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 are talking about getting started with the integration of equity into quality work. We've been talking throughout this season about some of the barriers, some of the levers. We're hoping that we've given some action steps with every single episode and every single podcast, because you shouldn't have to wait till the end for that. But we'd like to talk a little bit about getting started and what the individual can do. I think that listening to all of this, it's heavy stuff. It can be really hard stuff. It's some of its mental shift for some listeners and maybe not for others. Let's talk about that, about sort of the freezing that can happen and how we get ourselves moving in the right direction.

Yeah, I think the first thing is the desire to want to change. Understanding that it's going to be hard. This work is hard. It's not easy to talk about race. It's not easy to talk about a lot of these topics. But it's, the desire to want to change is where you start. And once you've made that decision, that's when you unfreeze. You realize that what you're doing right now is not necessarily what you need to be doing, that something needs to be different. And so that's when you unfreeze what you're currently doing and then start to develop those new processes.

I think that the freezing is such a normal human reaction with the overwhelm. The situation that we describe with inequities and the disparities that result and the things we know about the gaps in the care we can provide people. Are truly overwhelming. And I think that there's also something of a misconception in culture that birth is supposed to be purely a happy event. And so the expectations start out at a really different level. You very rarely go into the hospital for good reason. I remember I was an ICU nurse for more than 10 years. And after I gave birth to my daughter, I worked in the same hospital I gave birth in and I'd never been on the labor and delivery floor prior to that. And after every night when I would go into work in the ICU, I was like, somebody up there is having a baby tonight. This is amazing. Even as a nurse who knew all of the risks and the things. And that's how I ended up working in labor and delivery because it was just mind blowing to me that the healthcare system had the honor of participating in that kind of event. And it truly is an honor. I don't know any provider who doesn't at least have glimmers of that come in front of them on a really regular basis. We talked a little bit in an episode about joy that there should be joy in birthing. That's some of what keeps me going because I believe that that is more common than not and that we need to make it accessible for all people that are giving birth and all families. But I also acknowledge the very real barriers to that happening. And I think, some of it is recognizing. We're using the word recognizing. I think in our culture, we've made a little bit of a joke about the word woke. Woke culture, et cetera. I'm not talking about that, but I will talk about an awakening. I think when you start to see injustice and you start to see more than just the, even the person in front of you, but you start to recognize the systems you work in, it's waking up, but it's waking up in really bright sunlight and it can be a lot. And I think it. It means acknowledging some realities that can be painful. And then sometimes you see too many things and it's a little overwhelming. So let's talk about some practical things. We talked about awareness of our own systems and where we are. We've talked about doing some work yourself to work through your own biases and understanding. And that is not a one and done. That's the rest of your life, but in the best possible way. Let's talk a little bit about maybe providers and maybe different levers they can pull within systems. We've talked about MMRCs, PQC

Yeah, and then even just boots on the ground at your hospital, talking to your quality department at your hospital. I find a lot of times, for whatever reason, this is through our PQC, that the quality department is not necessarily working
with the obstetric unit. And so I think a lot of the principles that we’re talking about carry over to all levels of quality. So internal medicine quality, Ramey and like all of those things that don’t really touch us as much. But talk to your quality department to make sure that they are disaggregating data, that they understand equity and what the goals are, that they are doing their own work so that when they’re looking at the data to understand why we need to do it in a disaggregated way, thinking about how you are going to partner again with your registration individuals that do registration to work on self identity and race. But there are a lot of things that you can do boots on the ground in just your hospital, thinking about what the environment looks like in your hospital. And I say this because I was on a call with somebody, I’m not going to say where the hospital was. But the person was talking and I completely did not hear a thing the person said because all I saw in the background was this picture of a plantation. So things like that that are in the environment, those are systems that are physical that also lead to inequities and they do not help your culture of trying to be more inclusive. So again, boots on the ground, there are things that you can do in your own hospital.

