And I think that's an important focus to keep. I also think it prevents us from placing accountability with the wrong parties. Or with parties that are doing the absolute best they can with what they were given. And that includes, at times, clinicians who are working within a really broken system. I don't know if you have more thoughts to add on ways potentially that health systems, facilities, or individual clinicians can work within those systems in maybe different ways.

Veronica - 00:18:17:

Yeah, that's a tough one. I always go to first, just acknowledgement, just self-awareness. You can't change what you don't know and what you can't measure. So first, understanding that we all have biases and then knowing what your biases are so that you can work so that you're not perpetuating a system in a negative way. But then also thinking about what things that can be done to help address and meet patients where they are. This may sound like a very small, well to me it sounds like a very small change, but it's very impactful. Our patients at one of the hospitals that I work at, they raised that a lot of the patients coming in for their internal medicine appointments were having trouble getting there because they were using the public transportation and that the bus stop was about a mile away from the hospital. And so it was a simple phone call to the city transportation association and saying, hey, we'd like a bus stop in front of the hospital. The city had no problem, put a bus stop in front of the hospital. So there are things that we can do that I think we may not think about because we feel like this is such a big problem and it's such a big system. But there are things that you can do, there are things that you can contribute to. It's the reason I am in public health now. I mean, I'm a clinician as well, but it's also why I'm in public health because there are things that you can do to break the system and can make the system different.
Christie - 00:19:45:

Well, we’re grateful you’re in public health because you’re taking the time to talk about all this with me and I really appreciate it. There are innovative ways. And I think in our next episode, we’re going to talk a little bit about why sometimes we don’t go to the innovative ways. But I think of things I’ve heard of like embedded food pantries at outpatient offices or clinics about different ways to provide folks with access in a non-stigmatizing, supportive and integrated model. I have seen facilities that have, for instance, integrated in or dental or walk-in preventative care. If you can walk in and get a mammogram, you’re probably more likely than trying to wait for three months, catch a bus, you know, you can do it on kind of on demand on your schedule. We like streaming platforms, we like on demand. You can listen to podcasts that way. There’s a lot of shifts and health care doesn’t work that way. You make the appointment, they fit you in where they can. And so I do think patient-centeredness, and anytime we can shift a policy procedure. Even office hours. I mean, I remember, so I was a nurse for a long time at the bedside, and you work 12 hour shifts, or 8 hours in different configurations, and you have days off during the week. And I went and started working for, Medicaid program, and I worked Monday through Friday, 8 to 4:30. And I was like, when do people go to the post office? Like, I literally can’t get to the post office. I’ve been trying to mail a package for three months. And if you’re not partnered and can’t ask someone to run for you, or if you also then are rushing to pick up a child from childcare, or how do people do this? And so small shifts, right? And I think that there are ways that we don’t think of as we’re setting up clinics, outpatient, inpatient. People coming back, do we ask if they have a transportation plan, for instance, someone with severe hypertension? And if they don’t, is there a way to do something remotely? Is there a way to leverage technology so that they have that access? It might not be the most private appointment if you’re doing it over a platform, but it is better than not having eyes on someone who we’re really concerned about, where they can ask or tell you how they’re doing. I think that that’s the safety net, right? And leaning into that, is again back to creating safety. Creating trust. And building. A system that can work for everyone involved. Thank you for tuning into 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 - 00:22:12:

And to learn more about the alliance for innovation on maternal health, visit saferbirth.org. I’m Veronica Gillispie-Bell.

Christie - 00:22:21:

And I’m Christie Allen. And we’ll talk with you next time on AIM for Safer Birth. This podcast is supported by the health resources and services 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 usg government.