Christie - 00:05:38:

Well, I think looking for what's there that might not be appropriate as you discuss. There's also what's missing. I have the experience of visiting a facility and noticing that all of the pictures on the walls, beautiful pictures depicting families, typically mothers with babies, were white women. This hospital predominantly served black and brown people. It's an oversight. We purchased the art, we put up the art, the art's beautiful. All of that can be true and it cannot be representative of the people walking through the doors. It's an automatic othering. And so, I think being cognizant of that is super helpful, not making assumptions, but trying to improve the space. Day-to-day pieces that are really meaningful. I talked a little in another episode about body positioning when you talk to people. We talked about the words we use. Words are important. And we all have catchphrases. I think that we repeat to patients. Like, and some of it, I started to examine some of mine. And just because I feel this is a day-to-day event, I need to remember that this could be terrifying to someone, that this could be disempowering, this could be triggering to people with trauma. There are pieces I can't anticipate, so making sure that I stay on the moment and don't rattled off my usual spiel, which is hard to do when you are short on time and you are busy. And then I also think ultimately trying to lean into that quality improvement culture, if you are engaging in huddles and debriefs. You should be, they're very important and they help improve care. Even a brief debrief after something happens. And not only when bad things happen, when something goes really well, but raising, you know, what went well, what could we have done better? Pretty typical. But were there any equity considerations or ways you think I could have provided more equitable care? If that's something you wanna do, ask people. It's probably gonna confuse people the first time you ask or the first couple of times you ask, but it opens a door for conversation.

Veronica - 00:07:32:

Yeah, I think that's really important. We in our PQC call it an equity pause, where we encourage our teams during their debriefs, just as you've said, to do an equity pause. And were there ways that we could have acted in a way that was more respectful? Also making sure when you're doing that debrief, that it's not just the doctor and the nurse or maybe the anesthesiologist, but the patient is part of the team and having the patient as part of that debrief as well.

Christie - 00:08:01:

That's a culture shift.

Veronica - 00:08:03:

Definitely a culture shift.

Christie - 00:08:04:

That's a culture shift. It's a worthwhile one, but it's a culture shift. I think what you're speaking to, to some extent, that I also feel is critical and something that we say. I think for us it's becoming a really automatic thing to say, but we can't underestimate or overestimate the importance, which is calling people in and not calling people out. When we talk about things like this, there's automatic defensiveness. I have it all acknowledged upfront. I try to do good work. I'm doing the best I can. I've made all these changes. I still have a long way to go. It's a lifetime sort of journey process learning. And I think that it's really important. Our job is not to catch people doing wrong. Admittedly, just like in quality
improvement and a patient safety culture, if you see something overtly wrong, you need to stop the line. There, you
know, a wrong medication dose, you're gonna say, stop, I'm uncomfortable. I think that's an incorrect dose. You're
gonna be very direct. But there are other ways to communicate about this. You know, after the code, you weren't
speaking up very loudly. I couldn't hear your order well. Next time, do you think you could speak up a little bit? There's
different ways we adjust feedback. And I think calling people in, this is not a gotcha. This is not trying to hunt people
down. This is trying to globally improve equity, to fully improve quality, and to make sure that the two are totally
interwoven and we can't do that without people hearing. Sometimes they'll take it. Sometimes you'll offer feedback
and people don't take it right away and you don't notice anything. And then six months later, they may circle back. It
takes time.

Veronica - 00:09:33:

It does. And as we've mentioned before, this is not finger pointing. This is about breaking a system. Understanding
that we have systems that have created these inequities, systems that have created our biases and undoing those
systems.

Christie - 00:09:48:

Absolutely. We also early on in the podcast talked about acknowledging our identities. One thing I wanted to highlight
is I think your identities can shift over time. To some extent, I think people evolve and change. But I also want to offer
that as identities change, there are core pieces. I think of when we first started working with patient experts and
patients with lived experience, often I was asked to serve as a patient with lived experience on a hospital family
advisory group. Do I have the lived experience? Yes. Am I fully inculturated into the medical system to the point
where I'm not probably the best representative of the system? Also, yes. So I think continuing to acknowledge your
identity in new contexts as you move through learning and process is also really important. As much as I want to
inform the process, because I like to improve all the processes, it's kind of my personality. It's why I do what I do.
That's not my job. My job is to sit down and help identify patients and really amplify their voices. That's also true as a
white woman.

Veronica - 00:10:44:

I think that's important. I mentioned in a previous episode that we've worked with our hospital teams, with the PQC.
To develop patient partners so that each PQC team has a patient partner as part of the improvement team for at least
one of the initiatives. And we have had teams who in that very same situation say, well, we have a nurse that works
here that was a patient that wants to be the patient partner, and you have to understand what your lens is. And if you
are a nurse at that hospital, you have a bias, good or bad, but you have a bias. And so thinking about what the intent
of the patient partner is, I think that helps to determine who should be at that table and who that patient partner
should be.

Christie - 00:11:28:

I think also, as you say that, I'm thinking about different ways we partner with people. And I think we sometimes
partner with people during drills and simulations to tie it back to quality. We've talked about trust. And I think that there
is a different level of trust when you are a healthcare provider, sometimes positive, sometimes negative. But when
you know your colleagues, I think about doing drills and simulations and like when the nurse is playing the patient and
we're all laughing and it's, that's real different than when you have someone you don't know there who feels
vulnerable. There's a power dynamic, they're scared. You do your simulation a little bit differently when you don't
know that person, for better or worse.

Veronica - 00:12:26:

And I think that the work of working with patients with lived experience and helping them to be comfortable in the
space is important, but it's also important that maybe we don't know them that well, that we build that partnership
because they can speak more to the trust issues, to what establishes that and what would have made them more
comfortable with their own lived experience. And I think a lot of hospitals get very hesitant to, quote unquote, air their
dirty laundry in front of a patient. But the truth is, you already did. The patient's been there. So the patient knows. So
we don't do so good at hiding our dirt under the rug like we think we do. And so it behooves you to call that patient in and have that patient be a part of your experience and part of your improvement for change.

Christie - 00:12:55:

I think the airing of the dirty laundry, for better or worse, brings me to another topic, which is data transparency. I have seen, in the course of my career, a real shift in quality work. Where it was. We don't want anyone to know we're working on that. We didn't talk about process improvement. The nurses knew we were doing a QI project, but it was like a secret. And patients, families would never know that. Patients, there's something of a shift in that where people are proud to be engaged in this work because the secrets aren't a secret anymore. We talk about it's in the New York Times, it's in the Washington Post. It's in your local newspaper. It's in social media. People are posting TikToks from your delivery rooms. There are not the secrets. We don't have the doors closed like we once did. I see that as a benefit in the position that I'm in right now, because I believe quality should be in every person. Every staff member, every team member, every patient activity. I love it when patients know why we're doing what we're doing and why it might look different than they expected. That's part of my role as a nurse is to explain that and to interpret that for the patient. But I think that data transparency is the next frontier in that. And I think folks really struggle with that.

Veronica - 00:14:05:

100% they do. I think there is a concern for litigation on the hospital side, the provider side. There's a concern of, well, how is this going to impact my evaluation scores, whether that be CG-CAHPS or HCAHPS or any of the ones that you can find online where you can score your doctor. I think there's a concern about that. But more and more reporting agencies are making the data transparent. It's where we are moving. I'm actually in favor of it as well. The more we can make the data transparent, the more we can, one, know how you compare to other places, other facilities on certain measures. It's how we learn from each other. If this hospital over here is doing it well and I'm not, let me figure out what they're doing, how can we collaborate. It creates a little competition so that we do try to rise above. If you're not compared to anybody else, if you only know how you're doing and don't know how you're doing compared to someone else, you may think you're blowing it out of the water when actually you're not. So there's a lot of benefit to that data transparency. I think we do have to do some work around litigation and some things around that. Data is never meant to be punitive. Those of us that do quality improvement know that and understand that, but that doesn't mean that other people that have access to the data won't use it in a punitive way. And so we have to address that as well.

Christie - 00:15:38:

A couple of thoughts around that. I think that the data transparency is complicated when it lacks context. We've talked about contextualizing data and the importance of that and why we need experts to contextualize it. I would also offer that the context with QI data is it is not the data people think it is. This is not research data. We are not gonna have full validity and it's not gonna be completely accurate at all times. And it needs to be accurate enough that we can trend, that we can compare benchmarking with what you're describing to against like. And that we are comparing to similar. I think there are very real things when we publish C-section rates and TSV rates, and it's without context. If you work at a large hospital that handles higher risk, making air quotes again, patients, but patients that need a higher level of care, your C-section rate absolutely should be higher. That is appropriate. So comparing like to like is important, and it's another reason for the transparency. In clinical practice, in a setting I was in, there's critical glucose measurement. And when you get that, you have to document it a really specific way. It's a requirement. And I thought I did a good job of it. And then one day, the nurse educator published with names the full list. In our break room, of all the nurses in our percentage of doing it correctly, oh, it was uncomfortable. I did not like it, and I was not doing it well, and I never missed it again. Some of us are inherently a little competitive. I want to compete with myself. I want my percentage month over month to be better and more accurate. It was a little bit of incentive, too. So I'm not saying we are seeking to make clinicians uncomfortable, and I understand that there is mis-contextualization of the data. Well, that doctor's not doing well. It's a little like a doctor who chooses to do a certain kind of surgery and takes higher risk patients. And their outcomes are gonna look a little different, those patients still need care and they need expert care, but we have to look at it within that context. I think that's important for QI professionals to remember and a hospital administration and evaluators as well.

Veronica - 00:17:41:
Yeah, and I think the way we look at data transparency can be different. Just as an example, we have been working on our NTSV C-section rate for our state for the last year, a little over a year now through our PQC. One of the things that we have advocated for, and I've seen it work at where I practice, is giving the providers their report card. And we do show the data. We de-identify it so you don't know which provider has which C-section score, but it creates this competition. Now, the whole group may not know which provider is which one, but each provider knows who they are. So they know if they are, again, they think they're doing so great, and then they look at this and they're like, actually I'm not. We have found that to be very, very effective for getting that buy-in for the quality improvement. So transparency can happen in a lot of different ways. It doesn't always have to be national transparency. It doesn't have to always be hospital-level transparency. It may be transparency on a department level, and it may be de-identified. But regardless, having that data so that other people can see creates that competition and it really helps move the work forward.

Christie - 00:18:54:

Yeah, I think the other push I would make is if a hospital is going to report the NTSV rates of the physicians who are performing them. I think consider letting nurses know what their NTSS rate is. Labor support is so incredibly critical. Nurses do play a role in prevention of primary cesarean. A really important role. They're part of the team. And I think that I would want to know that as a nurse at the bedside and there are hospitals doing it really effectively. It's not a performance measure. It's a QI measure. It's a benchmarking. It lets you know what you're doing. And it isn't saying that that nurse is the reason this cesarean happened. It just contextualizes it a little and it gives that nurse something to be aware of as they're thinking about how to support their patient and how to involve with the care and how to involve physicians or other folks that are providing care when necessary.

Veronica - 00:19:45:

Yes, and we've had some hospital teams, to your point, to do that, to look at their C-section rate by the nurse caring for the patient, and it has helped to move the needle, especially those hospitals that don't have the provider in-house. Ooh, the way that you call and give that message to the doctor. That can make or break that patient, the decision about whether or not a C-section is needed for that patient. Of course, what we hope to be happening is that there's shared decision-making between the patient, the nurse, and the provider, but nurses have a significant role to play in that C-section rate.

Christie - 00:20:23:

I think if we're gonna talk about quality, we talk about it with teams. That's a core, fundamental part of it, and the teams, we've discussed this already, is broader than you probably think of. We've talked about staff that does a registration process for patients. We've talked about, you know, there's blood bank. There's people that we didn't use to immediately think of, and we recognize the need for that integration, I think bringing folks to the table. And not making it purely the role of the physician to improve quality is incredibly critical. Nurses are educated people who wanna do better. I am speaking as a nurse. I am deeply engaged in quality and I was at the bedside too. I just didn't have all the tools and didn't get the feedback and honestly didn't get to sit in the quality meetings. To hear about it. So the more you can engage the broader team as a shared responsibility. I think of that with clinical champions. I have seen QI projects rise and fall on who your unit administrator or secretary is. The unit secretary who slaps the paper down, you need to fill out front of you, goes, can't do this until you do this part. And then we have better data about VBAC or TOLAC or about Cesarean or about, because they're gatekeepers and they can hold that line. There are people you need to engage as champions that you may not even be thinking of.

Veronica - 00:21:33:

Absolutely, I've always appreciated this very early in my career of doing quality improvement. I always had a nursing dyad. I will as a nurse, when we're trying to do quality improvement and trying to change different processes and ways we do things, the nurse can't tell the doctor, well, you need to do this now because this is how we're doing with quality improvement. Quite frankly, we're too arrogant. We're not going to take it from a nurse. Me as a doctor, yes, I can tell the nurse you need to do this because we're doing quality improvement. But there's no engagement. One, it's not fair for me to do that because I don't know what the workflow is for the nurse. And two, the nurse is gonna do it because I am the doctor, but begrudgingly she'll do it and not, she or he will do it and not do it well. You have to have, for your quality leaders, you have to have a quality nurse, you have to have a quality physician working together. To be able to move the work forward. And as you mentioned, depending on what work you're doing, you may need also
a quality anesthesiologist is helping with that. It's beyond just one or two people and it's also beyond just one discipline. We have to understand that medicine and obstetrics is a team sport, and we have to have all the members of the team.

Christie - 00:22:48:

Incredibly important. You can't argue with it. It just doesn't work without it in my experience and in the data, candidly. I think another component to think about is how we're leveraging systems or structures already in place. And I'm thinking of. These are pretty specific to hospital quality improvement by root cause analysis and peer review. What I see happen more often than not with that across the country at many different health systems is something like a root cause analysis is done and we identify needs. And that's it. We identified the needs, and then maybe you see a later root cause analysis that identifies the same needs, and we might have been able to prevent that. I think similar can happen in peer review. Peer review is an incredibly valuable tool and should be. There should be a set list of things that trigger that review. We should all be very clear on what that is, that it's non-punitive, that it is looking at the lens of how we provide care. But I think it's often very closed doors. And to your point about litigation and policy sometimes hasn't caught up with the QI process. But the findings, non-clinician findings, don't always get relayed to quality. Quality doesn't always have a seat at that table or whoever your implementers are. Maybe your nurse manager is your quality person for OB because you're working in a hospital without a quality department. So with that in mind, having action steps, and we talk about in healthcare a lot about closed loop communication. We love closed loop communication. It means that you close the loop, you finish up. You don't just throw the idea into the atmosphere and hope somebody heard you and is gonna do it. I think we need closed loop communication for team members, all of the team members, when we know something bad happened, or we know an undesired outcome occurred, or we know a near miss occurred. If we can catch it at a near miss, beautiful, right? So the idea would be then that these are the things that come from that. I think so often the cases that influence the QI project we're doing are disconnected in people's minds. We don't tie it back. So now I need to do this new thing. Instead of we're doing this new thing because it could prevent this thing. And I think that that's incredibly important.

Veronica - 00:24:54:

Extremely. And I mentioned in an earlier episode that when I started doing quality improvement, I was very clear this is not Veronica's project.

Christie - 00:25:04:

Please.

Veronica - 00:25:04:

Not Veronica's project. That we were doing this because our data showed X, Y, and Z. And that was the why. And I think anytime you're doing quality improvement, you always need a strong why and you need to be able to communicate that why very effectively. And you need to continue to go back to the why.

Christie - 00:25:23:

And the Y might be different for different members of the team, right? It could improve multiple pieces, you know, I think about, I've seen a facility struggling with scheduling TOLACs, a trial of labor after cesarean. And we want that person to have a successful vaginal birth after cesarean if that is the plan and what they want. So we want them to have the right support. The problem was they were being scheduled for induction. On the same time when their anesthesia staff was not in the building, but were required to be in the building if the person was gonna TOLAC. Obviously, as I described that, easy fix, let's just schedule them when they're gonna be in the building. But the system had broken down to the point where I think anesthesia was having their free time carved into and was exhausted. OB was frustrated because they wanted people to be able to have VBAC with adequate support. It just took someone outside being like, hi, you know what you could do? We lose the thread because we don't close the loop or we don't bring the right people in. And I can promise you that a QI project and process improvement in that was gonna make everyone happier, but they're different whys. The staff that are providing direct care to the patient in that moment might have very different intention. They're all valid. But sometimes we have to find multiple whys. I feel sometimes I
call it razzle dazzle jokingly, but sometimes we do a little marketing with QI and change management of like, this is how it's gonna benefit you. That's not wrong. That's what human brains need to change.

Veronica - 00:26:43:

Absolutely. Everybody is like you said, the human brain, what is in it for me. And I think this applies to quality, applies to when we're doing equity work. I think sometimes that why has to be very strong and the what is in it for me has to be very strong because sometimes when we're doing equity work, of course we're trying to make sure that everybody is getting equitable care. We have marginalized communities that we know are not. And depending on who your audience is that you're trying to inspire for this, why they may not identify with that group. Again, as you pointed out, I think it's really important to understand and to communicate the why for each individual person that's going to be doing the quality improvement.

Christie - 00:27:30:

And I think being willing to be flexible in that space. Like I can want the overall outcome, but like what's the lever, right? And it's not a bad thing. I think what you're describing is just incredibly human. It's buy-in, it's all the things we talk about have buzzwords for, but it really comes down to the why. So thank you for joining me in these conversations about equity and quality.

Veronica - 00:27:51:

Thank you for having me.

Christie - 00:27:58:

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 - 00:28:06:

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

Christie - 00:28:14:

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

Outro - 00:28:39:

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